Wisconsin Public Psychiatry Network Teleconference (WPPNT)

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WPPNT Reminders

How to join the Zoom webinar

- **Online:** https://dhswi.zoomgov.com/j/1606358142
- **Phone:** 669-254-5252
- Enter the Webinar ID: 160 635 8142#.
  - Press # again to join. (There is no participant ID)

Reminders for participants

- Join online or by phone by 11 a.m. Central and wait for the host to start the webinar. Your camera and audio/microphone are disabled.
- The evaluation survey opens at 11:59 a.m. the day of the presentation. A link to the evaluation survey is posted when the materials are posted.
- Ask questions to the presenter(s) in the Zoom Q&A window. Each presenter will decide when to address questions. People who join by phone cannot ask questions.
- Use Zoom chat to communicate with the WPPNT coordinator or to share information related to the presentation.

- Participate live to earn continuing education hours (CEHs). Complete the evaluation survey within two weeks of the live presentation and confirmation of your CEH will be returned by email.
- A link to the video recording of the presentation is posted within four business days of the presentation.
- Presentation materials, evaluations, and video recordings are on the WPPNT webpage: https://www.dhs.wisconsin.gov/wppnt/2025.htm

Supportive Conversations and Counseling for Those with Terminal Illness

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Objectives

- Identify the effect of life limiting illness on emotional and psychological well being.
- List the barriers to care that those with mental illness may experience with life-limiting disease.
- Review common phases of grief
- Systematic ways to screen for distress
- Consider words to avoid
- Address requests to hasten death or SI
- Ethical considerations

“It is seldom easy to talk to those who are not well, but it is far harder when both you & they know that recovery is not possible. What does one say that has any kind of honesty, and yet does not carry with it the breath of despair?”

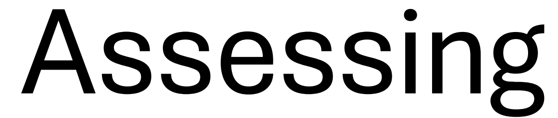
Ann Perry (2013) Mystery Author *“Dorchester Terrace”*

Goals

- Assist the patient to maintain a sense of personal integrity, dignity, hope, meaning and purpose in the face of disease and impending death.
- Help them to adjust to the diagnosis, treatment and impending death.
- Be present for the patient as a safe person that they can confide in and assist them in identifying their life values and goals of medical care.
- Recognize and cope with your own distress and grief.
- Reflect on what did not go well. (John)

Response to diagnosis

- Shock and disbelief
- Anxiety, fear, depression
- Mistrust (initial symptoms misdiagnosed)
- Guilt (ignored symptoms or blame life-style)
- Hopelessness
- Anger
- Blame
- No response if they do not understand the prognosis
- Relief



Assessing

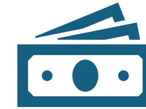
- Patient past medical and mental health history may or may not be relevant.
- Personality traits
- Past coping style likely to continue
- What is their understanding of Dx and Rx?
- Prognosis?
- What is the above based on (loved one died cancer)
- Practical vs emotional support

Individual Variables
John

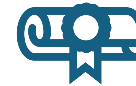
Medical literacy.
Perception of type and stage of illness.

Co-morbid medical dx

Relationship and trust with medical / nursing team



Social variables: finances, housing, transportation



Amount of "available" practical, social & emotional support

Age

Cognitive functioning

Psychiatric diagnosis and treatment (side-effect and efficacy of med's)

Psychiatric Morbidity on Medical Staff Perception

- Less resiliency, may respond with self-defeating, isolating, alienation. Misperception of team.
- May appear demanding, aggrandizing, chaotic, dramatic, odd, angry, threatening or uncaring.
- Staff may feel frustrated, angry or impatient.
- May not understand how difficult medical care for patients who are anxious, insecure, depressed…..
- Uncomfortable or little experience with MI

Personality

- **<u>Character Rigidity</u>**: A limited ability to think about oneself & others in varied ways & holding a set repertoire of behaviors. (presenting feature of personality disorder). When routine is disrupted for medical care, it may become very stressful for anxious or insecure personalities. Close contact may cause avoidance to protect their emotional vulnerability. Avoid labeling and identify their fears with care.

Personality Disorders

Diagnosis

- <u>Paranoid:</u>
- <u>Schizoid & Schizotypal</u>

Interventions

- Seek out their understanding. Take time to explain problem & reason for Rx. Repeat and reassure.
- Less need for connection, less skill in related to others. Educate staff on their restricted range, unusual behaviors, straightforward info, no humor, avoid over stimulation.

