Antipsychotic Alternatives

The following information suggests ideas for reducing antipsychotic drug use. A carefully monitored use of the alternatives with frequent reassessment is suggested. Always start by assessing the resident for pain*.

General Principles

- Start with a pain assessment.
- Provide for a sense of security.
- Apply the 5 Magic Tools (Knowing what the resident likes to See, Smell, Touch, Taste, Hear).
- Get to know the resident, including their history and family life, and what they previously enjoyed. Learn the resident's life story. Help the resident create a memory box.
- Play to the resident's strengths.
- Encourage independence.
- Use pets, children and volunteers.
- Involve the family by giving them a task to support the resident.
- Use a validated pain assessment tool to assure non-verbal pain is addressed.*
- Provide consistent caregivers.
- Screen for depression & possible interventions.
- Reduce noise (paging, alarms, TV's, etc.).
- Be calm and self-assured.
- Attempt to identify triggering events that stimulate behaviors.
- Employ distraction methods based upon their work and career.
- Offer choices.

What to try when the resident resists care

Therapeutic Intervention

- Evaluate recent medication changes, especially if the behavior is new.
- Determine if the resident is in pain, and if so, why? Treat the pain.*
- Evaluate whether the care can be performed at a different time.
- Determine if the resident is trying to communicate a specific need.
- Evaluate the resident's sleep patterns.
- Place the resident in bed when he or she is fatigued.
- Evaluate if there has been a change in the resident's routine.
- Provide a positive distraction, or something the resident enjoys.
- Is the resident hungry? Offer the resident a snack prior to providing care.
- Provide a periodic exercise program throughout the day (e.g. A walk to dine program).
- Encourage wheelchair/chair pushups, or assist the resident to stand periodically.
- Provide activities to assess and provide entertainment.
- Encourage repositioning frequently.

Environmental & Equipment Intervention

- Use assistive devices (wedge cushion, solid seat for wheelchair, side or trunk bolsters, pommel cushion, Dycem, etc.).
- Evaluate the resident for an appropriate size chair and proper fit.
- Evaluate alternative seating to relieve routine seating pressure/pain.
- Use an overstuffed chair, reclining wheelchair, non-wheeled chairs, or wingback chair.
- Place a call bell in reach of the resident.
- Provide an over-bed table for to allow for diversional activities.
- Place a water pitcher in reach of the resident.
- Place the resident's favorite items in their room to provide them comfort.
- Allow access to personal items that remind the resident of their family, especially photos.
- Encourage routine family visits with pets.
- Provide consistent caregivers.
- Evaluate if the resident's environment can be modified to better meet their needs. (i.e. Determine if the resident's environment can be more personalized.)

* A pain assessment should include non-verbal signs of pain. If you do not have a pain assessment that includes non-verbal identifiers, go to: http://www.dads.state.tx.us/providers/qmp/docs/painad.pdf

Continued →

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What to consider when resident is disruptive in group functions

Therapeutic Intervention

- Evaluate new medications, antibiotics especially, and asses pain.
- Remove resident from group, evaluate for group stress
- Determine if resident requires toileting.
- Determine if resident is hungry, and if so, provide them with a small snack. If the resident is thirsty, provide the resident a beverage.
- If this is a new behavior in a group, evaluate what is different this time.
- Assure resident has had a rest period prior to group activity.
- Assure there are no medical complications (low/high blood sugar).
- Assure resident is not in pain.*
- Return resident to group function, if possible.

Environmental & Equipment Intervention

- Determine whether clothing is appropriate for a particular function.
- Evaluate is the resident has well-fitting shoes, and ensure they do not rub the resident's feet.
- Evaluate ambulation devices (wheelchair, walker) that are in good working condition.
- Ensure there is adequate lighting, especially at night.
- Ensure room/function is not overly crowded.
- Ensure room is not too warm or cold.
- Consider providing snacks and refreshments for all group functions.
- Ensure sound in group functions is loud enough so the resident can hear.
- Provide consistent caregivers.
- Evaluate if this program fits into the resident's area of interest.

