UNDERSTANDING SCHIZOPHRENIA IN LONG-TERM CARE

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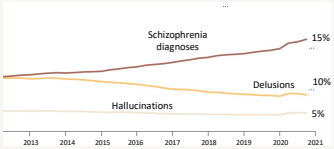
CHE BEHAVIORAL HEALTH SERVICES

AGENDA

- What is schizophrenia and how it presents in LTC
- Etiology and risk factors for schizophrenia
- Differential diagnosis (dementia related psychosis)
- Symptom Management
- Behavioral interventions to support residents with psychosis
- Q&A

SCHIZOPHRENIA STATISTICS IN LONG TERM CARE

- 1 in 9 LTC residents across the country have a diagnosis of schizophrenia.
- According to CMS tracking in 2021, 15% of residents are prescribed an antipsychotic medication (does not account for those with schizophrenia diagnosis).



By The New York Times | Source: Centers for Medicare & Medicaid Services MDS 3.0 Frequency Reports

4

STATISTICS CONTINUED

- 2018 study by Dept. of Health and Human Services Inspector General found 1/3 of residents with diagnosis had no medical history of it.
- However, in the US the general population prevalence of schizophrenia is only 0.25%-0.64%
- 2021 study indicated 20%-70% of people will dementia will develop psychosis as part of the condition

5

WHY THE INCREASE?

No other institutionalized option for severely mentally ill

Unfounded diagnoses
- Manage dementia
- Improve facility star ratings

Understaffing: negative correlation between facility staffing and use of antipsychotic medication

6

DIAGNOSING SCHIZOPHRENIA

Significant disturbances in thoughts, behaviors, and emotions that result in functional impairments such as interpersonal relationships, capacity to work and/or live independently.

Symptoms
Positive
Negative
Disorganized

Phases
Prodromal
Active
Residual

SYMPTOMS

Positive
Delusions
Grandiose
Persecutory
Thought broadcasting
Ideas of reference

Hallucinations
Sensory experience w/o sensory stimulation
Auditory, visual, tactile

Negative
Avolition
Anhedonia
Lethargy
Withdrawn
Blunted/flat affect
Alogia

Disorganized
Speech
Disrupted thought process
Loose associations
Bizarre thinking
Poor emotional regulation

Behaviors
Agitation, body posturing or rigidity, unusual dress

PHASES

Typical onset occurs in 3 phases:

1. **Prodromal** – earliest stage, can be difficult diagnose: isolation, anhedonia, changes in movement, difficulty expression emotions, sleep and appetite disturbances, anxiety
2. **Active** – positive symptoms: thought broadcasting, delusions, hallucinations, disorganized speech
3. **Residual** – negative symptoms: social isolation, lethargy, blunted affect, alogia

HOW TO DIAGNOSE DSM-V

- At least 2 out of 5 main symptoms: delusions, hallucinations, disorganized or incoherent speaking, disorganized or unusual movements and negative symptoms
- Duration: key symptoms must last for at least 1 month, and effects of symptoms must last for 6 months
- Social or occupational/living dysfunction

10

ETIOLOGY

Exact causes of schizophrenia are unknown however, some factors with higher positive correlation:

1. Genetics
   - Family hx (especially parent or sibling) increases risk for development of disease
2. Environment
   - Certain viral infections and autoimmune diseases
   - Exposure to toxins
   - Extreme environmental stress (trauma, war, poverty)
3. Birth complications and development
   - Low birthweight, premature labor, lack of oxygen during birth
   - Brain development abnormalities, prenatal famine

11

ETIOLOGY

Neurochemicals

- Substance abuse
  - Amphetamine, PCP
- Dopamine theory
  - Excess dopamine in the brain to cause schizophrenia however, new research (and medication) is effective without blocking dopamine.

12

OTHER PSYCHOTIC DIAGNOSES

- Schizoaffective Disorder
  - Symptoms of both schizophrenia and either depressive or manic episode
- Delusional Disorder
  - Thought disorder: persecution, being followed, erotomania. No other symptoms.
- Schizophreniform Disorder
  - Symptoms duration greater than 1 month but less than 6 months; need 1 of hallucination, delusion, or disorganized speech
- Brief Psychotic Disorder
  - Symptom duration of 1 day to 1 month, often triggered by stress

13

AGE OF ONSET

Men – early 20s
Women - late 20's to early 30's

It is uncommon for schizophrenia to be diagnosed younger than age 12 or older than age 40.

