THE PSYCHOPATHOLOGY OF SCHIZOPHREΝIA: ESSENTIALS FOR THE OCCUPATIONAL THERAPIST

Sally Harris, Sr. COTA
Ben Taub Mental Health Services – Harris Health System
Course Objectives

- Understand the history of schizophrenia and prevalent beliefs
- Identify the DSM IV and DSM V criteria and the diagnostic process
- Differentiate between psychosis presenting in schizophrenia vs other diagnoses you may encounter
- Become familiar with psychiatric medications and have the ability to recognize and identify side effects you may see during treatment
- Utilize treatment interventions and specific techniques to employ with patients who have been dx with schizophrenia and may be experiencing psychosis
- Understand Occupational Therapy’s unique role in the treatment of patients with schizophrenia
Ben Taub Mental Health Services

Neuropsychiatric Center
1502 Taub Loop, 4th floor
Ben Taub Mental Health Services
Ben Taub Mental Health Services

- Inpatient psychiatry unit for Harris Health System, fka County Hospital District
- Mission: To provide top quality care for the indigent of Harris County, particularly those with concomitant medical issues
- Multi-disciplinary patient care in a biopsychosocial model
- 20 bed acute, locked psychiatric unit
- Patients are divided into two teams with two attendings
- Attending Physicians, Residents, Med Students are from Baylor College of Medicine
- Patients are either voluntary or involuntary
- Admitted from presentation to the EC
Services Offered at BTMHS

- Occupational Therapy (4 – 5 x per day in groups and PRN in 1:1 sessions)
- Social Services (PRN)
- LCDC (referral, 1 x peer week)
- Physicians, Nurses, Doctors, Psych Techs (daily and PRN)
- Chaplaincy (PRN and 1 group per week)
- Psychology (1 x day and PRN for testing)
Types of OT Treatment Interventions on the Inpatient Unit

- Initial Evaluations (OTR)
- Groups (OTR/COTA)
- Individual Sessions (OTR/COTA)
- Discharge (OTR/COTA)
- KELS (OTR and COTA with service competency training)
Daily OT Groups

- ADL / Life Skills
- Task/Cognitive & Reality Orientation
- Leisure x 2 to 3
Where It All Began…

“Reconstruction Aides” working with returning WW1 Vets building toys in a Psychiatric Hospital”
Where We Are Today...

Task activities in the BTMHS Occupational Therapy Clinic
09/14/2017
Where We Are Today...

Task activities in the BTMHS Occupational Therapy Clinic
09/14/2017
Craft as a Therapeutic Modality

Educational Poster in the OT clinic

Why Crafts?
- To improve your organization
- To organize your thoughts
- To have you solve problems
- To help you make decisions
- To exercise your work skills
- To boost your self-confidence
- To increase your independence
- To help you interact with others
- To increase your sense of control
- To keep you alert and involved
Task Example

Example of completed doorknob hanger project in clinic
Client Project

Client’s foam doorknob hanger with freehand painted message

“WE BELI [eve] DAD”
and radiant cross
Task Example

Example of ceramic box with bas relief of heart design on lid
Client Project

Ceramic box with bas relief of heart design on lid as completed by client
Task Example

Wooden Fighter Jet from S&S
Client Project

Wooden Fighter Jet from S&S
Task Example

Foam masks decorated freehand with acrylic paint
Client Project

Foam mask decorated with acrylic paint. Note missing chin area, teeth painted in a grimace, forceful brush strokes, and strong color choices.
Electricity Makes You Float
Found in Asylum in the 1940s
Auditory Hallucinations
Schizophrenia

- Major disturbances in thought, emotion, and behavior
  - Disordered thinking
  - Lack of emotional expressiveness
  - Disturbances in movement or behavior

- Can disrupt interpersonal relationships, diminish capacity to work or live independently
Brief Hx of Schizophrenia

- **Emil Kraepelin**: This illness develops relatively early in life, and its course is likely deteriorating and chronic; deterioration resembled dementia (Dementia praecox), but was not followed by any organic changes of the brain, detectable at that time.