Personality

Diagnosis

<u>Antisocial:</u>

Intervention

- Educate staff to anticipate splitting, open discussion between staff to share information. Reinforce plan who will do what, consistent response to complaints, threats and demands.

Personality

Diagnosis

- Borderline

Intervention

- Help-seeking behavior.
- Look for bargaining, seduction, manipulation & unrealistic expectations.
- Staff stick with role and task.
- Encourage staff discuss their emotional responses in a professional way.

Personality

Diagnosis	**Intervention**
• Histrionic:	• Avoid over medicating • Look for splitting and attraction
• Narcissistic:	• Avoid feeling special or worthless.
• Avoidant:	• Explain vulnerability & aversion to staff. Tend to their needs gentle.

Personality

Diagnosis

- <u>Dependent:</u>

- <u>Obsessive-Compulsive:</u>

Intervention

- Describe & explain procedures, give options, encourage decision making.
- They may appear “perfect” “compliant” and staff may feel they are being watched closely or judged.

Schizophrenia

- Reduced life span by 15 years. Unhealthy lifestyle leads to illness.
- May have cognitive impairment in attention & executive systems.
- Maladaptive denial of disease even with obvious/grotesque signs.
- Satisfaction with health information is low. Less likely to have or obtain primary or medical care.
- Unusual pain insensitivity may lead to delayed dx.
- Decision capacity when patient refuses treatment.
- Few have POAHC
- Differentiate delirium from worsening psychosis

Substance Use Disorder

- Creates additional obstacle for treatment and pain management
- Important for medical team to know this history
- Avoid stigmatizing: Better words :nonmedical opioid use" SUD"
- Pain is as high as 75% in those with advanced cancer
- Pseudo-addictions: Misinterprets behavior from undertreatment of pain as drug seeking. (Bob MVA chronic pain, lung ca met to bones)
- Tolerance Need of increase dose to maintain effects
- In recovery: At risk for relapse
- Risk of death if taking substance with prescribed meds.

Grief Theories

- Bowlby's: Insecure attachment greater difficulty with loss and greater risk for severe grief reactions. (BPD, PTSD)
- CBT: Personality and mental health affects the ability to cope with grief. Maladaptive cognitions & behaviors contribute to serious grief reactions.
- Sociological & Cultural: Understanding the language and practices of people
- Anticipatory Grief: normal sometimes dysfunctional
- Kubler Ross: Denial, Anger, Bargaining, Depression & Acceptance
- Moral distress

Barriers to care to those with MI

- Consider barriers to medical care in general
- Limited support from family or friends
- Understanding medical treatment
- Getting medications and taking as prescribed

- Continue to use previous scales. Ask if scale reflects their status.
- Differentiate between depression, anxiety, grief and distress.
- Add specific tools for detecting emotional distress.
- **Distress**: Psychosocial Adjustment to Illness scale PAIS, BSI-18, Distress thermometer, Emotional Thermometer, Profile of Mood States
- **Anxiety**: Beck Anxiety Inventory, Hospital Anxiety & Depression Scale (HADS), Impact of Events Scale
- **Depression**: Beck Depression Inventory, HADS. Patient Health Quest (PHQ-9) Zung Self-rating Depression Scale

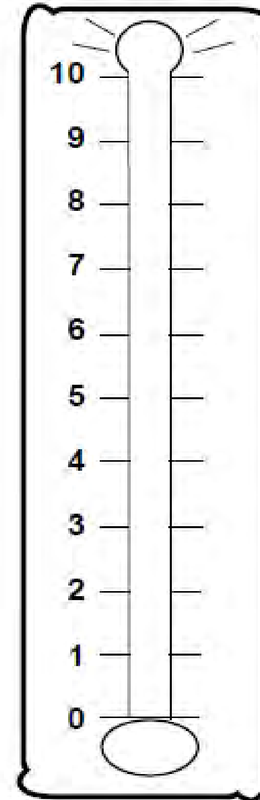
NCCN Distress Thermometer

NCCN DISTRESS THERMOMETER

Distress is an unpleasant experience of a mental, physical, social, or spiritual nature. It can affect the way you think, feel, or act. Distress may make it harder to cope with having cancer, its symptoms, or its treatment.

Instructions: Please circle the number (0–10) that best describes how much distress you have been experiencing in the past week, including today.