What to consider with a sudden mood change, such as depression

Therapeutic Intervention

- Evaluate any new medications and assess pain*.
- Evaluate for orthostatic hypotension and change positions slowly.
- Reevaluate physical needs such as toileting, comfort, pain, thirst and timing of needs.
- Rule out medical problem (high/low blood sugar changes).
- Engage resident in conversation about their favorite activity, positive experiences, pets, etc.
- Touch if appropriate while recognizing personal body space.
- Anticipate customary schedules and accommodate personal preferences.
- Evaluate balance for sub-clinical disturbances such as inner ear infections.
- Validate feelings and mobilize the resident. For instance, if the resident states, I want to get up, reply, You want to get up? to confirm you heard them correctly. If so, act on the resident's request.
- Evaluate hearing and vision.
- Discern if talk therapy is possible.
- Assess sleep patterns.

Environmental & Equipment Intervention

- Assess for changes in the resident's environment.
- Assess for changes in the resident's equipment.
- Involve family members to assure them that there have been no changes within the family, without the facility's knowledge.
- Provide routines for consistency.
- Provide consistent caregivers.
- Provide nightlights for security.
- Employ the use of a memory box.
- Employ functional maintenance / 24-hour plan.
- Encourage the resident, if able, to verbalize his or her feelings.
- Eliminate noise and disruption.
- Employ the use of a sensory room or tranquility room.

Continued →

Verbally Abusive/Physically Abusive

Therapeutic Intervention

- Begin with medical evaluation to rule out physical or medication problems.
- Evaluate the resident for acute medical conditions such as urinary tract infections, upper respiratory infections, ear infections or other infections.
- Evaluate the resident for pain, comfort and/or other physical needs such as hunger, thirst, position changes, bowel and bladder urges.
- Attempt to identify triggering events or issues that stimulate the behavior.
- Consider using a behavior tracking form to assist in identification of triggers and trending patterns.
- Consult with the resident's family regarding past coping mechanisms that proved effective during times of increased stress levels.
- Provide companionship.
- Validate feelings such as saying, You sound like you are angry.
- Redirect.
- Employ active listening skills and address potential issues identified.
- Set limits.
- Develop trust by assigning consistent caregivers whenever possible.
- Avoid confrontation. Decrease you voice level.
- Provide a sense of safety by approaching in a calm/quiet demeanor.
- Provide rest periods.
- Provide social services referral if needed.
- Provide a psychologist/psychiatrist referral if needed.
- Provide touch therapy and/or massage therapy on the hands or back.
- Reduce external stimuli (overhead paging, TV, radio noise, etc.).
- Evaluate staffing patterns and trends.
- Evaluate sleep/wake patterns.
- Maintain a regular schedule.
- Limit caffeine.
- Avoid sensory overload.

Environmental & Equipment Intervention

- Use relaxation techniques (i.e. tapes, videos, music etc.).
- Help the resident create theme/memory/reminiscence boxes/books.
- Help the resident create a magnification box to create awareness of the resident's voice level and provide feedback.
- Use a lava lamp, soothe sounders, and active mobile.
- Play tapes and videos of family and/or familiar relatives or friends.
- Move to a quiet area, possibly a more familiar area, if needed. Decrease external stimuli.
- Use fish tanks.
- Encourage family visits, and visits from favorite pets.
- Identify if another resident is a trigger for this behavior.

Pacing/ Wandering At Risk for Elopement

Therapeutic Intervention

- Find ways to meet a resident's needs to be needed, loved and busy while being sensitive to their personal space.
- Provide diverse activities that correspond with past lifestyles/preferences.
- Consider how medications, diagnoses, Activites of Daily Living schedule, weather or how other residents affect wandering.
- Evaluate the need for a Day Treatment Program for targeted residents.
- Help resident create theme/memory/reminiscence boxes.
- Provide companionship.
- Provide opportunities for exercise particularly when waiting.
- Pre-meal activities.
- Singing, rhythmic movements, dancing, etc.
- Identify customary routines and allow for preferences.
- Help the resident create a photo collage or album of memorable events.
- Provide structured, high-energy activities and subsequent relaxation activities.
- Take the resident for a walk.
- Provide distraction and redirection.
- Provide written/verbal reassurance about where he/she is and why.
- Alleviate fears.
- Ask permission before you touch, hug etc.
- Assess/evaluate if there is a pattern in the pacing or wandering.
- Assess for resident' personal agenda and validate behaviors.
- Ask family to record reassuring messages on tape.
- Evaluate for a restorative program.
- Perform a physical workup.