- **Eugen Bleuler**: He renamed Kraepelin’s dementia praecox as schizophrenia (1911); he recognized the cognitive impairment in this illness, which he named as a “splitting” of mind.

- **Kurt Schneider**: He emphasized the role of psychotic symptoms, as hallucinations, delusions and gave them the privilege of “the first rank symptoms” even in the concept of the diagnosis of schizophrenia. He argued that a delusion should not be diagnosed by the content of the belief, but by the way in which a belief is held.
Brief Hx of Schizophrenia

- **Schneiderian First-Rank Symptoms** or simply, first-rank symptoms
- **First-rank symptoms in schizophrenia**
- **Auditory hallucinations**
  - Hearing voices conversing with one another
  - Voices heard commenting on one's actions (hallucination of running commentary)
  - Thought echo (a form of auditory hallucination in which the patient hears his/her thoughts spoken aloud)
- **Passivity experiences** (in which the individual has the experience of the mind or body being under the influence or control of some kind of external force or agency; delusions of control or of being controlled)
- **Thought withdrawal** (the delusional belief that thoughts have been 'taken out' of the patient's mind)
- **Thought insertion** (thoughts are ascribed to other people who are intruding into the patient's mind)
- **Thought broadcasting** (also called thought diffusion)
- **Delusional perception** (linking a normal sensory perception to a bizarre conclusion, e.g. seeing an airplane means the patient is the president)
NIMH Definition of Psychosis

“The word psychosis is used to describe conditions that affect the mind, where there has been some loss of contact with reality. When someone becomes ill in this way it is called a psychotic episode. During a period of psychosis, a person’s thoughts and perceptions are disturbed and the individual may have difficulty understanding what is real and what is not. Symptoms of psychosis include delusions (false beliefs) and hallucinations (seeing or hearing things that others do not see or hear). Other symptoms include incoherent or nonsense speech, and behavior that is inappropriate for the situation. A person in a psychotic episode may also experience depression, anxiety, sleep problems, social withdrawal, lack of motivation, and difficulty functioning overall.”
Psychosis Is Also Present In:

- Psychotic symptoms may also be seen in:
  - Schizotypal personality disorder
  - Certain personality disorders at times of stress (including paranoid personality disorder, and borderline personality disorder)
  - Major depressive disorder (MDD) in its severe form, although it is possible and more likely to have severe depression without psychosis
  - Bipolar disorder in the manic and mixed episodes of bipolar I disorder and depressive episodes of both bipolar I and bipolar II; however, it is possible to experience such states without psychotic symptoms.
  - Post-traumatic stress disorder
  - Induced delusional disorder
  - Sometimes in obsessive-compulsive disorder
  - Dissociative disorders, due to many overlapping symptoms, careful differential diagnosis includes especially dissociative identity disorder
Phases of Psychosis

There are three phases to a psychotic episode:

**Prodromal Phase:**
This is a period before the psychosis became evident and are usually marked by changes in feelings, thoughts and behaviours. Some prodromal symptoms may include: reduction in concentration and attention, sleep disturbance, anxiety, social withdrawal, suspiciousness or depressed mood.
2. Acute Phase:

During the acute phase, typical psychotic symptoms emerge. The symptoms of psychosis are frequently separated into “positive” and “negative” categories.
3. Recovery Phase:
The recovery process vary from person to person in duration and degree of functional improvement. While some recover from the psychosis very quickly and be ready to return to life and their responsibilities, others will need longer to respond to treatment and may need time to respond gradually.
Schizophrenia Stats

- Lifetime prevalence ~1%
- Affects men slightly more often than women
- Onset typically late adolescence or early adulthood
  - Men diagnosed at a slightly earlier age
- Diagnosed more frequently in African Americans
  - May reflect diagnostic bias
Workup of New-Onset Psychosis:  
“Round Up The Usual Suspects”

Good clinical history including collateral  
Physical exam, ROS  
Labs/Diagnostic tests:  

- Metabolic panel  
- CBC with diff  
- B12, Folate  
- RPR, VDRL  
- Serum Alcohol  
- Urinalysis  
- Thyroid profile  

