Psychological models that help hospice workers perform mental status evaluations

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Abstract

All hospice workers share responsibility for emotional support of patients. The effectiveness of this support depends on accurate assessments of patients' mental and emotional status. The use of psychological models assist in understanding patients and make it easier to develop appropriate and effective interventions. Several psychological models are used to 1) assist in the spiritual care or supportive counseling of patients who seek to resolve issues or find closure in their lives; or 2) support patients who exhibit patterns of avoidance and denial, supplemented by appropriate medications.

Key words: hospice, mental status evaluations, emotional status, transactional analysis, psychological models

Introduction

Hospice workers focus on comfort rather than cure. They employ a palliative model in serving patients who are certified by a physician as terminal and assured that their end of life is imminent. Caring for patients and their families in end-of-life situations is one of the most challenging tasks any professional faces.

Hospice patients need caregivers who are sensitive to the whole person, not just their physical needs. Ignoring or discounting patient fears, moods, or attitudes can engender feelings of rejection that may escalate feelings of anxiety, amplify fears, or reinforce depression.

Hospice workers draw conclusions from their interaction with each patient. Often they organize their observations in a manner roughly equivalent to a mental status examination. This may or may not be a conscious process.

The ultimate aim of a full mental and emotional status examination and diagnosis is to determine a patient's unique feeling of need, level of awareness, and ability to function.[1] Such examinations yield an understanding of how a person organizes their inner strengths and weaknesses into predictable attitudinal and behavioral responses. This data can indicate a person's level of stress and coping abilities.

An accurate assessment enables a more complete understanding of the patient and increases the likelihood of empathetic and effective responses to their needs.

Formal mental status examinations tend to be stressful and intrusive: often, they involve asking the subject's address, the current year, the day of the week, and the name of the current president of the United States. Questions designed to assess patient comprehension ability, alertness, and abstract reasoning can be disquieting, if not distressing. Asking terminal patients to subtract seven from 100 and to subtract seven from the result might not be well received. In view of the stress and confusion these examinations can produce, they are generally regarded as impractical.

A mental status assessment of a hospice patient is usually inferred from careful observation of the patient's usual reactions and responses. People perform mental status assessments on others all the time. They make ongoing assessments of the intelligence, awareness, interest, and other qualities in the people with whom they interact. Inaccurate assessments mean that some people may not get what they want or need in their situation.

Hospice workers automatically develop hypotheses to explain their observations of patients' behaviors and attitudes. In doing so, they construct a psychological model that enables them to make sense of their patients. Often, they make value judgments that fit the patient into an existing psychological model to explain patient behaviors and attitudes. Whether their method is simple or complex,

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they need to do this in order to understand the patient in their present situation. The effectiveness of their responses is dependent upon accuracy of their assessments.

Psychological models are based on a realization that every person is different, and, therefore, treatment is different for every patient. Each person operates in a habitual manner that is unlikely to change even in strange and unfamiliar situations.

In this paper, we explore several psychological models that are verbal descriptions purporting to explain the range of human behavior. Each model describes distinct personality styles and can help us understand individual patient strengths and weakness and the defense mechanisms they use to deal with stressful situations.

Psychological models can be a resource for hospice workers making mental and emotional evaluations. Psychological models can enable a worker to validate a "hunch," and although they are less complex than a formal mental status examination, they could provide an equally accurate assessment.

Pitfalls facing hospice workers

Hospice workers caring for patients need to be mindful of two potentially significant pitfalls: 1) a natural tendency to emphasize cure over care in working with a patient, and 2) a natural tendency to project their own needs onto the patient.

It is natural to develop feelings for patients, especially those who are young or especially likable. Their helplessness and hopeless condition can evoke a strong desire to rescue them from the inevitable. The seeming injustice of the patient's fate can induce feelings of anticipatory grief that reduce the worker's effectiveness. Hospice workers may empathize with the poet Edna St. Vincent Millay[2]:

> Down, down, down into the darkness of the grave./ Gently they go, the beautiful, the tender, the kind./ Quietly they go, the intelligent, the witty, the brave./ I know, but I do not approve. And I am not resigned. (p. 314)

The worker who strongly identifies with their patient loses objectivity and has difficulty maintaining primary focus on providing care. Their vain hope for a cure can undermine their sensitivity to the patient's felt needs.