Environmental & Equipment Intervention

- Remove objects that remind the patient/resident of going home (hats, coats, etc.).
- Individualize the environment. Make the environment like the resident's home. Place objects within the environment that are familiar to the resident.
- Place a large numerical clock at the resident's bedside to provide orientation to time of day as it relates to customary routines.
- Ensure the courtyard is safe for the resident.
- Decrease noise level (especially overhead paging).
- Evaluate floor patterns.
- Evaluate rest areas in halls.
- Evaluate camouflaging of doors.
- Evaluate visual cues to identify safe areas.
- Play a favorite movie or video.
- Put unbreakable or plastic mirrors at exits.
- Place Stop and Go signs.
- Evaluate the WanderGuard system.
- Use relaxation tapes.
- Evaluate and use, as necessary, visual barriers and murals.
- Evaluate wandering paths.
- Evaluate room identifiers.

Be DADS Wise

With the use of Antipsychotics

Identify the individuals with dementia who have the following substances in their regimen

Haloperidol (Haldol®) Aripiprazole (**Abilify®**) Asenapine (**Saphris®**) **Chlorpromazine** (Thorazine®) **Fluphenazine** (Prolixin®)
Iloperidone (**Fanapt®**) Lurasidone (**Latuda®**) Olanzapine (**Zyprexa®**) Paliperidone (**Invega®**) **Quetiapine** (**Seroquel®**)
Risperidone (Risperdal®) Ziprasidone (**Geodon®**)

- Antipsychotics are no longer considered an acceptable therapy to treat the behavioral and psychological symptoms of dementia (BPSD).
- The FDA has issued a Black Box Warning on these drugs highlighting the increased risk of death when prescribed for individuals with dementia or dementia-related psychosis.
- Thorough evaluations by an interdisciplinary team and formal documentation must be present in the clinical record of each individual with dementia on an antipsychotic drug (this includes individuals who enter the facility from either the hospital or community setting already on these medications).
- Assessments of possible medical, physical, functional, emotional, psychological, social, and environmental causes of behavior should be documented prior to antipsychotic use and re-assessed at least quarterly or more often.

Start documenting and monitoring behaviors prior to the initiation of a psychotropic drug

- Observe and document the following: **Who** the resident affected (did the behavior involve others or just the individual themselves)? **What** happened before, during, and after the behavioral occurrence? **Where** did the behavior take place (identify any trends in location, or the environmental factors surrounding the occurrence)? **When** did the behavior occur, and are there any trends in time of day or changes in staff? **Why** did the behavior happen, and can it be avoided or anticipated in the future to minimize its likelihood? **How** frequent and severe was the behavior (is it causing harm to others or severe distress to the individual themselves)?
- Get proactive with implementing individualized person-centered non-pharmacological interventions, therapeutic approaches, and activities. Care plans should outline and highlight these approaches, as well as contain a timeline for proposed gradual dosage reductions.
- Get to know each resident's likes, dislikes, personal life history, activities that they enjoy, interests they like to talk about, environmental preferences (e.g., temperature, food, beverages, acceptable levels of noise, etc.), their emotional and psychosocial needs, as well as the potential triggers for behavior. This information should be carried forward to all members of the staff.

The National Campaign to Improve Dementia Care is promoting the use of non-drug approaches

- Visit the Advancing Excellence in America's Nursing Homes website to learn more and download toolkits: https://www.nhqualitycampaign.org/participantNH.aspx.
- Adopt the use of Consistent Assignment in your nursing home. This is where members of the staff (especially CNAs) are responsible to care for the same residents 80-85% of the time. This is a proven technique for reducing resident and staff frustrations.
- Staff members should periodically review the information found in the **Hand in Hand Toolkit** (if you do not already have this DVD series visit: http://www.cms-handinhandtoolkit.info/Index.aspx to download the free product)

References:
Drugs.com/professionals: http://www.drugs.com/pro/
FDA Black Box Warning: http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm124830.htm
State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf
Advancing Excellence in America's Nursing Homes: https://www.nhqualitycampaign.org/participantNH.aspx
Hand in Hand Toolkit: http://www.cms-handinhandtoolkit.info/Index.aspx