**URINE DRUG SCREEN!!!**  
**CT/MRI/EEG**  
**HIV Serology**

Schizophrenia is a diagnosis of exclusion!
Differential Diagnoses

What to rule out:

A Personality D/O: Borderline, Antisocial, Paranoid
PTSD
Malingering: R/O with MFAST
Culturally Specific Phenomena:
   Religious experiences
   Meditative States
   Belief in UFO, etc

Schizophrenia is a diagnosis of exclusion!
DSM-IV Diagnostic Criteria

- Psychotic symptoms (2 or more) for at least one month

- Hallucinations
- Delusions
- Disorganized speech
- Disorganized or catatonic behavior
- Negative symptoms
- Impairment in social or occupational functioning

**Duration of illness:** Disturbances (incl PD) have endured for at least 6 mo.

- Symptoms not due to mood disorder or schizoaffective disorder
- Symptoms not due to medical, neurological, or substance-induced disorder
## Clusters of Schizophrenia

### Table 9.1 Summary of the Major Symptom Domains in Schizophrenia

<table>
<thead>
<tr>
<th>Positive Symptoms</th>
<th>Negative Symptoms</th>
<th>Disorganized Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delusions, hallucinations</td>
<td>Avolition, alogia, anhedonia, blunted affect, asociality</td>
<td>Disorganized behavior, disorganized speech</td>
</tr>
</tbody>
</table>

Table 9.1
© 2012 John Wiley & Sons, Inc. All rights reserved.
Clinical Features of Thought Disorders

Neologisms, Clanging, Verbigeration
Tangentiality
Derailment
LOA (word salad)
Perseverations
Nonsequiturs
Clinical Features of Delusions

Firmly held beliefs
Contrary to reality
Resistant to disconfirming evidence
  Paranoid/percusatory
  IOR
External Locus of Control
Thought Broadcasting
Thought Insertions
Jealousy
Guilt
Grandiosity
Religious Delusions
Somatic Delusions
Clinical Features of Hallucinations

Sensory experiences in the absence of sensory stimulation

Auditory
Visual
Olfactory
Somatic/tactile
Gustatory
Clinical Features of Behaviors

Bizarre dress and appearance
Catatonia
Poor impulse control
Anger, agitation
Clinical Features of Mood and Affect

Features of **Mood and Affect**

- Inappropriate/Incongruent
- Blunting/Flat
- Isolative
- Alogia
- Anhedonia
- Asociality
- Avolition
# Mental Status Exam

## Brief Mental Status Exam (MSE) Form

<table>
<thead>
<tr>
<th>Member Name:</th>
<th>UCare ID #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td></td>
</tr>
<tr>
<td>Care Manager Name:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>UCare</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1. Appearance</th>
<th>Casual dress, normal grooming &amp; hygiene</th>
<th>Other (describe)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Attitude</td>
<td>Calm &amp; cooperative</td>
<td>Other (describe)</td>
</tr>
<tr>
<td>3. Behavior</td>
<td>No unusual movements or psychomotor changes</td>
<td>Other (describe)</td>
</tr>
<tr>
<td>4. Speech</td>
<td>Normal rate/tone/volume w/out pressure</td>
<td>Other (describe)</td>
</tr>
<tr>
<td>5. Affect</td>
<td>Reactive &amp; mood</td>
<td>Normal range congruent</td>
</tr>
<tr>
<td></td>
<td>Labile</td>
<td>Depressed</td>
</tr>
<tr>
<td></td>
<td>Tearful</td>
<td>Constricted</td>
</tr>
<tr>
<td></td>
<td>Blunted</td>
<td>Flat</td>
</tr>
<tr>
<td></td>
<td>Other (describe)</td>
<td></td>
</tr>
<tr>
<td>6. Mood</td>
<td>Euthymic</td>
<td>Anxious</td>
</tr>
<tr>
<td></td>
<td>Irritable</td>
<td>Depressed</td>
</tr>
<tr>
<td></td>
<td>Elevated</td>
<td>Other (describe)</td>
</tr>
<tr>
<td>7. Thought Process</td>
<td>Goal-directed &amp; Logical</td>
<td>Disorganized</td>
</tr>
<tr>
<td></td>
<td>Other (describe)</td>
<td></td>
</tr>
<tr>
<td>8. Thought Content</td>
<td>Suicidal ideation</td>
<td>Homicidal ideation</td>
</tr>
<tr>
<td></td>
<td>None</td>
<td>Passive</td>
</tr>
<tr>
<td></td>
<td>If Active:</td>
<td>Plan</td>
</tr>
<tr>
<td></td>
<td>Intent</td>
<td>Means</td>
</tr>
<tr>
<td></td>
<td>Delusions</td>
<td>Obsessions/compulsions</td>
</tr>
<tr>
<td></td>
<td>Phobias</td>
<td>Other (describe)</td>
</tr>
<tr>
<td>9. Perception</td>
<td>No hallucinations or delusions during interview</td>
<td>Other (describe)</td>
</tr>
<tr>
<td>10. Orientation</td>
<td>Oriented X 3</td>
<td>Other (describe)</td>
</tr>
<tr>
<td>11. Memory/Concentration</td>
<td>Short Term Intact</td>
<td>Long Term Intact</td>
</tr>
<tr>
<td></td>
<td>Distractible/Inattentive</td>
<td>Other (describe)</td>
</tr>
<tr>
<td>12. Insight/Judgment</td>
<td>Good</td>
<td>Fair</td>
</tr>
</tbody>
</table>

