Schizophrenia and Psychotic Disorders

Rachel Speer

Class 6

Schizophrenia Spectrum and Other Psychotic Disorders

- Definition: Includes schizophrenia, other psychotic disorders, and schizotypal (personality) disorder.
- Defined by abnormalities in five domains: delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behavior (including catatonia), and negative symptoms.

Schizophrenia Spectrum and Other Psychotic Disorders

Delusions:

- Fixed beliefs not amenable to change.
- Types: persecutory, referential, grandiose, erotomanic, nihilistic, somatic.
- Bizarre vs. non-bizarre delusions.
- Cultural considerations in delusion assessment.

Hallucinations:

- Perception-like experiences without external stimuli.
- Commonly auditory; may occur in other modalities.
- Cultural context of hallucinations.

Disorganized Thinking (Speech):

- Inferred from speech patterns.
- Types: derailment, tangentiality, incoherence ("word salad").
- Religious and cultural contexts influencing speech.

Schizophrenia Spectrum and Other Psychotic Disorders

Grossly Disorganized or Abnormal Motor Behavior (Including Catatonia):

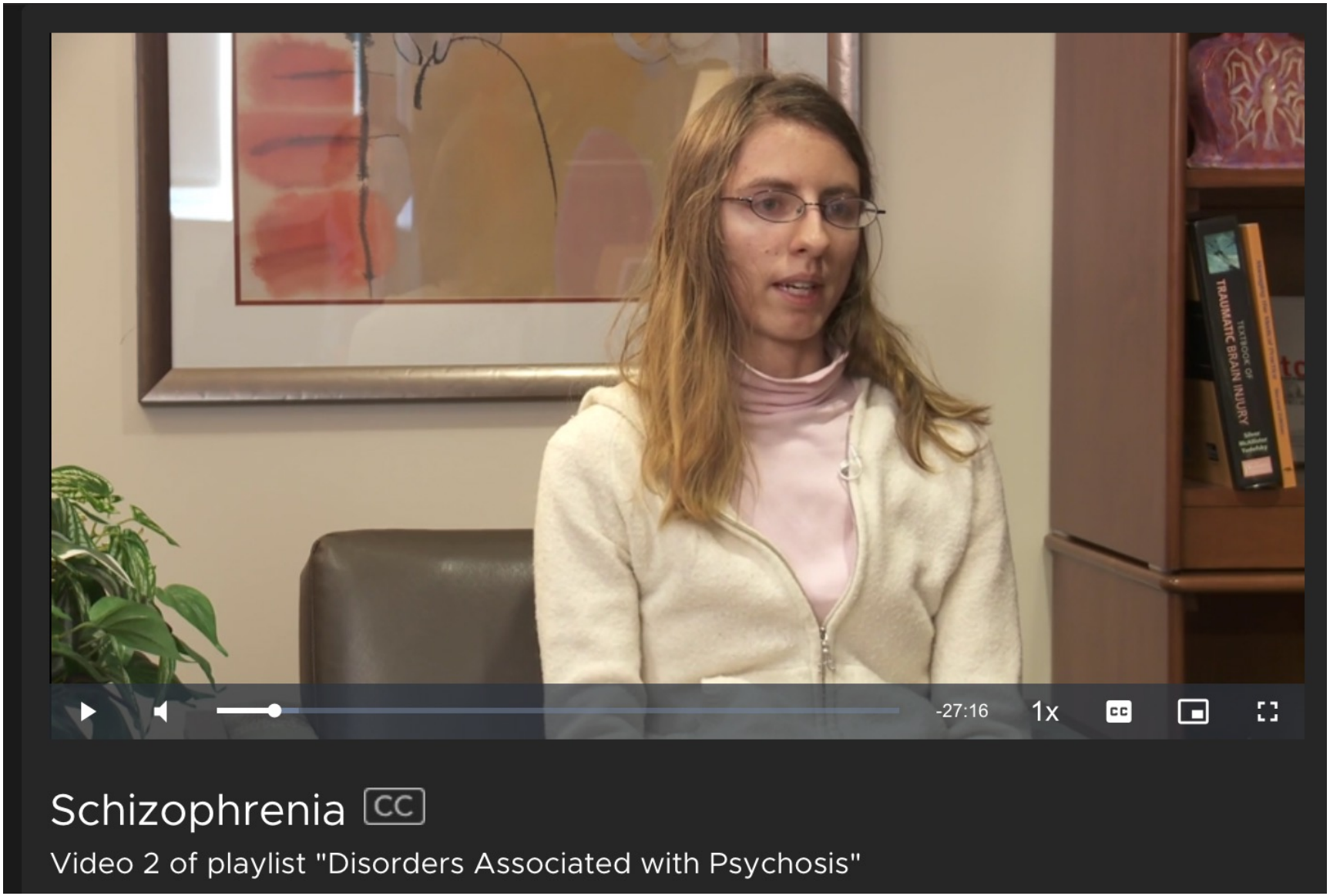
- Range of abnormal behaviors affecting daily living.
- Types of catatonia: mutism, stupor, excitement.
- Associated conditions beyond schizophrenia.