BEHAVIORAL or PSYCHOLOGICAL SYMPTOMS OF DEMENTIA (BPSD)

GUIDANCE FOR ANTIPSYCHOTIC USE IN LONG-TERM CARE

- Appropriate diagnoses: Schizophrenia, Schizo-affective disorder, Schizophreniform disorder, Delusional disorder, Mood disorders (bipolar disorder, severe depression w/ psychotic features), Psychosis in the absence of dementia, Medical illness w/ psychotic symptoms, Tourette's disorder, Huntington's disease, Hiccups, Nausea and vomiting associated w/ cancer therapy
- Antipsychotic medication are only appropriate for elderly residents in a minority of circumstances – See diagnoses above
- All antipsychotic medications carry a Black Box Warning associated with increased risk of death in elderly patients treated for dementia-related psychosis
- Causes of behaviors such as medical, physical, functional, psychological, emotional psychiatric, social, and environmental must be identified and addressed before antipsychotic medications are considered for elderly residents.
- Antipsychotic medications must be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and review.
- Antipsychotic medications should <u>not</u> be used if the only indication is one or more of the following: wandering, poor self-care, restlessness, impaired memory, mild anxiety, insomnia, indifference to surroundings, sadness or crying not related to depression, fidgeting, nervousness, or uncooperativeness
- Diagnoses alone do not satisfy the criteria for using antipsychotics for BPSD unless the symptoms present a danger to the resident or others <u>and either</u> the symptoms are identified as due to mania or psychosis <u>or</u> behavioral interventions have been attempted and are included in the plan of care, except in an emergency.
- Use of Antipsychotic medications in an Emergency Situation (acute onset or exacerbation of symptoms):
    - Use must meet the above criteria
    - Acute treatment Period is limited to seven days or less
    - Clinician in conjunction with interdisciplinary team must evaluate and document the situation within 7 days to identify and assess contributing causes
    - If behaviors persist beyond emergency situation, non-pharmacological interventions must be attempted
- Use of Antipsychotic medication to treat Enduring Condition
    - Use must meet the above criteria
    - Targeted behaviors must be clearly identified and documented

    - Monitoring must ensure that behavioral symptoms are not due to medical problems, environmental stressors, or psychological stressors that are expected to improve if problem is addressed and resolved
    - Persistent behaviors are documented when other approaches attempted have failed and resident's quality of life is negatively affected.
- New Admissions
    - Provider responsible for preadmission screening for mentally ill and intellectually disabled individuals and for obtaining physician's orders for immediate care
    - If PASRR Level 1 screening is negative for mental illness or intellectual disability: must re-evaluate the use of antipsychotic medication at the time of admission and/or within 2 weeks after admission to consider if medication dose can be reduced or discontinued
- Antipsychotics already in place
    - Treatment should be lowest possible dose to improve target symptoms monitored
    - Monitor ongoing effectiveness, potential adverse consequences
    - Evaluate use of any other psychopharmacological medications
    - After initiating or increasing dose of antipsychotic medication, behavioral symptoms must be reevaluated periodically to determine effectiveness and the potential for reducing or discontinuing the dose
    - Monitor for adverse consequences
        - Potential side effects of antipsychotic drug class
        - Risk for cardiovascular effects
        - Potential metabolic effects and neurological side effects
        - Risk for life threatening events or permanent/irreversible conditions

Antipsychotics are NOT Approved for Behavioral and Psychological Symptoms of Dementia (BPSD)

FDA Black Box Warning: Increased Mortality in Elderly Patients with Dementia-Related Psychosis

Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Analyses of 17 placebo-controlled trials (modal duration of 10 weeks), largely in patients taking atypical antipsychotic drugs, revealed **a risk of death in drug-treated patients of between 1.6 to 1.7 times the risk of death in placebo-treated patients**. Over the course of a typical 10-week controlled trial, the rate of death in drug-treated patients was about 4.5%, compared to a rate of about 2.6% in the placebo group. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (e.g., heart failure, sudden death) or infectious (e.g., pneumonia) in nature. Observational studies suggest that, similar to atypical antipsychotic drugs, treatment with conventional antipsychotic drugs may increase mortality. The extent to which the findings of increased mortality in observational studies may be attributed to the antipsychotic drug as opposed to some characteristic(s) of the patients is not clear.