14

DEMENTIA RELATED PSYCHOSIS

Dementia – group of cognitive conditions that cause a decline in cognitive functioning (thinking, memory, problem-solving)

- Alzheimer's disease
- Vascular dementia
- Lewy body dementia
- Parkinson's disease

Psychosis can be a complication of dementia and present with **hallucinations, delusions, paranoia, agitation, mood changes.**

15

ASSESSMENT TOOLS

History

Imaging and labs to rule out medical condition

Observation

Collateral Information with family, social support

Screening Tools

SCREENING TOOL – POSITIVE AND NEGATIVE SCREENING SCALE (PANSS)

PANSS RATING FORM

		absent	minimal	mild	moderate	moderate severe	severe	extreme
P1	Delusions	1	2	3	4	5	6	7
P2	Conceptual disorganisation	1	2	3	4	5	6	7
P3	Hallucinatory behaviour	1	2	3	4	5	6	7
P4	Excitement	1	2	3	4	5	6	7
P5	Grandiosity	1	2	3	4	5	6	7
P6	Suspiciousness/persecution	1	2	3	4	5	6	7
P7	Hostility	1	2	3	4	5	6	7
N1	Blunted affect	1	2	3	4	5	6	7
N2	Emotional withdrawal	1	2	3	4	5	6	7
N3	Poor rapport	1	2	3	4	5	6	7
N4	Passive/apathetic social withdrawal	1	2	3	4	5	6	7
N5	Difficulty in abstract thinking	1	2	3	4	5	6	7
N6	Lack of spontaneity & flow of conversation	1	2	3	4	5	6	7
N7	Stereotyped thinking	1	2	3	4	5	6	7
G1	Somatic concern	1	2	3	4	5	6	7
G2	Anxiety	1	2	3	4	5	6	7
G3	Guilt feelings	1	2	3	4	5	6	7
G4	Tension	1	2	3	4	5	6	7
G5	Mannerisms & posturing	1	2	3	4	5	6	7
G6	Depression	1	2	3	4	5	6	7
G7	Motor retardation	1	2	3	4	5	6	7
G8	Uncooperativeness	1	2	3	4	5	6	7
G9	Unusual thought content	1	2	3	4	5	6	7
G10	Disorientation	1	2	3	4	5	6	7
G11	Poor attention	1	2	3	4	5	6	7
G12	Lack of judgement & insight	1	2	3	4	5	6	7
G13	Disturbance of volition	1	2	3	4	5	6	7
G14	Poor impulse control	1	2	3	4	5	6	7
G15	Preoccupation	1	2	3	4	5	6	7
G16	Active social avoidance	1	2	3	4	5	6	7

NAME: ____________ DATE: ____________
PATIENT ID#: ____________ MD: ____________

BRIEF PSYCHIATRIC RATING SCALE (BPRS)

Please enter the score for the term which best describes the patient's condition.
0 = not assessed, 1 = not present, 2 = very mild, 3 = mild, 4 = moderate, 5 = moderately severe, 6 = severe, 7 = extremely severe

