The DSM-5 Schizophrenia Spectrum & other Psychotic Disorders includes:

- Delusional Disorders
- Brief Psychotic Disorder
- Schizophreniform Disorder
- Schizophrenia
- Schizoaffective Disorder
- Substance/medication-Induced Psychotic Disorder
The focus on this education module will include Delusional Disorders & Schizophrenia

1. Key features of psychotic disorders will be overviewed
2. Delusion Disorders
3. Schizophrenia

More details of other Psychotic Disorder can be found in the DSM-5.
The presence of one or more of the following are key features found in Psychotic Disorders

1. Delusions
2. Hallucinations
3. Disorganized thinking
4. Abnormal motor behavior
5. Negative symptoms
1. Delusions

- Fixed, false beliefs that do not go away with evidence to support otherwise. Themes of delusions includes:
  - Persecutory delusions – belief that one is going to be harmed
  - Referential delusions – belief that certain gestures or comments is directed at oneself
  - Grandiose delusions – belief of having exceptional abilities, wealth, and/or power
  - Erotomanic delusions -false belief that someone is in love with you
  - Nihilistic delusions – belief that a major catastrophe will occur
  - Somatic delusions – preoccupied and focused on health problems
2. Hallucinations

- Are vivid and clear perceptions that occur without an external stimulus.
- May be auditory, visual, tactile (being touched or bugs crawling on you), olfactory (smell), and gustatory (taste).
- Auditory hallucinations most common in schizophrenia.
3. Disorganized Thinking (Speech)

- A person’s disorganized thinking is seen thru their speech patterns.
  - Loose associations – switch from topic to topic
  - Tangentiality - answers to questions but be distantly related to the questions or completely unrelated
  - Incoherence – Word Salad – speech pattern so disorganized that is it difficult to comprehend
4. Abnormal Motor Behavior

- Ranges from child-like behaviors to unpredictable agitation
- May be Catatonic behavior which is a marked decrease in reacting to one's environment. Ranges of catatonia include:
  - Negativism – range from resistant to instruction to keeping a rigid bizarre posture
  - Stupor – not responding verbally or thru motor activity
  - Catatonic excitement – purposeful & excessive motor activity
5. Negative Symptoms

- Most prominent in schizophrenia
  - Decreased emotional expression
    - includes face, eye contact, hand, head and face movements
  - Avolition decrease in purposeful movements
    - Sits for long periods of time
Other negative symptoms

- Alogia – decreased speech
- Anhedonia – decreased ability to experience pleasure
- Asociality – loss of social interests
Historically

The key features of psychotic disorders have been said to be positive or negative

Positive symptoms—hallucinations, delusions, disorganized thinking, or abnormal behaviors

Negative symptoms— are those previously described—and affect how one interacts with daily functions of living.
In Review

Key Features seen in Psychotic Disorders include:

1. Hallucinations
2. Delusions
3. Disorganized thinking
4. Abnormal motor movement
5. Negative symptoms
Delusional Disorder

Diagnostic Criteria includes:

- Delusions for one month or longer
- Does not meet schizophrenia criteria
- Functioning and behaviors not acutely impaired
- Behaviors are not associated to a substance or medical condition

Further details of diagnostic criteria found in DSM-5.
Subtypes of Delusional Disorders

- Persecutory delusions – belief that one is going to be harmed
- Referential delusions – belief that certain gestures or comments are directed at oneself
- Grandiose delusions – belief of having exceptional abilities, wealth, and/or power
- Erotomanic delusions - false belief that someone is in love with you
- Nihilistic delusions – belief that a major catastrophe will occur
- Somatic delusions – preoccupied and focused on health problems
Prevalence of Delusional Disorder

- Lifetime prevalence 0.2%
- Most frequent subtype is persecutory
- No gender differences
- More prevalent in older adults
Delusional Disorders

- May lead to marital, social, or work problems
- May lead to increase in irritability, anger, and violent behaviors.
- May cause legal problems (more in erotomanic and jealous type)
Schizophrenia

Diagnostic Criteria includes:

- At least 1 of delusions, hallucinations, or disorganized thinking
- 2 or more of key psychotic features
- Level of functioning in work, home, or self-care is affected
- Continuous disturbance for at least 6 months
- Other psychiatric disorders (i.e., depression) ruled out
- Behaviors are not associated to a substance or medical condition

Further details of diagnostic criteria found in DSM-5.
Prevalence of Schizophrenia