The hospice approach to palliative care distinguishes clearly between curing and healing. For example, Charles Garfield,[3] Olympic weightlifting medallist, explores the distinction in his book, *Psychosocial Care of the Dying Patient.* He asserts that curative effort is not appropriate for the dying patient because it focuses on diagnosis and treatment, which are the objective aspects of a patient's case. Garfield identifies care—a tender and loving effort to help patients find courage for the task they now face—as the primary focus. Emphasis should be on supporting patients in ongoing affirmations of self rather than accepting their denial of self and avoidance of life. "Cure is . . . doing things to the patient," says Garfield, "while care is doing things with the patient." (p. 35)

A second challenge is the need to keep the patient's fear and anxiety separate from their own. It is easy for workers to project their own anxiety about nonbeing onto patients, who are in the midst of this struggle. Theologian Paul Tillich[4] reminds us that all anxiety tends to materialize as fear. It is tempting to project anxiety regarding death onto the patient. In helping the patient deal with their anxiety regarding death, hospice workers may unconsciously focus on their own unresolved issues.

Hospice workers who have not met these challenges will encounter difficulty rising above their own anxieties. They are not likely to be helpful to patients seeking the courage to face their end-of-life challenge.

The psychological hardiness/frailty model

One potentially useful method of assessing patients is to identify their ability or inability to cope with stress. We easily distinguish between those who are physically robust and those who are frail. The hardy seldom get sick, exhibit great stamina, and recuperate quickly, while their counterparts are frequently ill, lack stamina, and are slow to rebound from exertion or illness.

Likewise, it is not difficult to distinguish between people who are psychologically frail and hardy. Studies have identified people who are naturally resistant to emotional stress and suggest that they have very specific attitudes toward life. Myra Pynes[5] developed a concept of psychological hardiness that identified openness to change, intense involvement in life, and a sense of being in control of one's life as primary indicators.

The hardy welcome adversity and seem to thrive on challenge. They possess positive outlooks and take the difficulties of life in stride. The frail resist change and avoid challenge. Stress often makes them ill.

To help people cope in end-of-life situations, hospice workers must accurately assess the hardiness or frailty of their patients, which will indicate their vulnerability to stress and their ability to cope with it. Subsequent interventions will be based on this assessment.

Douglas C. Smith[6] also stresses the importance of accurate assessment of patients and wonders if self assessment is not equally important. Accurate assessment of patients is based on the hospice worker's self-understanding.

Persons in the end-of-life phase carry the same emotional baggage

they have always carried. What is different for them are the irrevocable time constraints and "now or never" messages their situation generates. While hardy and frail respond differently, each operates with some degree of awareness that continuing denial and ongoing procrastination will deny them a sense of closure in their lives.

On a routine hospital visit, a pastor encountered a psychologically hardy person facing death. Rosemary was a 47-year-old, never-married woman. Though suffering from terminal cancer, she declined spiritual care because she was not a religious person. Her manner was upbeat and cheerful. Over the next six weeks the pastor visited her daily and became a trusted companion.

He learned that Rosemary had left college when an auto accident claimed her father's life and seriously injured her mother. For the next 20 years, Rosemary was her invalid mother's primary caregiver and only source of income.

To supplement her meager income, she worked as a bookkeeper for a local business. Social opportunities were limited and she never developed any romantic relationships. Three years after her mother's death, Rosemary became terminally ill with cancer.

Again, Rosemary demonstrated a remarkable ability to accept what was unchangeable. She took life as it came and exhibited no hint of regret, resentment, or victimization. She remained in control of her life and continued to show keen interest in people until she was physically unable.

The pastor noted that while many people are able to say "Yes" to life, Rosemary's response was a "Yes, Yes!" In their last meeting, Rosemary told her pastor she had no regrets. "I have done what was important to me," she said. "I would have welcomed a longer life, but it didn't happen. I did the best I could in the time I had." She accepted pain and death as part of life.

The pastor recognized Rosemary's hardiness and did not press her to accept counsel she did not request. He disregarded his religious or professional agenda and responded to her warmth and friendliness. It was effective because, as Hockenberry-Eaton notes,[7] the greatest spiritual need is to know that one is valued simply because of whom they are.