## Psychotic Disorders

<table>
<thead>
<tr>
<th></th>
<th>Onset</th>
<th>Symptoms</th>
<th>Course</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>Usually insidious</td>
<td>Many</td>
<td>Chronic</td>
<td>&gt;6 months</td>
</tr>
<tr>
<td>Delusional disorder</td>
<td>Varies (usually insidious)</td>
<td>Delusions only</td>
<td>Chronic</td>
<td>&gt;1 mo.</td>
</tr>
<tr>
<td>Brief psychotic disorder</td>
<td>Sudden</td>
<td>Varies</td>
<td>Limited</td>
<td>&lt;1 mo.</td>
</tr>
</tbody>
</table>
Psychosocial Factors

Expressed Emotion
Stressful Life Events
Low Socioeconomic Class

Downward Drift vs. Social Causation

Limited Social Network
Drug Usage
Genetics

Take home message: Vulnerability likely inherited
Odds Ratio

Source: PLOS Medicine
Anatomical Abnormalities

Enlargement of lateral ventricles

Implies loss of brain cells
Correlate with
- Poor performance on cognitive tests
- Poor premorbid adjustment
- Poor response to treatment

Smaller than normal total brain volume
Anatomical Abnormalities

Cortical Atrophy
AH correlation
Reduced $O_2$ @ childbirth

Widening of the third ventricle
DD in childhood

Smaller hippocampus
PTSD/Combat/S Abuse
Anatomical Abnormalities

**PET scans show ↓ activation in prefrontal cortex**

(problem solving, adaptation, coping with change)
## Typical Neuroleptics/Antipsychotics

<table>
<thead>
<tr>
<th>Drug Category</th>
<th>Generic Name</th>
<th>Trade Name</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First-generation drugs</strong></td>
<td>Chlorpromazine</td>
<td>Thorazine</td>
</tr>
<tr>
<td></td>
<td>Fluphenazine decanoate</td>
<td>Prolixin</td>
</tr>
<tr>
<td></td>
<td>Haloperidol</td>
<td>Haldol</td>
</tr>
<tr>
<td></td>
<td>Thiothixene</td>
<td>Navane</td>
</tr>
<tr>
<td></td>
<td>Trifluoperazine</td>
<td>Stelazine</td>
</tr>
<tr>
<td><strong>Second-generation drugs</strong></td>
<td>Clozapine</td>
<td>Clozaril</td>
</tr>
<tr>
<td></td>
<td>Aripiprazole</td>
<td>Abilify</td>
</tr>
<tr>
<td></td>
<td>Olanzapine</td>
<td>Zyprexa</td>
</tr>
<tr>
<td></td>
<td>Risperidone</td>
<td>Risperdal</td>
</tr>
<tr>
<td></td>
<td>Ziprasidone</td>
<td>Geodon</td>
</tr>
<tr>
<td></td>
<td>Quetiapine</td>
<td>Seroquel</td>
</tr>
</tbody>
</table>
# Medication Quick Reference