- Lifetime prevalence 0.3 – 0.7%
- Variations of prevalence within race, ethnicity, or geographic locations
- Men have a 30%-40% higher life-time risk than woman
- Immigrant populations have an increased risk
  - With highest risk being first-generation of the immigrants
Development and Course of Schizophrenia

- Psychotic features may begin in early teen years or not until a person is in their mid-30’s.
- Peak age first psychotic episode early 20’s for males and late 20’s for females.
- Usually manifest over a slow period of time with a gradual development of symptoms.
- Age of onset related to prognosis (the earlier the onset the worse the diagnosis).
- Psychotic symptoms may diminish over one’s life.
Typical Course of Schizophrenia

Prodromal period 5 years
- Suspiciousness, Perceptual distortion, Sleep problems, obsessive thinking, decline socially

Psychosis period 1-2 years (if untreated) Acute Phase
- Presentation of Positive symptoms and Begin antipsychotics

Post-Psychotic Period Maintenance Phase
- Negative Symptoms with associated cognitive difficulties
Causes of Schizophrenia

No one distinct cause but theories include:

- **Environmental** – season of birth with late winter/early spring being prevalent
- **Genetics** – unspecified at this time but have found that siblings and parents with schizophrenia increase an individual's risk by 10 times of the general population. Increase age of father with fathers 50 years plus being 3 times higher risk than father 25 years old
- **Physiological** – pregnancy & birth complications such as hypoxia and greater prenatal age are associated with higher risk
Suicide and Schizophrenia

- 5-6% people with schizophrenia dies by suicide
- 20% people with schizophrenia attempt suicide more than once – some may be following command hallucinations
Schizophrenia and Life Expectancy

- Increase in medical conditions, lack of medical follow-up, and increase in tobacco use all play a role at life expectancy being reduced with those with schizophrenia.
Adherence due to lack of insight of need for long term medication is often problematic and causes frequent acute psychotic episodes – leading to frequent hospitalizations
Treatment of Schizophrenia

Acute Psychotic Phase
- Stabilization
- Diagnosis of schizophrenia
- Initiation of antipsychotics

Maintenance Phase
- Continue antipsychotics – estimates as high as 40% may relapse each year
Groupings of Antipsychotics

Typical Antipsychotics –
- is the older antipsychotic medications, now referred to as typical antipsychotics. These are primarily effective in reducing the positive symptoms of schizophrenia (refer to DU module on schizophrenia).
- medications have an exhaustive side effect profile that complicates treatment and contributes to noncompliance.

Atypical Antipsychotics –
- is the newer generation. The atypical antipsychotic medications have an impact on the neurotransmitter serotonin as well as on dopamine. Therefore, they help produce a reduction in positive symptoms as well as an impact on the negative, or less obvious, psychotic symptoms.
- less severe side effect profile than the typicals.
For details on antipsychotic medications please review “Psychiatric medication Review – July 2015” on the Diamond University site
Working with Patients

The following slides will discuss techniques to guide you in providing care to the psychotic patient.

Communication

- Observation
- Practice techniques
- Daily living strategies
- Managing the environment
- Handling paranoia
- Crisis prevention
Communication

- Speak in a calm, clear, concise manner. Avoid whispering and laughing.
- Use clear, concrete statements.
  - For example: “Susie, it’s time to get out of bed.”
- Use clear, direct verbal communication rather than unclear or non-verbal gestures. (Do not shake your head ‘yes’ or ‘no’ or point to indicate directions.)
- Approach the patient in a slow, calm, matter-of-fact manner.
- Maintain facial expressions and behaviors that are consistent with verbal statements.
- Refrain from touching a patient who is experiencing delusions, hallucinations or paranoia.
Communication

- Reassure the patient (frequently if necessary) that the patient is safe and will not be harmed.

- Use simple declarative statements when talking to the patient who demonstrates fragmented, disconnected, non-coherent or tangential speech patterns that reflect loose associations.
  
  For example, “I want to understand. Can you tell me again?”

- Offer the patient a clear and simple explanation of environmental events and the behaviors of other patients, when necessary.
  
  For example, “That remark was not meant for you. It was directed to all of us in the community meeting.”

- Ask patient directly about his or her hallucinations.
  
  For example, “Are you hearing voices? What are they saying to you?”