Lucille seemed to be one of the frail. I was asked to provide respite care for an afternoon to give her brothers and sister some needed time to themselves. She was a 63-year-old divorced woman with breast cancer. Her hospice nurse informed me that Lucille was flighty and unpredictable. She had been a victim of physical abuse by her husband and, following their divorce, by subsequent male companions. She was submissive and compliant during visits from her priest. Pain and antianxiety medication had made her relatively comfortable.

I found Lucille sleeping fitfully, turning and thrashing her arms and legs. When a nurse arrived to attend to her needs, Lucille awakened and was cooperative. Her only response to the nurses' questions or other comments was, "Too late, too late." Requests for elaboration only brought a repeated murmuring of "Too late, too late." She offered no other response. Lucille's siblings returned and were apprised of her response to the nurse. They could not provide any explanation. She died the next afternoon. Her psychological instability, level of anxiety, and inability or reluctance to explore her predicament indicated a psychological frailty that rendered medication and attention to her physical needs as the only effective relief for her confusion and despair.

The self-discovery model

The self-discovery model is a composite taken from a variety of sources. It was first formulated by Richard Wallen and Barry Oshry based on the work of Lewis Mumford.[8] It identifies strengths and weaknesses of persons by identifying an individual's personal style, which includes emotional and mental status observations sufficient for the purposes of the hospice team.

This model presupposes three types of people which tend to operate primarily as what Wallen and Oshry call "friendly helpers," "tough battlers," or "objective thinkers." Everyone's life style fits more or less neatly into one of these fixed patterns, learned early in life.

Friendly helpers are usually supportive and sympathetic, comfortable with tender emotions and affectionate responses, and uncomfortable with aggressive or hostile individuals and situations. They tend to avoid conflict and try to smooth troubled waters when they cannot avoid them.

Tough battlers are naturally aggressive and comfortable with tough or even hostile emotions and situations. Frequently, they challenge and confront others. They are uncomfortable accepting or expressing warm, tender emotions and have difficulty giving or receiving praise.

Objective thinkers are not comfortable with any kind of emotion—tough or tender. They approach life rationally and examine situations carefully before making decisions. They are comfortable with problem solving and weigh their words carefully.

These personality styles are not mutually exclusive: a friendly helper can become angry and aggressive on occasion; a tough battler can have infrequent moments of tenderness, and, on rare occasions, an objective thinker loses his objectivity and becomes emotionally involved.

Patients and families of these three types come to their end-of-life situations with their natural strengths and weaknesses. Awareness of their natural tendencies can be helpful in determining an effective approach to their needs and requests.

Art and Nellie had been married 51 years when he was diagnosed with cancer and she with leukemia. They were childless and of moderate means. Both were hospitalized several times, and their medical expenses quickly exhausted their meager savings.

Art was a tough battler—easily irritated, argumentative, and cantankerous. Nellie was warm, supportive, and passive—ever deferring to her husband's wishes. When they received their terminal diagnoses, Art insisted they be discharged from the hospital. His wish was to die at home. Of course Nellie concurred. Art hoped their medical needs could be met satisfactorily by hiring a nurse to look in on them twice daily. His physician warned that the level of care would not prove sufficient, but Art was adamant that it was all he could afford.

They were discharged and returned to their home. Friends and neighbors visited regularly and their pastor made daily visits.

Art loved baseball and faithfully watched the televised games of his favorite team. Nellie shared his interest. His reluctance to discuss their medical or economic situation made baseball the easiest point of access to his feelings.

Things did not go well, however. The pastor advised Art of their eligibility for admission to a local nursing home. The arrangements seemed too much like charity for Art, who said that he did not wish to consider it. For several days, he stoically made the best of his situation. Soon their condition deteriorated to a point where even Art could not cope. Art casually asked the pastor if admission to the nursing home was still an option. Assured it was, he indicated that he and his wife should seek admission. His request was fulfilled within hours.