http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm124830.htm

CMS Allowed Diagnoses for Antipsychotic Medications:

Long-term Chronic Conditions

- **Schizophrenia (Schizo-affective disorder and Schizophreniform disorder)**
- **Tourette's disorder**
- **Huntington's disease**
- Delusional disorder
- Bipolar disorder
- Severe depression refractory to other therapies and/or with psychotic features

CMS Allowed Diagnoses for Antipsychotic Medications: Acute Conditions

Short-term Acute Conditions

- Psychosis in the absence of dementia
- Medical illness with psychotic symptoms and/or treatment related psychosis or mania
- Hiccups (not induced by other medications)
- Nausea and vomiting with cancer/chemotherapy

MDS: Significant Change of Condition (SCSA)

- Only the **bold** diagnoses trigger an exclusion on the MDS, Section N
- Adding antipsychotic medication and a new diagnosis meet the criteria for significant change of condition and require a new MDS assessment

PASRR: Considerations

- A new diagnosis of mental illness must be referred for a possible Level II PASRR evaluation
- Referral should be made as soon as the criteria indicating such are evident

REGULATORY: Considerations

- F-222 for deficiencies concerning **chemical** restraints
- F-278 assessment must accurately reflect the resident's status
- F-329 Unnecessary Drugs

CRITERIA: An appropriate diagnosis alone does not warrant the use of an antipsychotic:

- Non-pharmacological interventions and therapeutic approaches are considered first-line therapy for behavioral or psychological symptoms of dementia (BPSD)
- Behavioral symptoms present a danger or severe distress to the resident or others
- Symptoms are due to mania or psychosis without dementia
- Behavioral interventions are attempted and included in care plan, except in an emergency

References: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html

http://info.sos.state.tx.us/pls/pub/readtac$ext.ViewTAC?tac_view=4&ti=40&pt=1&ch=19

TEXAS Department of Aging and Disability Services

Psychotropic Medication Tracking Tool for Nursing Homes

www.TexasQuaility Matters.org (Use with antipsychotic, antianxiety, and hypnotic medications)

RESIDENT:	**ROOM#:**	**DATE:**
Prescribing Clinician:		
Medication:	Dose:	Frequency:
Route:	Scheduled or PRN:	
Diagnosis/clinical rationale:		
Target behavior(s):		
Target behavior(s) observed w/in last 7 days:		

Document the ongoing progress and/or possible causes of the target behavior(s). Include **who** was involved, **what** happened, **where** and **when** it occurred, **why** it possibly occurred, and **how** it affected the resident or others:

_____

_____

_____

_____

_____

FACILITY PROCESSES

Is there documentation of an evaluation of possible environmental, medical, physical, emotional, social, functional or psychiatric causes or triggers of the resident's behavior?	**YES**	**NO***
Has pain been considered as a possible cause of behavior?	**YES**	**NO***
Have medications been considered as a possible cause of behavior?	**YES**	**NO***
Are there individualized, person-centered non-medication interventions and therapeutic approaches included in the care plan?	**YES**	**NO***
Are these interventions and approaches utilized by the staff?	**YES**	**NO***

If any of the above are answered* NO, *action is necessary to include these in resident's clinical record.

Notes on effectiveness of non-medication interventions and therapeutic approaches used:

_____

_____

_____

Continued on other side

Is there documentation of risk/benefit discussion with resident or legal representative when obtaining consent and interdisciplinary team before the initiation of medication? **YES** **NO***

If answered* NO, *action is necessary to include this in resident's clinical record.

Describe any observed changes in the frequency/intensity of the primary target behavior(s) after medication was started:

_____

_____

_____

CLINICAL MONITORING

In the last six months has resident gone to the ER or Hospital secondary to target behavior? **YES** **NO**

Has the resident experienced adverse effects or functional decline due to medication? **YES** **NO**

If **YES**, describe:_____

_____

_____

If started outside facility, is medication still necessary after individual has acclimated to the facility? **YES** **NO**

Has a gradual dosage reduction (GDR) been attempted in the last 3 months? **YES** **NO**

If **YES,** outcome of the GDR:_____

_____

_____

If **NO**, is GDR appropriate at this time? **YES** **NO**

(NOTE: GDR is recommended every three months when behavior frequency/intensity remains at a manageable level. Consult with prescribing physician.)