## Antipsychotics

<table>
<thead>
<tr>
<th>Name</th>
<th>Brand</th>
<th>Drug Range</th>
<th>Dosage Range</th>
<th>Equivalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlorpromazine</td>
<td>Thorazine</td>
<td>50-800 mg</td>
<td>100 mg</td>
<td>10 mg</td>
</tr>
<tr>
<td>Perphenazine</td>
<td>Trilil</td>
<td>50 mg</td>
<td>5 mg</td>
<td>1 mg</td>
</tr>
<tr>
<td>Thioridazine</td>
<td>Thiothixene</td>
<td>100 mg</td>
<td>10 mg</td>
<td>1 mg</td>
</tr>
<tr>
<td>Haloperidol</td>
<td>Haldol</td>
<td>5 mg</td>
<td>1 mg</td>
<td>1 mg</td>
</tr>
<tr>
<td>Benzotropine</td>
<td>Benactyzine</td>
<td>10 mg</td>
<td>1 mg</td>
<td>1 mg</td>
</tr>
<tr>
<td>Thioridazine</td>
<td>Melleril</td>
<td>10 mg</td>
<td>1 mg</td>
<td>1 mg</td>
</tr>
<tr>
<td>Clozapine</td>
<td>Clozaril</td>
<td>100 mg</td>
<td>10 mg</td>
<td>1 mg</td>
</tr>
<tr>
<td>Oxiapine</td>
<td>Glycolazide</td>
<td>10 mg</td>
<td>1 mg</td>
<td>1 mg</td>
</tr>
<tr>
<td>Fluphenazine</td>
<td>Prolixin</td>
<td>5 mg</td>
<td>1 mg</td>
<td>1 mg</td>
</tr>
<tr>
<td>Haloperidol</td>
<td>Decapran</td>
<td>10 mg</td>
<td>1 mg</td>
<td>1 mg</td>
</tr>
<tr>
<td>Risperidone</td>
<td>Risperdal</td>
<td>1 mg</td>
<td>0.5 mg</td>
<td>0.5 mg</td>
</tr>
<tr>
<td>Aripiprazole</td>
<td>Abilify</td>
<td>5 mg</td>
<td>1 mg</td>
<td>1 mg</td>
</tr>
</tbody>
</table>

## Antihistamines

<table>
<thead>
<tr>
<th>Name</th>
<th>Brand</th>
<th>Drug Range</th>
<th>Dosage Range</th>
<th>Equivalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphenhydramine</td>
<td>Benadryl</td>
<td>50 mg</td>
<td>25 mg</td>
<td>12.5 mg</td>
</tr>
<tr>
<td>Doxylamine</td>
<td>Unisom</td>
<td>25 mg</td>
<td>12.5 mg</td>
<td>6.25 mg</td>
</tr>
<tr>
<td>Hydroxyzine</td>
<td>Atarax</td>
<td>50 mg</td>
<td>25 mg</td>
<td>12.5 mg</td>
</tr>
<tr>
<td>Phenhydramine</td>
<td>Phenergan</td>
<td>50 mg</td>
<td>25 mg</td>
<td>12.5 mg</td>
</tr>
</tbody>
</table>

## Antidepressants

<table>
<thead>
<tr>
<th>Name</th>
<th>Brand</th>
<th>Drug Range</th>
<th>Dosage Range</th>
<th>Equivalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amitriptyline</td>
<td>Elavil</td>
<td>25 mg</td>
<td>10 mg</td>
<td>5 mg</td>
</tr>
<tr>
<td>Desipramine</td>
<td>Norpramin</td>
<td>25 mg</td>
<td>10 mg</td>
<td>5 mg</td>
</tr>
<tr>
<td>Nortriptyline</td>
<td>Pertofrane</td>
<td>25 mg</td>
<td>10 mg</td>
<td>5 mg</td>
</tr>
<tr>
<td>Imipramine</td>
<td>Tofranil</td>
<td>25 mg</td>
<td>10 mg</td>
<td>5 mg</td>
</tr>
<tr>
<td>Venlafaxine</td>
<td>Effexor</td>
<td>50 mg</td>
<td>25 mg</td>
<td>12.5 mg</td>
</tr>
<tr>
<td>Sertraline</td>
<td>Zoloft</td>
<td>50 mg</td>
<td>25 mg</td>
<td>12.5 mg</td>
</tr>
<tr>
<td>Citalopram</td>
<td>Celexa</td>
<td>20 mg</td>
<td>10 mg</td>
<td>5 mg</td>
</tr>
<tr>
<td>Escitalopram</td>
<td>Lexapro</td>
<td>20 mg</td>
<td>10 mg</td>
<td>5 mg</td>
</tr>
</tbody>
</table>