After six weeks in the nursing home, Art died. Nellie became comatose and died three days later. When the pastor called on Nellie for the last time, the nursing home administrator said, "When you first asked about admitting Art and Nellie, I almost refused. I knew Art well and was certain he would be my most difficult patient ever, but actually he was my best patient. I know he was in terrible pain, but he never complained. He was an inspiration."

Art and Nellie's caregivers witnessed the companionship of Art and Nellie without attachment to any predetermined outcome.[9,10] This enabled Art and Nellie to continue supporting each other in dealing with their crises and to remain in control of their lives. As a result, they met their situation with a courage that deeply touched their friends and caregivers.

The transactional analysis model

Another helpful approach to understanding self and others is the transactional analysis (TA) model developed in the 50s by Eric Berne.[11] It is a theory of personality development offering a therapeutic approach for helping people change. Hospice workers could find it helpful in their effort to understand patient and family behaviors and attitudes.

Studies show that a large portion of the population demonstrates significant psychopathology. Therefore, hospice workers can expect to encounter mild to severe disturbance in patients and families, perhaps more often than not.

TA assumes that people are OK regardless of their behavioral style or pathology. People with healthy attitudes will see a basic core in others that is lovable, and all persons have the potential for growth and self-actualization. This includes persons in end-of-life situations. TA explains difficult or inconsistent behavior by presuming that our early experience produces one of four basic assumptions about ourselves and others. The fundamental and natural position is "I'm OK, you're OK." Some people, however, develop neurotic positions such as "I'm OK, you're *not* OK" or "I'm *not* OK, you're OK." Still others, the deeply disturbed, adopt an "I'm *not* OK, you're *not* OK." position.

People adopt one of these fundamental positions in the first six to eight years of life and thereafter pursue happiness and fulfillment from this frame of reference. They tend to employ a variety of psychological strategies for ongoing validation of their beliefs about themselves and their world view.

Berne[12] defines games as a series of ongoing transactions arising from an ulterior motive and progresses to clearly predictable outcomes. The ulterior motive of our games is to reinforce our belief that our fundamental life position is accurate.

According to Berne, people with an "I'm not OK, you're OK" position play games such as "kick me," "ain't it awful," and "poor Me." Alcoholics fall into this category.

Typical of the games played by people who believe "I'm OK, you're not OK" are NIGYSOB (Now I've Got You, You Son-of-a-Bitch), or "See what you made me do" or "If it weren't for you."

These games demonstrate organized behaviors people often encounter. Most people have played these or other games themselves, or had them played on them.

Since the psychological gameplayers make the rules and have the "home court advantage," they rarely lose. They become expert players and their partner-victims are never fully aware of what is happening. Victories in their games validate and reinforce their basic life position of "I'm not OK, you're OK," or "I'm OK, you're not OK."

Douglas C. Smith[13] tells the story of Glenda, an 85-year-old woman with limited mobility due to chronic obstructive pulmonary disease. Glenda

was unable to move without the aid of a walker but remained intensely interested in her condition and determined to remain active and mobile. Glenda's nurse advised her that she would soon be unable to use her walker. The next day the nurse found Glenda crawling about on her hands and knees. Glenda explained, "I'm preparing myself for the future. You know I think I'll be ready when the time comes to get rid of my walker." Glenda's calm acceptance of the nurse's bad news and active preparation for the inevitable indicated an "I'm OK, you're OK" life position.

Hospice workers often find patients and their family members with "not OK" positions playing less healthy games. Caregivers unaware of patient needs to operate from a "not OK" position may become involved in these games without realizing what is happening.

Leon grew up in a small farming community, stigmatized by an alcoholic grandfather, who was an embarrassment to the family. Leon struggled throughout his life to overcome the shame resulting from community scorn. Others described Leon as having a "chip on his shoulder."

Leon moved to the city upon graduating from high school and found work as the office boy in an industrial plant. He was determined to amount to something and through hard work and devotion to duty advanced steadily, eventually becoming the plant manager.

Leon took great pride in his accomplishments, but he remained defensive and uncomfortable in social situations. His plant and his home were the recipients of his considerable drive and energy.

Unfortunately, Leon became a victim of corporate downsizing. When his company's product became outmoded, they began cutting back on their operations. Leon was discharged. Unable to find another managerial position, he took a lesser position as an electrician. He accepted his fate stoically and functioned effectively, but unhappily, until he was able to retire. His "I'm not OK, you're OK" life position prevented him from escaping the shame of his early years.