If GDR is not appropriate, has physician documented a clinical explanation for maintaining the medication at the current dose? **YES** **NO**

(NOTE: For residents with dementia, at least one attempt at GDR should be initiated within the facility unless behaviors are causing severe distress or harm to self or others.)

Comments:_____

_____

Signature:_____ Date: _____

(Name/Title/Credentials)

Clues to Identifying Causes of Common Behavior and Psychiatric Disturbances

Delirium

□ Assessment of cognitive function (as with MMSE) reveals deficits in orientation, concentration, memory, language, and praxis-deficits
□ Recent onset of changes in cognition, alertness, attention, sleep patterns
□ Frequent fluctuation or "roller coaster" of consciousness
□ Reduced or fluctuating level of consciousness and impaired attention
□ Disturbed sleep-wake cycle; i.e., individual cannot sleep at night and drowsy during the day, or delirium symptoms begin and are worse at night
□ Changes follow a recent medical illness, condition change, or addition or change of medications associated with psychiatric and behavioral symptoms
□ Individual is either hypoactive-hypoalert or hyperactive-hyperalert
□"Clouding" of consciousness and difficulty in focusing and sustaining attention
□ Individual inert and drowsy, seems indifferent to their environment, speaks little, and cannot attend for more than a few seconds; condition is not abolished by sleep or rest
□ Individual is restless and aroused, and/or very awake but not very aware of their surroundings
□ Individual is so distractible that they are incoherent when interacting with others
□ Individual shows new or worsening abnormalities in perception, belief, and mood; illusions and hallucinations, especially visual ones; persecutory delusions, with anxiety and/or restlessness
□ Individual has risk factors for delirium (e.g., age, neurological disorders, medications, recent hospitalization)

Key Points:
- To identify delirium, the patient typically must be examined carefully (not just observed superficially)
- Unless patients with hypoactive-hypoalert delirium are examined–rather than merely observed–their psychomotor retardation and constricted affect may lead to erroneous conclusion that they are profoundly depressed or have catatonic schizophrenia
- Delirium is also known as acute brain syndrome, acute confusional state, encephalopathy, intensive care unit (ICU) psychosis, toxic psychosis
- Basic features are disturbances in consciousness, attention; abnormalities in perception, behavior, and mood often occur
- Delirium may be precipitated by many factors, alone or in combination; usually 1 of 2 forms: hypoactive-hypoalert or a hyperactive-hyperalert
- Confusion Assessment Method (CAM) screen may or may not yield positive results
- Delirium should be considered in the differential diagnosis of acute or subacute changes in the mental state or behavior of any patient (especially old or very ill) with a disease of the central nervous system and/or medications that affect the central nervous system
- Unless a cognitive assessment is performed, the hyperactive-hyperalert patient's abnormal behavior can be mistakenly attributed to mania or paranoid schizophrenia. Such diagnostic errors are more common when delirious patients are hallucinated or delusional.
- Typically, delirious patients cannot sleep at night and are drowsy during the day. Further, delirium often begins at night and is worse at that time. Patients with mild delirium may be disturbed only at night and report their illusions and hallucinations as bad dreams the next morning

Psychosis
□ Hallucinations, delusions, and/or thought disorder (especially, paranoid ideation)
□ Absence of prominent mood symptoms
□ No identifiable underlying medical cause
□ Escalate in intensity, frequency, duration from day to day and/or week to week
□ Not associated with fluctuating level of consciousness
□ Individual provides detailed description of disordered thoughts

Schizophrenia
□ Hallucinations, delusions, and/or thought disorder
□ Deterioration of social, occupational, and interpersonal function over time
□ Absence of prominent mood symptoms
□ Chronic persistent or recurrent course
□ Delusions are present, e.g., persecution (sometimes referred to as "paranoid delusions") or grandiose delusions without mood elevation or elation
□ Additional abnormalities of thought
□ Misinterpretations and excessive personalization of everyday situations or interactions
□ Ideas contained in sentences are not connected in a manner that can be understood in the context of usual speech
□ Mood disorders (major depression and bipolar disorder) and cognitive disorders (delirium and dementia) have been considered and ruled out
□ Any mood-related depressive delusions are self-blaming or hopeless or grandiose