Negative Symptoms:

- Diminished emotional expression and avolition in schizophrenia.
- Other negative symptoms: alogia, anhedonia, asociality.
- Impact on social interactions and daily functioning.

Schizophrenia

- 1% of the population of persons over the age of 65
- 85% are living in the community
- Associated with family history of schizophrenia
- Often co-occurring with substance abuse (25%)
- Must rule out organic cause for any psychotic symptoms
- Early and Late Onset
  - Early
    - more common in men
    - first symptoms in young adulthood
  - Late
    - more common in women
    - first symptoms age 40-65
    - less negative symptoms
    - paranoid type more common
    - less cognitive impairment than early onset patients



Optional Video

Pharmacological Treatment of Schizophrenia

- Antipsychotic Medications
- 1952 Thorazine
- Revolutionized Treatment of Schizophrenia
- Supported deinstitutionalization efforts in the 1970s
  - 1955-Half a million people in state hospitals
  - 1990-100,000 people in state hospitals
- Typical Antipsychotics
  - Haldol, Clozaril, Prolixin, Stelazine
    - Side Effects-Tardive Dyskinesia (involuntary neurological movement disorder), blunted affect, slowness of motion
- Atypical Antipsychotics
  - Risperdal, Zyprexa, Seroquel
    - Preferred to typical drugs because of less bothersome side effects
    - Cause increased appetite, glucose intolerance, weight gain

Double Jeopardy: Mental Disorder and Health Outcomes

- In middle age, persons with mental disorders are more likely to have significant physical health problems
  - Diabetes, hypertension, cardiovascular disease, COPD, HIV
- In tandem with natural aging, older adults with mental disorders are increased risk for poor health outcomes including admission to nursing home or premature mortality
  - Medicaid and Medicare expenditures for persons with Schizophrenia over the age of 65 exceed costs for any other patient group, including those with dementia
- Persons with serious mental disorders often have less access to caregivers or are more socially isolated
- These persons die on average 25 years earlier than the general population
- The frail nature of this population creates significant barriers to quality of life, as well as a major public health concern

Predictors of Physical Health Problems among Persons with Mental Disorders

- Poverty, history of homelessness, or poor housing related to marked problems in functioning
- Stigma against those with mental disorders lessens access to quality relationships with providers, as well as access to services
- Morbid obesity caused by atypical antipsychotic medications, poor diet and nutrition, lack of exercise
- Abuse of tobacco, alcohol, and illicit drugs (50% of the population has some history)
- Utilize less health services than those without mental disorders (exception, those with anxiety disorders)
- Have less access to quality health service (coordination, continuity, and comprehensiveness)

Suicide and Schizophrenia

- Great risk of suicide
- 1 in 10 die of suicide

Strategies for Improving the Well-being of Persons with SMI

- Examination of key policies in mental health and aging
- Orientation to available mental health services
- Focus on coordination of care
- Facilitating disease management and use of health services
- Promoting adherence to treatment
- Working effectively in teams and across systems of care

The Role of Coordination of Care for Persons with SMI (Serious Mental Illness)

- Coordination of care is a key issue for quality of care
  - Although access to care may be possible, care is poorly coordinated among service sectors
- Separation of the health, mental health, and aging service systems
  - Care planning for these persons is exceedingly complex for providers, and equally complex for patients
  - Requires effective interdisciplinary collaboration

