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Acute Care
Physical Therapy

Guest Editor: Sharon Gorman, PT, DPTSc, GCS

Continued

Physical Therapy Virtual Conference

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             John Corsino, PT, DPT
Management of Psychiatric Comorbidities for the Acute Care PT

Emily Fleischman, PT, DPT, GCS

Learning Outcomes

After this course, participants will be able to:

- Describe key features of at least three psychiatric comorbidities common in the acute care setting.
- Outline the way in which acute medical issues interact with at least three psychiatric comorbidities.
- Identify at least three ways in which acute care physical therapists are uniquely positioned to be effective with patients with psychiatric co-morbidities.
- Describe at least two strategies to effectively implement motivational interviewing and handling disruptive symptoms.
Course Overview

- Introduction to psychiatric comorbidities
- Psychiatric diagnoses
- Medical diagnoses in relationship with psychiatric diagnoses
- PT’s role
- Communication tools
- Case studies

Definitions

- Psychiatry - branch of medicine dealing with mental illness
- Comorbidity - presence of two or more diagnoses
- Acute Care - practice in a skilled nursing facility, acute rehab unit, acute inpatient hospital; will not be including inpatient psychiatric unit
Psychiatric History\(^1\)

- BCE 460-370: Hippocrates
- 1672: Thomas Willis writes *De Anima Brutorum*
- 1808: Johann Christian Reil coins term psychiatry
- 1919: International Psychoanalytical Association founded by Sigmund Freud
- 1948: John Cade develops lithium carbonate
- 1952: DSM: first edition released
- 1988: Prozac, first SSRI, released

Demographics\(^2,3\)

- Inpatient: 40% incidence of psychiatric comorbidity
  - General population: 18.9%
- Presence of a psychiatric comorbidity increases length of stay, medical costs, and rehospitalization
Legalese

- Involuntary hold
  - Danger to self
  - Danger to others
  - Grave disability
- Involuntary commitment
- Conservatorship
  - Temporary and permanent

Psychiatric Diagnoses

- Anxiety
- Depression
- Bipolar Disorder
- Borderline Personality Disorder
- Delirium
- Functional Motor Disorder
Anxiety

- Most prevalent in any age category
- Highly comorbid with other disorders
- Common anxiety disorders
  - Specific Phobia
  - Social Anxiety Disorder
  - Panic Disorder
  - Generalized Anxiety Disorder (GAD)

Depression

- Major Depressive Disorder (MDD)
  - Lifetime prevalence of ~20%
  - Specifiers
- Treatment options for treatment-resistant depression
  - Ketamine
  - ECT
  - Exercise
Bipolar Disorder

- Mood episodes
- Bipolar I
  - At least 1 manic episode
  - Not required depressive episode for diagnosis
- Bipolar II
  - At least 1 hypomanic episode
  - At least 1 major depressive episode
  - No manic episode
- Change with DSM-5 organization

Delirium

- Neuropsychiatric syndrome, involves a generalized disturbance of brain function that occurs in the context of physical illness
- Disturbance in 3 domains
  - Cognitive
  - Circadian
  - Higher-order thinking
- Hypoactive versus hyperactive
Borderline Personality Disorder\textsuperscript{5,9}

- Characterized by distressing disturbances in self-image, impulsivity, problems with emotional regulation, and pervasive problems with interpersonal relationships
- Key considerations for the clinician-patient relationship
  - Collaboration
  - Knowing yourself
  - Maintaining boundaries
  - Responsibility
  - Time and consistency

Functional Movement Disorder\textsuperscript{10}

- Many different names
- Symptoms of weakness, paralysis, tremor, and dystonia that do not have another identifiable cause
  - Diagnosis of exclusion?
- Prognosis
Medical Diagnoses

- Cardiac Disease
- Lung Disease
- Cancer
- Neurological Disorders
- Kidney Disease
- Liver Disease