Extreme distress



No distress

PROBLEM LIST

Have you had concerns about any of the items below in the past week, including today? (Mark all that apply)

Physical Concerns

- ❑ Pain
- ❑ Sleep
- ❑ Fatigue
- ❑ Tobacco use
- ❑ Substance use
- ❑ Memory or concentration
- ❑ Sexual health
- ❑ Changes in eating
- ❑ Loss or change of physical abilities

Emotional Concerns

- ❑ Worry or anxiety
- ❑ Sadness or depression
- ❑ Loss of interest or enjoyment
- ❑ Grief or loss
- ❑ Fear
- ❑ Loneliness
- ❑ Anger
- ❑ Changes in appearance
- ❑ Feelings of worthlessness or being a burden

Social Concerns

- ❑ Relationship with spouse or partner
- ❑ Relationship with children
- ❑ Relationship with family members
- ❑ Relationship with friends or coworkers
- ❑ Communication with health care team
- ❑ Ability to have children
- ❑ Prejudice or discrimination

Practical Concerns

- ❑ Taking care of myself
- ❑ Taking care of others
- ❑ Safety
- ❑ Work
- ❑ School
- ❑ Housing/Utilities
- ❑ Finances
- ❑ Insurance
- ❑ Transportation
- ❑ Child care
- ❑ Having enough food
- ❑ Access to medicine
- ❑ Treatment decisions

Spiritual or Religious Concerns

- ❑ Sense of meaning or purpose
- ❑ Changes in faith or beliefs
- ❑ Death, dying, or afterlife
- ❑ Conflict between beliefs and cancer treatments
- ❑ Relationship with the sacred
- ❑ Ritual or dietary needs

Other Concerns:

____

____

____

- **Words** can cause fear or disempower (cancer, bleeding, radiation, chemo, nothing more we can do, not operable, hospice.....)
- Is there **decision making**?
- What are their **values and preferences**?
- **C.L.E.A.R** (connect, listen, empathize, align & respect) (Awdish, RL et al 2017
- **Barriers**: Lack of time, who's responsibility is it to give information to patient, sorting out what is their understanding of what they have been told, your experience with those with same disease as your patient. Your own denial or grief.

Words to Avoid

- I know how you feel
- It is in God’s plan/will
- “You should get a second opinion” instead ask what is their sense of trust and understanding
- There is nothing else that they can do
- Why did you wait so long to get medical care/how long did you have those symptoms
- Agree with blaming or being mis-diagnosed.
- Fight this battle vs we will face this difficulty together
- Withdraw care vs transition care to pain/symptom management

Suicidal Ideation or Desire to Hasten Death

- My mentor Dr. Heiland, the patient Sweet William & then my research
- Distress associated with cancer or other illness may lead to SI or DHD
- Cancer patients have a higher rate of suicide
- Identifying distress allows for interventions to decrease suicide & suffering
- Suicide not routinely assessed in medical clinics: not trained, screening tools do not include SI, no MH available, lack of time, don't want to give wrong impression by asking, not their responsibility, its the right of all patients

Ethical Issues

- Distress should be assessed, documented & treated
- Interdisciplinary systems must support this as a priority
- Staff should be educated and available
- We are obligated to prevent suicide and intervene including detaining and restraining.
- Detaining offers opportunity to treat the suffering.
- Advance directive is not binding in suicide attempt
- PAS legal issues. Can one make a rational decision when depressed, in pain or feel they are a burden?

Ethics

APA Neutral on PAS

APA psychiatry: “psychiatrist should not prescribe or administer intervention to a non-terminal ill patient for purpose of causing death.

ANA: RN’s prohibited from acting with sole intent of ending a patient’s life

ONS & HPCNA: No support for legalizing PAS, RN’s to decide on their moral & ethical belief

Ethics

- Moral obligation to address pain, other symptoms & suffering
- Spiritual care: Hope, dignity & reconciliation
- Truth-telling
- Informed consent
- Decision Making Capacity
- Advanced Care Planning & Surrogate decision makers
- With holding, withdrawing life-sustaining treatments
- Artificial nutrition & Hydration
- Responding to requests for futile or inappropriate care
- Palliative sedation

Thank You for Your work!

Do you know there is a halfway world between each ending & each new beginning? It’s called the hurting time. It’s a fog, it is where your dreams & worries & forgotten plans gather. Our stops are heavy during that time. Don’t underestimate the transition between farewell & new departure. Some thresholds are too wide to be taken in one stride….. Author unknown (from historical fiction)

References

- Adwish, RL, Buick D, Kolas M. et al.   A communications bundle to improve satisfaction for critically ill patients and their families a prospective cohort pilot study. Pain Symptom Management. 2017 53(3):644-649