## Benzodiazepines

<table>
<thead>
<tr>
<th>Name</th>
<th>Brand</th>
<th>Drug Range</th>
<th>Dosage Range</th>
<th>Equivalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diazepam</td>
<td>Valium</td>
<td>10 mg</td>
<td>5 mg</td>
<td>2.5 mg</td>
</tr>
<tr>
<td>Lorazepam</td>
<td>Ativan</td>
<td>1 mg</td>
<td>0.5 mg</td>
<td>0.25 mg</td>
</tr>
<tr>
<td>Clonazepam</td>
<td>Klonopin</td>
<td>1 mg</td>
<td>0.5 mg</td>
<td>0.25 mg</td>
</tr>
<tr>
<td>Alprazolam</td>
<td>Xanax</td>
<td>0.25 mg</td>
<td>0.125 mg</td>
<td>0.0625 mg</td>
</tr>
</tbody>
</table>

## Over The Counter

<table>
<thead>
<tr>
<th>Name</th>
<th>Brand</th>
<th>Drug Range</th>
<th>Dosage Range</th>
<th>Equivalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin</td>
<td></td>
<td>325 mg</td>
<td>162.5 mg</td>
<td>81 mg</td>
</tr>
<tr>
<td>Ibuprofen</td>
<td>Advil</td>
<td>200 mg</td>
<td>100 mg</td>
<td>50 mg</td>
</tr>
<tr>
<td>Acetaminophen</td>
<td>Tylenol</td>
<td>500 mg</td>
<td>250 mg</td>
<td>125 mg</td>
</tr>
<tr>
<td>Diphenhydramine</td>
<td>Benadryl</td>
<td>5 mg</td>
<td>2.5 mg</td>
<td>1.25 mg</td>
</tr>
</tbody>
</table>

## References

Typical Neuroleptic Side Effects

- Acute Dystonia
- EPS Parkinsonian side effects
- Akathesia
- Tardive dyskinesia
- Sedation
- Orthostasis
- Lower sz threshold
- Increased Prolactin
Atypical Antipsychotics

**Benefits:**
Lower profile of side effects
May be better at alleviating negative sxs and cognitive dysfunction
Clozaril associated with agranulocytosis, seizures. Must join registry.

**Side effects:**
Sedation
New Onset Hyperglycemia
Anticholinergic effects
Increased lipids
Some EPS
Tenets of OT

- Occupation-Based Practice
- Empowerment
- Client-Centered Approach
- Holistic Approach
- Strengths-Based
- Context-Based Practice
- Cultural Diversity
AOTA Mental Health Promotion, Prevention and Intervention

**Settings**
- Inpatient behavioral mental health
- Community mental health
- Alternative and public schools
- Residential (group homes, nursing homes)
- Home-based services
- Organizational workplaces