Care Planning in Health and Mental Health Settings

- Requires a great deal of work and resources at the beginning, but the pay off is greater stability
- Care plans should be individualized and focus on the individual's particular strengths and challenges, access to resources
- Include clear goals for health or mental health problems in the care plan
  - Might include outlining expectations in terms of self care, disease management, medication adherence, utilization of health or mental health services
  - Focus on client-centered goals
  - Monitor progress, implementation with these goals
  - Reassess after key transition points such as a hospitalization
    - Hospitalizations can be quite disruptive, so stay close
  - Provide support to facilitate success
    - Transportation, gathering medical records, help with insurance requirements

Facilitating Participatory Health Decision-Making

- Consider using a *Mobile Medical Record*
- In attending medical appointments with patients; you can
  - Assist with communicating the patient's needs, concerns
  - Gather important information for the patient
  - Help weigh the pros and cons of particular courses of treatment or medical decisions
  - Educate health providers about the strengths and abilities of the patient, be an advocate*

*If you can't attend appointments, you might educate a caregiver on this process, or another provider

Promoting Treatment and Medication Adherence

- Adherence; the extent to which persons' use of medication coincides with health advice of professionals
- Adherence is often facilitated through agency policies that mandate compliance with particular treatment goals
- Medication adherence is of particular concern to mental health providers
- Key issues for patients
  - Drugs may interfere with daily activities
  - Medication regimens unclear
  - Changes in medication regimens often unclear, especially after a hospitalization
  - Regimen may be too complicated
  - Drugs may be perceived to be too expensive
  - No perceived benefit

Promoting Medication Adherence

- Use patient education to gain buy in
- Respond to patient concerns when possible
- Go for simplicity where possible
  - Ask physician if there is any overlap in medications
  - Use medications that can be taken as few times as possible
- Use reminders, structure to aid adherence (i.e. pill boxes, caregiver support)
- Consider injectable medications
- Consider directly observed treatment (DOT)

Collaborating Effectively

- Coordinated care planning is contingent on working effectively with interdisciplinary teams and across systems
- Challenges to effective work in teams and across systems
  - Understanding professional roles
  - Constraints on service providers
  - Building trust

Patient Perspectives:Understanding Roles

- Patients often confused about who does what
  - May be particularly challenging working across health and mental health systems
- Lack of familiarity/comfort with certain professionals
- Over-reliance on one person in the team

Provider Perspectives:Understanding Roles

- Professionals should
  - Educate other professionals on what you do
  - Educate other professionals on the ways in which your system of care or treatment context constrains your role with the patient
  - Avoid too much rigidity, or too much flexibility in their role and responsibility to patient
    - Don’t be everyone to everybody…
    - Don’t be defensive…
  - Don’t make assumptions about other team members

Recovery Movement

- Anthony and others in Boston, Corrigan
- Focus on building “fulfilling lives” in the context of having a serious mental illness
- Non-pathologizing, strengths-based perspective
- Focus on