Death did not come easily for Leon. He accepted his illness stoically and strongly resisted any indication of weakness. He did accept tenderness in family and caregivers, but his "not OK-ness" kept him from reciprocating. He remained in charge of his tough emotions to the end.

The demoralization model

Some degree of demoralization accompanies unwelcome intrusions in our lives, especially if they cannot be managed well. The dictionary says demoralized persons are "deprived of spirit and courage and become disheartened and bewildered." All depressed, anxious, obsessive, or guilt-ridden persons feel some degree of demoralization.

End-of-life patients are vulnerable to demoralization. In their situation, they may also feel the nagging presence of an irrevocable deadline added to the usual emotional baggage they carry. It can be a heavy load, alarming for some, overwhelming for others. Thus, a demoralization model may explain attitudes and behaviors of end-of-life patients.[14]

Individuals often become demoralized by significant loss or failure that deprives or humiliates them, especially if they also have unresolved inner conflicts and low self-esteem. Demoralization, if not addressed, may escalate to clinical depression.

Mary Jane became demoralized following the death of her two-year-old daughter and was unable to resolve her grief. Depression resulted and she was hospitalized. Her psychotherapist discovered that her husband had handled his grief by plunging into his work. His solution evoked feelings of rejection in Mary Jane.

"Have your friends been helpful?" the therapist asked. "No," Mary Jane replied, "They have mostly avoided me. They don't feel sorry for me. They only feel sorry for a woman who has lost her baby. They can't afford to feel sorry for me, for then they would feel the way I do."

Mary Jane's isolation prevented her from coming to terms with her loss. She had lost touch with her child and couldn't grieve until it became real to her. That was not possible as long as no one dared to enter her world and empathize with her. She became disheartened and bewildered. Her spirit was crushed, and she lost courage. In treatment, an empathetic therapist was able to help her express her grief and restore her to herself.

Whether end-of-life patients are psychologically hardy or frail, they may become uncomfortable in usual patterns of denial or procrastination. Whether they feel "OK" or "not OK" about themselves, their unfinished business may take on a "now or never" quality that amplifies their desire for a sense of fulfillment or completion. These challenges easily evoke feelings of demoralization.

Demoralized people are conscious of having failed to meet their own expectations or those of others. They feel powerless to change their situation or themselves. Those deeply demoralized may have difficulty controlling their thoughts and feelings. They feel their world is caving in on them, and they do not know what to do. Often, they cower in a psychological corner fearing they are "going crazy."

Hospice workers often find their patients experiencing some degree of demoralization. The patient may be overwhelmed by a sense of failure in some significant area of their life or terrified because they lack the skill or courage to reconcile with estranged loved ones.

Hospice workers who operate from an "I'm OK, you're OK" position are sensitive to patients and receptive to their thoughts and feelings. They are predisposed to make use of frank and honest communication, which helps build trusting relationships. This position sensitizes workers to demoralized patients and increases the likelihood of empathetic responses.

Conclusions

An appropriate treatment plan and effective interventions depend on an accurate assessment of the patient's emotional and mental status and awareness of their inner strengths and weaknesses. Hospice workers employ some form of a psychological model to make sense of their observations and collateral information regarding their patients. While worker assessment of the emotional and mental status of patients is straightforward, rather than standardized, it is still important.

Hospice workers can use psychological models, which were designed to explain the range of styles in which persons operate, not as definitive models, but as examples of this process. Workers can use these models to assess and improve the models they currently employ.

Psychological models can facilitate understanding of patient attitudes and behaviors. This can help hospice workers to respond more directly to patient needs and diminish or eliminate preconceived agendas that thwart supportive connections with them. They can also help patients improve the quality of their responses to the anxiety implicit in their end-of-life situation.

Hospice workers, therefore, may endeavor to help patients in either of the following ways: 1) they can support patient effort to accept and deal with their anxiety in an effort to achieve greater self-affirmation and discovery (as might be available in companioning or spiritual care); or 2) they can accept and support patient choice to follow in patterns of denial or avoidance and employ anxiety-reducing medications, as they are needed.

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