- Watch the patient for cues that he or she is hallucinating, such as eyes darting to one side, muttering, or watching a vacant room.
Communication

- Avoid reacting to hallucinations as if they are real. Do not argue back to the voices.
- Do not negate a patient’s experience but offer your own perceptions.
  - For example, “I don’t see the devil standing over you, but I do understand how upsetting that must be for you.”
- Focus on reality-based diversions and topics such as conversations or simple projects.
- Tell patient, “Try not to listen to the voices right now. I have to talk with you.”
- Be alert to signs of anxiety in the patient, which may indicate hallucinations are increasing.
- Be open, honest and reliable in interactions to reduce suspiciousness.
- Respond to suspicions in a matter-of-fact and calm manner.
Communication

- Ask the patient to describe the delusions.
  - For instance, “Who is trying to hurt you?”
- Avoid arguing about the content, but interject doubt where appropriate.
  - For example, “I don’t think it would be possible for that petite girl to hurt you.”
- Focus on feelings the delusions generate.
  - Such as, “It must feel frightening to think there is a conspiracy against you.”
- Once a patient describes delusions, do not dwell on it. Instead, focus conversation on more reality-based topics.
- If the patient obsesses on delusions, set limits on the amount of time devoted to talking about them.
Communication

- Observe for events that trigger delusions. If possible, discuss these with the patient.
- Validate if part of the delusion is real.
  - For instance, “Yes, there was a man at the nurse’s station, but I did not hear him talk about you.”
- Avoid pressure and criticism (creates stress and worsens symptoms).
- Include non-verbal communication. (Thoughts may be more organized when written down.)
Communication

- Acknowledge patient accomplishments, jobs well-done and goals met.
- Introduce or request one task or one step at a time.
- Avoid making decisions for the patient (leads to over-reliance on others and inhibits confidence).
- Avoid patronizing comments, authoritative statements or lengthy statements (lecturing).
- Don’t stand over the patient. (Sit if the patient is seated or lying down.)
- Make eye contact but avoid direct and continuous eye contact.
- Offer simple choices to help the patient feel in control.
  - For example, “Would you like to walk before or after lunch?”
Practice Tolerance

- Recognize unpleasant behaviors and responses as being indications of distress.
- Provide personal space and personal time. Patients will need periods of time alone.
- Provide easy quiet companionship (regardless of the person’s ability for verbal communication). Avoid lengthy interactions.
- Remember that patients often think, feel, and act in a normal fashion. (Only certain aspects of the patient’s world may not be based in reality.)
Daily Living

- Reduce restlessness and tension by limiting stimulants (coffee, tea, cola drinks, chocolate or cold tablets).
- Join the patient in his or her activity. (See if you can turn pacing into taking a walk.)
- Provide areas where the patient can be without disturbing others.
- Discourage daytime naps to increase the possibility of sound nighttime sleep.
Manage the Environment

- Facilitate learning of new tasks by providing an immediate reward upon completion.
- Establish daily routines and expectations for every part of the day (waking up, getting dressed, eating).
- Make gradual changes to the routine to prevent boredom.
- Ensure the patient knows his or her responsibilities and the consequences of not meeting them.
- Use distraction to prevent preoccupations from interfering with treatment and tasks.
- Gradually increase sensory and social stimulation as tolerated (new people, activities, and places).
Manage the Environment

- Too much stimulation can lead to escalating behavior.
- Start with low-key, low-skill activities that involve 1 or 2 people (card games, board games, ping-pong).
- Decrease distractions (turn off TV and/or radio, lower overhead paging system).
- Maintain a low-stress, controlled-stimulation environment (calm staff movements and voices).
- Use non-threatening physical positioning (remain slightly to one side, avoid staring).
Handling Paranoia

- Place yourself beside the patient rather than face-to-face. (Avoid direct eye contact.)
- Speak indirectly. (Substitute pronouns such as "it," "he," "she" or "they" for the words "I" and "you.")
- When possible, match the attitudes and emotional expressions of the patient – help the patient feel understood.
- Do not attempt to correct or contradict the patient or test reality – the patient is already overwhelmed and distressed.
- Attempt to find certain believable or credible aspects of the paranoid belief – this allows you and the patient to agree about something. (It is important to avoid collusion.)
- In step-by-step increments, introduce an explanation that is one notch less paranoid than the patient’s current belief.
Crisis Prevention

- Recognize early warning signs (sleeplessness, ritualistic preoccupation, suspiciousness, unpredictable outbursts).
- Help the patient regain control.
- Do nothing to agitate the scene. It is imperative that you remain calm and get help.
- Accept the fact that the patient is in an "altered reality state" and may "act out" the hallucination (i.e. attempt to barricade himself or herself to keep out a perceived threat).
References

American Psychiatric Association Diagnostic and Statistical manual of Mental Disorders, DSM-5, 5th ed. 2013