Cardiac Disease\textsuperscript{4, 11, 12}

- Close relationship between heart disease and anxiety/depression
  - ACS: 50% demonstrate anxiety
    - 25% patients with same level of anxiety as those admitted to an inpatient psychiatric unit
- PTSD
  - 8-16% post CABG or MI
  - Device shock
Cardiac Disease $^{4, 11, 12}$

- Depression
  - Independent risk factor for cardiac disease
    - SADHART study
  - INTERHEART Study
    - Attributable risk in the development of MI
    - Psychological risk factors accounted for 32.5% of attributable risk
  - Heart and Soul Study

Lung Disease $^{4, 15}$

- COPD
  - 4th leading cause of death in the US
  - Significant risk factor for psychiatric symptoms
    - Depression, anxiety, schizophrenia
- Post Transplant
  - Immuno-compromised
    - Balance between rejection and infection
    - Immunosuppressive agents and psychiatric side effects
  - High rate of dysfunctional breathing patterns
Cancer 4, 17

- Increased risk of psychiatric comorbidity starting from leadup to diagnosis through treatment and recovery
  - Depression, anxiety, substance abuse, somatoform/conversion disorder, and stress reaction/adjustment disorder
  - Psychological stress of condition plus effect of biochemical substances associated with cancer increasing rate of depression

Neurological Disorders 4, 14, 15

- Stroke
  - Post-stroke depression
  - Disinhibition syndromes
- Epilepsy
  - Psychiatric complications of antiepileptic drugs
  - Psychotropic medications
Kidney Disease\textsuperscript{4,18}

- Dialysis
  - Hemodialysis
  - Peritoneal dialysis
- Delirium
  - Electrolyte imbalance
- Depression
  - Most common psychiatric complication
- Challenges in receiving psychiatric care
  - Self denial

Liver Disease\textsuperscript{4}

- Chicken and the egg
  - High rate of liver disease among patients with psychiatric disorders
  - Liver disease creates neuropsychiatric symptoms
- Neuropsychiatric symptoms
  - Cognitive impairment
  - Fatigue
  - Depression and anxiety
- Hepatic encephalopathy
Physical Therapy’s Role

- Activity’s effect
- Mindful movement practice
- Functional movement disorder
- Refer, refer, refer!

Activity’s Effect$^{4,7}$

- Exercise has been found to be an excellent component of successful treatment of depression
  - Treatment resistant depression
    - Particularly beneficial later in life
- Circular problem
  - Exercise benefits patients with depression and anxiety, however patients with depression and anxiety often find it hard to consistently exercise
Activity’s Effect\textsuperscript{4,7}

- Cardiac rehab
  - Depressed patients that completed the cardiac rehab program had a 73% lower mortality rate than those who dropped out
- PT’s role as exercise experts that can guide the patients through a structured program is vital

Mindful Movement Practice\textsuperscript{19}

- Basic Mindfulness
  - Paying attention, on purpose, moment-by-moment without judgement
  - Typically stationary
    - For a patient that is highly anxious, this can be especially challenging
- By linking movement to a sense of calmness, we can help to make movement and exercise a safe space for patients
Mindful Movement Practice

- Set up
  - Low arousal environment
  - Slow movement
  - Visual cues/mirror patient
- Options
  - Time breath to movement
  - Counting movements

Functional Movement Disorder

- Primary treatment techniques
  - Education
    - You must have a good understanding of how the patient understands their condition before building on that education
  - Useful techniques
    - Use of the term “functional” instead of psychogenic
    - Symptoms are common and have been seen by this PT before
    - Describe PT’s role as “retraining” the nervous system
Functional Movement Disorder

- Primary treatment techniques
  - Demonstration that normal movement can occur
    - Hoover’s sign
    - Hip abductor sign
    - Distraction of entrainment of tremor

- Retraining movement with diverted attention
  - Cognitive tasks
  - Task-oriented exercises
  - Changing maladaptive behaviors related to symptoms
Refer, Refer, Refer!