1. **SOMATIC CONCERN** Degree of concern over present bodily health. Rate the degree to which physical health is perceived as a problem by the patient, whether complaints have a realistic basis or not.	SCORE	10. **HOSTILITY** Animosity, contempt, belligerence, disdain for other people outside the interview situation. Rate solely on the basis of the verbal report of feelings and actions of the patient toward others; do not infer hostility from neurotic defenses, anxiety, nor somatic complaints. (*Rate attitude toward interviewer under "uncooperativeness"*).	SCORE
2. **ANXIETY** Worry, fear, or over-concern for present or future. Rate solely on the basis of verbal report of patient's own subjective experiences. Do not infer anxiety from physical signs or from neurotic defense mechanisms.	SCORE	11. **SUSPICIOUSNESS** Brief (*delusional or otherwise*) that others have now, or have had in the past, malicious or discriminatory intent toward the patient. On the basis of verbal report, rate only those suspicions which are currently held whether they concern past or present circumstances.	SCORE
3. **EMOTIONAL WITHDRAWAL** Deficiency in relating to the interviewer and to the interviewer situation. Rate only the degree to which the patient gives the impression of failing to be in emotional contact with other people in the interview situation.	SCORE	12. **HALLUCINATORY BEHAVIOR** Perceptions without normal external stimulus correspondence. Rate only those experiences which are reported to have occurred within the last week and which are described as distinctly different from the thought and imagery processes of normal people.	SCORE
4. **CONCEPTUAL DISORGANIZATION** Degree to which the thought processes are confused, disconnected, or disorganized. Rate on the basis of integration of the verbal products of the patient; do not rate on the basis of patient's subjective impression of his own level of functioning.	SCORE	13. **MOTOR RETARDATION** Reduction in energy level evidenced in slowed movements. Rate on the basis of observed behavior of the patient only; do not rate on the basis of patient's subjective impression of own energy level.	SCORE
5. **GUILT FEELINGS** Over-concern or remorse for past behavior. Rate on the basis of the patient's subjective experiences of guilt as evidenced by verbal report with appropriate affect; do not infer guilt feelings from depression, anxiety or neurotic defenses.	SCORE	14. **UNCOOPERATIVENESS** Evidence of resistance, unfriendliness, resentment, and lack of readiness to cooperate with the interviewer. Rate only on the basis of the patient's attitude and responses to the interviewer and the interview situation; do not rate on basis of reported resentment or uncooperativeness outside the interview situation.	SCORE
6. **TENSION** Physical and motor manifestations of tension "nervousness", and heightened activation level. Tension should be rated solely on the basis of physical signs and motor behavior and not on the basis of subjective experiences of tension reported by the patient.	SCORE	15. **UNUSUAL THOUGHT CONTENT** Unusual, odd, strange or bizarre thought content. Rate here the degree of unusualness, not the degree of disorganization of thought processes.	SCORE
7. **MANNERISMS AND POSTURING** Unusual and unnatural motor behavior, the type of motor behavior which causes certain mental patients to stand out in a crowd of normal people. Rate only abnormality of movements; do not rate simple heightened motor activity here.	SCORE	16. **BLUNTED AFFECT** Reduced emotional tone, apparent lack of normal feeling or involvement.	SCORE
8. **GRANDIOSITY** Exaggerated self-opinion, conviction of unusual ability or powers. Rate only on the basis of patient's statements about himself or self-in-relation-to-others, not on the basis of his demeanor in the interview situation.	SCORE	17. **EXCITEMENT** Heightened emotional tone, agitation, increased reactivity.	SCORE
9. **DEPRESSIVE MOOD** Despondency in mood, sadness. Rate only degree of despondency; do not rate on the basis of inferences concerning depression based upon general retardation and somatic complaints.	SCORE	18. **DISORIENTATION** Confusion or lack of proper association for person, place or time.	SCORE

SCREENING TOOL – BRIEF PSYCHIATRIC RATING SCALE (BPRS)

SYMPTOM MANAGEMENT - SCHIZOPHRENIA

1. Medication – antipsychotics
2. Individual psychotherapy
3. Social skills and life skills training
4. Family/caregiver support
5. Vocational rehabilitation
6. Hospitalization – for crises and severe symptoms to ensure safety, proper nutrition, adequate sleep, and basic self-care hygiene.

19

SYMPTOM MANAGEMENT – DEMENTIA PSYCHOSIS

Dementia related psychosis – no pharmacologic treatment is FDA approved currently. Atypical antipsychotic medications are frequently used to treat these disorders despite significant safety concerns.

Medication of dementia related psychosis

- Certain antidepressants
- Atypical antipsychotics
- Anticonvulsants
- Pimavanserin (brand name Nuplazid) to treat psychosis in Parkinson's disease.

20

HOW DO YOU SUPPORT YOUR RESIDENTS WHO ARE EXPERIENCING PSYCHOSIS?

21

SYMPTOM MANAGEMENT - NONPHARMACOLOGICAL INTERVENTIONS

Adjusting the environment
- Declutter the room
- Remove any triggering pictures/objects
- Try to keep a consistent routine
- Keep lights on when appropriate to minimize shadows

22

SYMPTOM MANAGEMENT - NONPHARMACOLOGICAL INTERVENTIONS

Adjusting caregiver approach
- Try not to challenge delusions/hallucinations
- Validate their feelings
- Use softer voice, do not yell
- Try to ask questions and engage
  - "Tell me more about your mother"
  - "It sounds like you're excited to see your family, what would you like to wear today?"

23

SYMPTOM MANAGEMENT - NONPHARMACOLOGICAL INTERVENTIONS

Behavioral Activation
- Can help with negative symptoms
- Encourage participation in pleasant activities
  - Sitting in patio, listening to music, exercising
  - Giving them a task to "help"
- Facilitate social interaction to minimize isolation
- Provide small group gatherings, when appropriate, to minimize over stimulation
- Independent activities also count!

24

SYMPTOM MANAGEMENT - NONPHARMACOLOGICAL INTERVENTIONS

Coping skills

- Model health communication
  - Labeling feelings
  - Identifying needs
- Stress relieving techniques
  - Anxiety Management
    - Grounding exercises
    - 5 senses
    - Doesn't have to focus on internal relaxation

25

SUPPORT EACH OTHER!

Share your challenges and successes with each other.

It's not easy providing care for residents with psychosis.

26

THANK YOU!

QUESTIONS & ANSWERS

DR. TORNA LI

27

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