Managing Psychotic Disorders in the Primary Care Setting

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Presentation Outline

Introduction: Facts about Psychosis in Primary Care

Part I: Case Examples

Part II: Guidelines for Management
Psychosis Defined

Loss of ego boundaries or gross impairment in reality testing
Psychotic Symptoms

- Hallucinations
  - Auditory or visual
- Disorganized speech
- Catatonic behavior
- Delusions
  - Fixed, false beliefs
Prevalence

One study of 1,000 adults in primary care found 3.7% of patients being seen in the office reported one or more psychotic symptoms.

Most common was a belief that others were spying on them or following them.

Psychotic Disorders …

Psychotic symptoms are the defining feature.
Psychotic Disorders

- Brief Psychotic Dx
- Delusional Disorder
- Schizoaffective Disorder
- Schizophrenia
- Schizophreniform
- Shared Psychotic Dx
- Substance-Induced Psychotic Dx
## Prevalence

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Lifetime prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia + Schizophreniform</td>
<td>0.7-1.2%</td>
</tr>
<tr>
<td>Delusional Disorder</td>
<td>0.03%</td>
</tr>
<tr>
<td>Brief Psychotic Disorder</td>
<td>unknown, but uncommon</td>
</tr>
<tr>
<td>Schizoaffective Disorder</td>
<td>unknown, but less than schizophrenia</td>
</tr>
<tr>
<td>Substance Induced Psychotic Disorder</td>
<td>unknown, but probably highest</td>
</tr>
</tbody>
</table>
Disorders with Associated Psychotic Symptoms

- Alzheimer’s Dementia
- Lewy Body Disease/Dementia
- Amnesic Disorders
- Cognitive Disorders
- Mood Disorders with Psychosis Specifiers
  - Major Depression with Psychosis
  - Mania with Psychosis
PART I

Case Examples
Case I

71 yr old wf known to the PCP. Pt is always very well groomed, appropriate. Longstanding complaints re: husband, e.g. stealing her things, breaking her things. This appt. pt. tells PCP that husband has her followed, at all times, and has bugged the house. Husband is in the waiting rm.
Interventions

Cognitive Screen
- Normal range on Folstein
- Ramparts suggested frontal impairment
- Referred for neuropsychological assessment
- Referred to neurology
Interventions

Interviewed daughter
- Non-bizarre delusions noted

Held family meeting and discovered
- driving while taking photos of cars behind her
- disconnecting lights, phones looking for bugs
- purchasing secret storage areas for her belongings
- was hospitalized, briefly once, due to pointing gun at husband’s head
Interventions

MRI

- T2 signal abnormalities in subcortical white matter, some periventricular. Mildly atrophic frontal lobes and left superior parietal lobe
- EEG normal
Frontotemporal Dementia
Results

After two sessions, patient failed to follow through with geriatric psychiatry

Patient continues to be seen by the PCP who prescribes Klonopin, which does help to calm patient. SSRI tried with no positive effect.

Family failed to follow through with recommendations for guardianship
Case II

56 yr old white female sees her PCP for reoccurring abdominal pain (8 out of 10, sharp, transient, interferes with eating). She believes tubing was left in her stomach during surgery years ago. Pt. had several studies (x-ray, ultrasound) showing no object in the abdomen. Accompanied by her newly wed husband. No known psych hx.
Delusional Disorder
Interventions

- Obtained permission to have a meeting where x-ray results were viewed with both husband and pt, together
- Asked psychologist to join and attend this meeting
- Confronted patient with delusional diagnosis and need for treatment
Results

Husband believed wife who explained that the tubing moved around and was not always visible in the abdomen.

Strongly urged pt to see psychiatrist for evaluation, but she refused.

Decided on close f/u with PCP.
Other Possible Interventions

- Involuntary Hospitalization
- MRI
- Attempt to contact alternative family member
Case III

19 yr old AA male, HS graduate, unemployed, living with older sister. Sister says pt. has had slow decline in function over a year. Says he plays videos all day. Mood is sad or flat. Can’t make decisions, “like whether to turn the light switch on or off.” Sister took pt to the ER. They diagnosed Major Depression, urged her to bring the pt to his PCP for treatment.
Case III, Continued

Explored possible reasons for poor function
- No history of learning disability or MR
- No head injury
- Mild to moderate depression
  - No homicidal or suicidal ideation
- Psychosis
  - Pt. vague about hearing voices
  - Ideas of reference: music had a special messages for him
New Onset
Schizoaffective Disorder, Depressive Type
Interventions

- Made appt. to see psychiatrist in one month (first available appointment)
- Treated with Seroquel, (50mg daily for one week, increased to 100mg)
- F/u on a weekly basis until pt saw psychiatry
Results

- Dramatic improvement in behavior
- Psychotic symptoms controlled
- Pt care successfully transferred to psychiatry
Part II

Guidelines for Management
Guidelines for Management

Know the legal standards
Legal Standards

HIPPA allows for disclosure

“SPECIAL SITUATIONS”
We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety. We may use and disclose health information about you to prevent a serious threat to your health and safety or the health and safety of the public or another person.”

Know your state’s statutes for involuntary admission
Attempt to determine onset of symptoms

- Chronic course—more likely to be psychiatric
- Acute—could be medical or psychiatric in origin
- Late life onset—more likely to be related to dementia
General Treatment Plan

- Know legal standards
- Attempt to determine onset of symptoms
- Rule out medical causes
Rule out

- Head Injury
- substance use/intoxication
- Cognitive limitations
- Delirium
### Medical Tests for evaluation of late-onset psychosis

<table>
<thead>
<tr>
<th>Test</th>
<th>In absence of delirium</th>
<th>With delirium/dementia present</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood chemistries</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Thyroid Function Tests</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>CBC with differential</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Drug levels</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>ABG or oximetry</td>
<td>Only if clinically indicated</td>
<td>Yes</td>
</tr>
<tr>
<td>UA (culture as needed)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>EKG</td>
<td>Only if clinically indicated</td>
<td>Yes</td>
</tr>
<tr>
<td>Chest X-ray</td>
<td>Only if clinically indicated</td>
<td>Yes</td>
</tr>
<tr>
<td>EEG</td>
<td>Not indicated</td>
<td>If needed</td>
</tr>
<tr>
<td>LP</td>
<td>Not indicated</td>
<td>If needed</td>
</tr>
<tr>
<td>CT or MRI</td>
<td>May be needed</td>
<td>Yes</td>
</tr>
<tr>
<td>Heavy metal urine analysis</td>
<td>Usually not needed</td>
<td>Yes</td>
</tr>
<tr>
<td>Neuropsychological test</td>
<td>Only if clinically indicated</td>
<td>Only if clinically indicated</td>
</tr>
</tbody>
</table>
General Treatment Plan

✔ Know legal standards
✔ Attempt to determine onset of symptoms
✔ Rule out medical causes

Form collaborative treatment plan
Collaboration with others

- Obtain info from source other than pt
- Make a special effort to share information with other providers
- Be sure the patient is safe
- Persist until the patient is treated
Collaboration with others

Involve
- Neurology
  - Order necessary studies
- Psychiatry
- Psychology
  - Neuropsychology
In Summary

- Presentation of psychosis in PC may increase with poor economic conditions and fiscally constrained mental health resources.
- Management of psychosis in PC may involve temporary medical management or involuntary hospitalization.
- And so, we need to prepare our residents for managing psychosis, the third reason for hospitalization.
Thanks for the opportunity to present to you!