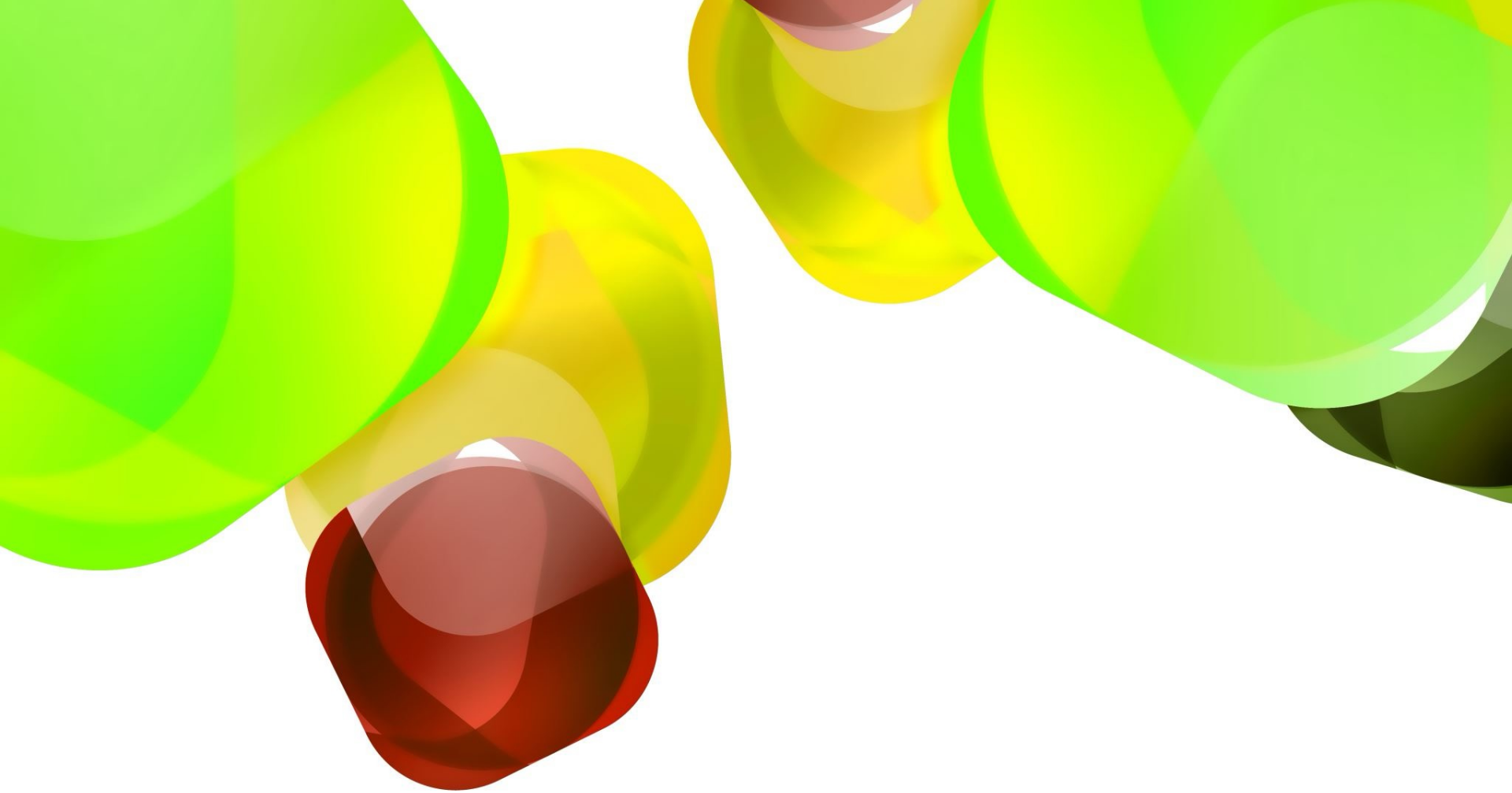
Future Directions

- Social workers in the arena of mental health, need to engage in direct advocacy on behalf of patients, and the service system, in order to build care options that offer integrated care
  - The separation of funding streams is a particular challenge; as such, creative and cost-effective solutions are necessary

Differentiating Dementia and Schizophrenia

Psychosis Related to Alzheimer's Dementia	Schizophrenia
Visual Hallucinations	Auditory
Delusions Not Bizarre	Bizarre and Complex Delusions
Frequent Misidentification of Caregivers	Infrequent Misidentification of Caregivers
Past History of Psychosis Rarely Present	Common to Have Past History of Psychosis
Psychotic Symptoms will Remit or Disappear	Psychosis will be long-standing
Use environmental modification to maintain safety, behavioral therapy, structured day activities, avoid challenging delusions	Use environmental modification to maintain safety, encourage socialization, social skills training, structured day activities, avoid challenging delusions

(Jeste & Finkle, 2000)



Personality Disorders

personality is viewed as the patterning of characteristics – including thoughts, feelings, and behaviors - across the entire matrix of the person; personality includes the total configuration of the person's characteristics: interpersonal, cognitive, psychodynamic, and biological.

character represents self concepts and is acquired during upbringing; it connotes a degree of conformity to social standards, and influences voluntary choices, intentions, and the meaning assigned to life experiences; character represents the crystallized influence of nurture.

temperament is a basic and automatic disposition toward certain experiences and represents the physically coded influence of nature; it is moderately biological and genetic.

Personality shaped by an interaction between:

* **Inherited tendencies/genes.** These are aspects of your personality passed on to you by your parents, sometimes referred to as temperament. It's often called "nature".

* **Environment/life situations.** The general surroundings, events, relationships with family members and others. It includes such things as the nature of parenting. It includes what is referenced as "nurture" part.

Personalities disorders are thought to emerge from an interaction between these two broad areas – genetic vulnerability coupled with life circumstances/stresses.