**Focus of Services (Direct–Individual or Group, Consultation)**
- Engagement in occupation to foster recovery and/or “reclaiming mental health” resulting in optimal levels of community participation, daily functioning, and quality of life
- Functional assessment and intervention (skills training, accommodations, compensatory strategies) (Brown, 2009, 2012)
- Identification and implementation of healthy habits, rituals, and routines to support wellness (Champagne & Gray, 2011)
- Social skills and friendship promotion groups (Bazyk & Arbesman, 2013)
- Community integration (recreation, leisure, work) (Arbesman & Logsdon, 2011; Bazyk & Arbesman, 2013)
- Normative life roles (Gibson, D’Amico, Jaffe, & Arbesman, 2011)
- Sensory strategies (Brown, 2009, Champagne, 2006, Downing, 2011)
- Supported employment, supported education (Arbesman & Logsdon, 2011)
- Cognitive behavioral strategies (Bazyk & Arbesman, 2013)
- Strategies for stress reduction (Downing, 2011)
- Trauma-informed care (Champagne, 2006)
- Motivational interviewing (Stoffel & Moyers, 2004)
- Intensive behavioral interventions (e.g., dialectical behavioral therapy)
OT Group Framework

- Importance of having a theoretical framework

- MOHO
  - Congruent with interdisciplinary views
  - Focus is on occupational behavior to delineate scope of services
  - Good fit for short term IP with goal of community reintegration
  - Allows for integration of information from other professionals (EE, support systems, etc.)
  - Allows for client diversity (dx, level of functioning)
  - Model specifies a continuum of occupational b
  - Directive group design
    - Exploration
    - Competence
    - Achievement
Psychosocial Treatment

Illness Education
  Medication Compliance
  Avoid ETOH and street drugs
Hospitalization for acute loss of functioning
IOP is rehabilitative
Psychoanalysis has limited value
Family engagement and education
Setting the Stage for Identifying Optimal Treatment

- **Repetition of task**
  - Oh! I get it now!
  - Each attempt in the repetition cycle is not a failed attempt but an additional trial of learning along the process of development and the acquisition of task.

- **Demonstration**
  - Traditional hands on, field treatment (learning through basic demo of concepts), “Let me show you how this is done”

- **Consistency in training the same way in all situations**
  - Generalization is a hard concept to teach. Try to teach in a variety of settings. Be consistent in your prompts, requests and general counsel.
  - Sequencing the same way each time
Setting the Stage for Identifying Optimal Treatment

- **Making the abstract concepts tangible, visual and concrete**
  - Abstraction is a more advanced thinking skill and difficult for someone whose thoughts are disordered. Concepts of emotion: anger, disappointment, temptation, loneliness and worry can be made more concrete with pictures of facial expressions and lists of specific causes that trigger these emotions. This improves functional coping skills. There are other abstract concepts that arise in therapy: grief/bereavement, dating and romance, social skills development, issues of spirituality.

- **Modeling and social observation**
  - Pointing out the importance of paying attention in social situations and encouragement to be more aware. Social learning can also be observed through learning by other’s mistakes.

- **Sequencing**
  - Provides structure and aids understanding. Organizes thought patterns. It can be applied to daily skills (a showering routine) for domestic chores, or to sequence events that need to be completed in a day’s routine.
Psychosocial Treatment

Medication PLUS psychosocial intervention

- Social skills training
  - Teach skills for managing interpersonal situations
    - Completing a job application
    - Reading bus schedules
    - Refill medications
    - Make appointments
Psychosocial Treatment

- Family therapy to reduce Expressed Emotion
  - Educate family about causes, symptoms, and signs of relapse
  - Stress importance of medication
  - Help family to avoid blaming patient
  - Improve family communication and problem-solving
  - Encourage expanded support networks
  - Instill hope

Involves role-playing and other practice exercises, both in group and *in vivo*
Tips for Handling Delusional Clients

The key to helping your patient deal with their delusions is being able to communicate with them and listen empathetically. Avoid laughing at them, ignoring them or telling them their thoughts are stupid. Remember that to your pt the delusions seem totally real and are also likely to make them feel very anxious.

You can acknowledge your client’s feelings without reinforcing the actual belief. You can communicate that you are on their side and want to help. This may give you a chance to discuss the delusions and how to try and deal with them. For example - “....this must be very frightening for you, maybe if we talk about it you may feel less anxious....”

Try to avoid agreeing with the beliefs as this may reinforce them. It is also unhelpful to challenge the delusions too directly as this can backfire, as research shows that if a person is confronted about their belief, they may end up believing in it more.