- Just as we screen patients for cardiac and pulmonary issues to provide treatment to the person as a whole, we must also be screening for psychiatric issues within our scope of practice
- For a multi-disciplinary approach to work, multiple disciplines must be at the table
- Encourage patients towards follow up care

Communication Techniques

- Motivational interviewing
- Handling disruptive symptoms
Motivational Interviewing

- Core Principles, Techniques, and Processes of MI
  - 4 Guiding Principles
    - Resist the righting reflex
    - Understand and explore the patient’s motivations for change
    - Listen with empathy
    - Empower the patient
  - OARS: pivotal interviewing techniques for applying MI
    - Open questions
    - Affirming responses
    - Reflective listening
  - Processes of MI
    - Engaging
    - Focusing
    - Evoking
    - Planning

Handling Disruptive Symptoms

- Preventing Violence
  - 3 general types of violent behavior
    - Reaction to or expression of psychotic symptoms
    - Loss of control and subsequent lashing out
    - Gestures or threats of violence given primarily to control others or to get one’s own way
Handling Disruptive Symptoms \(^{21}\)

- **Hallucinations**
  - **DO**
    - Ask if they saw/heard something
    - Ask how they feel about the situation
    - Discuss the possibility that the experience is a symptom, hallucination, etc.
  - **DON’T**
    - Act shocked or alarmed
    - Tell them it is not real or casually dismiss it
    - Enter into a lengthy discussion about the hallucination

- **Delusions**
  - **DO**
    - Listen neutrally, calmly, respectfully
    - Lead the conversation away from the delusional content
    - Explicitly tell them you want to change the subject
  - **DON’T**
    - Try to convince or argue someone out of a delusion
    - Question or discuss the delusion in detail
Handling Disruptive Symptoms

- Bizarre Behavior

  DO
  - Stay calm and nonjudgmental
  - Be concise and direct

  DON’T
  - Focus on changing a harmless behavior
  - Discuss the behavior in greater detail

Case Study #1

- 46 yo F, uterine CA dx, comorbid borderline personality disorder and morbid obesity (BMI >60) now s/p total hysterectomy. Independent with all mobility, ADLs/iADLs prior to surgery.
- PT and OT evals had been initiated POD#2 however were only completed at bed level 2/2 high pain and anxiety.
- Transfer out of ICU on POD#5, wound vac in place, PCA, had not been out of bed.
- Pt required anyone entering the room to wash hands instead of using hand sanitizer and wear precaution gown 2/2 c/o smell. Routinely “fired” healthcare workers from her team.
Case Study #1

- First treatment on step down med/surg unit: pt refused use of lift device, tolerated sitting EOB 1 minute before returning to supine 2/2 high anxiety and dizziness (no change in BP noted), promptly “fired” both PT and OT present, was verbally aggressive.
- Case manager informed team that between patient’s insurance (Medicaid) and morbid obesity, she would be unable to d/c to a skilled nursing facility that would provide rehab.

- What are some options open to you as the next PT on this case to optimize your treatment?

Case Study #2

- 65 yo M s/p bilateral lung transplant, longstanding hx of COPD and anxiety. Independent with all mobility prior to surgery, required some assistance from wife for iADLs or more strenuous ADLs.
- PT and OT consults initiated after extubation. Pt tolerates sitting EOB with you, performs sit to stand transfer min A with FWW.
Case Study #2

- When you perform transfer to bedside chair, pt becomes rapidly SOB, SpO2 remains >90% on 4L O2 via NC. Pt requires moderate assist for transfer primarily for poor safety awareness with FWW and placement of chair 2/2 increase in anxiety.

- What are some treatment strategies open to you as the PT in the room to optimize your treatment going forward?

Key Points

- As an acute care physical therapist, you are well placed to be effective with patients with psychiatric comorbidities
- By understanding the interaction between common psychiatric comorbidities and the medical conditions that lead to hospitalization, you can make your treatment sessions more meaningful and productive
- Small adjustments and additions to treatment techniques with this population can greatly improve outcomes
Don't let your learning lead to knowledge. Let your learning lead to action.

- Jim Rohn

References

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