Pathological characteristics of personality disorders:

* *lack resilience* under conditions of stress = use of same strategies regardless of circumstances or degree of success
* *adaptively inflexible* = because of this lack of personal flexibility, the environment must become even more flexible and when the environment cannot be arranged to suit the person, a crisis ensues
* *pathological themes* that dominate their lives tend to repeat as vicious cycles = pattern of replays of failure

Defining Features:

* distorted thinking patterns
* problematic emotional responses
* over or under regulated impulse control
* interpersonal difficulties

SCHIZOTYPAL DISORDER (A): a pattern of acute discomfort in close relationships, cognitive or perceptual distortions, and eccentricities of behavior

PARANOID PERSONALITY DISORDER (A): a pattern of distrust and suspiciousness such that others' motives are interpreted as malevolent

SCHIZOID PERSONALITY DISORDER (A): a pattern of detachment from social relationships and a restricted range of emotional expression

BORDERLINE PERSONALITY DISORDER (B): a pattern of instability in interpersonal relationships, self-image, and affects, and marked impulsivity

HISTRIONIC DISORDER (B): a pattern of excessive emotionality and attention seeking

NARCISSISTIC PERSONALITY DISORDER (B): a pattern of grandiosity, need for admiration, and lack of empathy

ANTI-SOCIAL PERSONALITY DISORDER (B): a pattern of disregard for and violation of, the rights of others

AVOIDANT PERSONALITY DISORDER (C): A pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation

OBSESSIVE-COMPULSIVE DISORDER (C): A pattern of preoccupation with orderliness, perfectionism, and control

DEPENDENT PERSONALITY DISORDER (C): A pervasive and excessive need to be taken care of that leads to submissive and clinging behavior and fears of separation

Categories of Personality Disorders

Cluster A: Odd or eccentric behavior
- ^Schizoid Personality Disorder
- ^Paranoid Personality Disorder
- ^Schizotypal Personality Disorder

Social awkwardness, social withdrawal, distorted thinking

Cluster B: Emotional or erratic behavior
- ^Antisocial Personality Disorder
- ^Borderline Personality Disorder
- ^Narcissistic Personality Disorder
- ^Histrionic Personality Disorder

Problems with impulse control and emotional regulation

Cluster C: Anxious fearful behavior
- ^Avoidant Personality Disorder
- ^Dependent Personality Disorder
- ^Obsessive-Compulsive Personality Disorder

Share high level of anxiety

Class 6 Activity: Assignment Two (in Moodle)

Choose a Psychotic or Personality Disorder from the DSM-5-TR, such as a diagnosis from the Schizophrenia Spectrum and Other Psychotic Disorder section or Obsessive-Compulsive Personality Disorder. Your task is to craft a clinical vignette within a single typewritten page. In this vignette, you should portray a client whose presentation aligns with the chosen disorder, meeting all diagnostic criteria. However, avoid merely listing criteria in the vignetter; instead, depict the client's symptoms in a real-world context. At the end of the vignette, please list the symptoms endorsed by the client.

Ensure your vignette addresses all criteria for the disorder, including screening criteria like "not attributable to" and "not better explained by" specifications. Include the complete diagnosis, including coding, full name of the diagnosis, and any relevant specifiers, using DSM, ICD-10-CM, or both if applicable.

Your vignette should be original, not derived or modified from any existing sources or open AI. To generate ideas and examples, you may refer to your notes, textbooks, scans, or external sources. However, refrain from seeking assistance from other students, past or present. Remember, the focus is on accurately and succinctly describing and diagnosing a single disorder, reflecting your comprehension and proficiency in clinical understanding and application.

Upon completion of the vignette, provide a list of symptoms endorsed by the client. This will offer a succinct summary of the depicted disorder's manifestation in the case.

Note: While real-world client presentations often involve complexity beyond the scope of this exercise, your task is to demonstrate your ability to convey a singular disorder within the constraints provided effectively. Additional symptoms or diagnoses beyond the chosen disorder will not enhance your assignment but may detract from its quality.

Resources

- https://www.nami.org/About-Mental-Illness/Mental-Health-Conditions/Schizophrenia
- https://www.psychiatry.org/patients-families/schizophrenia/what-is-schizophrenia
- https://www.youtube.com/watch?v=6ZhlRA79wtM