It can help to reassure them clearly and calmly. You can let them know that you understand they may see things in a particular way but you believe there is no problem or threat in the situation. This draws a line between his/her reality and your own.
Tips for Handling Delusional Clients

“I know you think the police are following you, but I don’t think this is true….”

If their belief causes certain emotions, try to respond to these emotions with a rational explanation about why they should not worry. For example “….you have no need to worry, you have done nothing wrong, so the police would not be interested in you"

Sometimes you can try to explore the evidence for a particular belief. This is not the same as challenging it. You could encourage your patient to consider the evidence for their belief by asking questions and being non judgmental.

Try to highlight the difference between a guess and a fact and try to work with them to provide alternative explanations for what they believe. It is important that discussing the evidence is done sympathetically and carefully to avoid challenging their beliefs too strongly

"You say that man was following you but can you be sure? How many times have you seen him? Did you see where he walked to? He could have just been walking in the same direction a few times because he lives nearby. "

Care for the Caregivers

- Don’t take their actions while in a decompensated state personally. See them as symptoms and not attitudes.

- Avoid compromises/bargaining services as rewards for compliance. Consumers should be provided services without conditions and regardless of attitude.

- “You only want to hurt me/keep me here.” Ground yourself in more rational thoughts, knowing that the treatment is provided out of love, compassion, concern and grounded in the mission of their well-being.

- Crisis intervention can be a long and difficult process and especially heartbreaking for care providers and family. Counsel and support should be ongoing with continued emphasis that this is typical and a normal course within psychotic disorders. Emphasize consistency & medication compliance.
Care for the Caregivers

- How do we measure success?
  - Psychiatrist – frequency counts, measures of duration, symptom intensity scales, recidivism
  - OT – Sensory organization, fine motor, ADLs, IADLs, occupational functioning and efficacy
  - SW – Obtaining stable housing and medications

- How do you measure your own success – what are your indicators? Do you update your own TP and goals?
  - Love – everything else pales in comparison
  - Connection to Family & Friends – Even when they frustrate you
  - Spirituality and Faith – It doesn’t matter in what, just as long as it is something
  - Impeccability – Doing the right thing will always feel good
  - Moments – Be in the present
  - Movement – Mind/Body Connection IADL

Encourage your clients to similarly refine their life priorities. To expect steady accomplishment or the full remission /elimination of psychotic symptoms is dysfunctionally optimistic. Getting down to the life basics helps a client gain perspective that they no longer have to “suffer” and that their diagnosis is not a sentence. It is a different, but not lesser way of life.
DSM IV to DSM V

**Schizophrenia:**
- The elimination of bizarre delusions.
- Rationale: Poor reliability in distinguishing bizarre vs. non-bizarre delusions.
- At least 1 of 2 required sx to meet Criterion A must be delusions, hallucinations, or disorganized speech.
- Rationale: Improve reliability and prevent individuals with only negative sx and catatonia from being dx with Schizophrenia.
Schizophrenia continued

- The DSM-IV subtypes of schizophrenia have been eliminated.

- Instead a dimensional approach to rating severity for the core symptoms of schizophrenia is included in DSM-5 Section III.

- Rationale: Limited diagnostic stability, low reliability, and poor validity
Schizoaffective Disorder:

- The primary change to schizoaffective disorder is that a major mood episode be present for the majority of the disorder's total duration after criterion A has been met.

- Rationale: To improve reliability, diagnostic stability, and validity of this disorder.
Delusional Disorder:
- Criterion A no longer has the requirement that the delusions be non-bizarre. A specifier is now included for bizarre type delusions.
- Delusional disorder is no longer separated from shared delusional disorder.

Catatonia:
- The criteria for catatonia is now uniform for all contexts and requires 3 sx from a total of 12.
Faces of Schizophrenia

Famous People With Schizophrenia

John Nash – Nobel Prize winner
Syd Barret – guitarist for Pink Floyd
Mary Todd Lincoln – wife of Abraham Lincoln

https://youtu.be/bWaFqw8XnpA

Albert J, Wood M. Targets and Emerging Therapies For Schizophrenia, Wiley and Son


National Alliance for Mental Health, www.nami.org


Contact Information

Thank you for your attention, & enjoy the conference!

sally.harris@harrishealth.org