Key Points
- In contrast to depression and demoralization, symptoms of schizophrenia are alien to usual human experience.
- Thought disorder can usually be distinguished from aphasia by absence of paraphasic errors, intact repetition, naming and following multistep commands, and by the presence of connecting words (absent in nonfluent aphasia) and both nouns and verbs (diminished in fluent aphasia)

Mania

□ Individual shows persistently elevated mood, elevated self-attitude and self-confidence, markedly increased energy and diminished need for sleep
□ Mood is labile rather than persistent
□ Self-attitude is grandiose, and/or based on delusions
□ Pressured speech and/or racing thoughts may be prominent
□ Effort made to identify and rule out a medical condition or medication known to be associated with mania

Key Points

- In mild mania (hypomania), an increase in energy makes patients more productive; in severe mania, it makes them less productive, because they are so hyperactive and distractible that they cannot complete any but the simplest task

Demoralization

□ Mood disturbance is related to the individual's circumstances and/or an identifiable precipitant
□ The individual shows somewhat decreased responsiveness and participation
□ There is usually a chronic, progressive, painful, debilitating, or disfiguring condition
□ A sad individual who also frustrated, irritable, pessimistic, or anxious
□ There is not evidence of psychosis
□ Any delusions or hallucinations are due to another condition
□ Unpleasant emotions tend to diminish as the individual's situation improves or when they discover that they are not powerless in the face of adversity
□ There is a more or less direct relationship between the patient's mood and his or her situation
□ Statements about possibly being "better off dead" (or similar so-called "suicidal thoughts") are accompanied by some hopefulness about their situation and/or statement about wanting to live
□ Individual responds positively to encouragement that time will bring improvement or that new approaches might help

Key Points

- Demoralization is a normal response to adversity
- Delusions and hallucinations never occur in demoralization
- Antidepressants do not relieve normal sadness and should not ordinarily be used for such individuals, especially without trying other measures first

Depression

□ Delirium been considered and ruled out
□ Sad mood persists over time, rather than being intermittent or labile
□ There is diminished self-attitude and self-confidence, and a pessimistic outlook
□ There is diminished energy and impaired sleep
□ The individual lacks the capacity to enjoy events that would ordinarily bring pleasure
□ Emotions occur and persist without much relationship to the patient's situation
□ Gloomy thoughts are repeatedly and noticeably delusional in nature; i.e., based on substantial misinterpretations that the individual accepts as true
□ Mood remains low despite improving circumstances
□ Suicidal expressions are accompanied by feelings of hopelessness and guilt, with an emphasis on death as the best or only way to end the suffering
□ The individual dismisses encouragement that time will bring improvement or that new approaches might help
□ Medical conditions and/or medications that may cause significant mood disturbance have been considered and ruled out
□ Any hallucinations that are present are delusional in nature
□ There is disturbed sleep, low energy, slowed thinking and movements not attributable to other causes
□ Possible mood disorder has been distinguished from poor activity tolerance, apathy, weakness, lethargy, and reduced responsiveness
□ Cognitive function has been assessed
□ Cognitive assessment does not show significant deficits in orientation, concentration, memory, language, and praxis
□ Any of the anxiety disorders can occur secondarily with major depression. A secondary anxiety state can be recognized by its occurrence episodically only when episodes of depression occur.

Key Points

- Because neurologic diseases and their treatments can disturb sleep, appetite, energy level, psychomotor activity, and libido, abnormalities in these vital functions are by no means proof of depression
- Before insomnia, anorexia, and the like can be seen as evidence of major depression, other causes must be excluded
- When major depression is being considered as the explanation for a patient's psychomotor retardation or lack of motivation (e.g., refusal to participate in physical therapy), delirium–not depression–may often be the cause
- When an individual remains sad despite antidepressant treatment, or when they are delusional or hallucinating, or when other symptoms persist, additional thorough review and reconsideration of the diagnosis is needed
- Apathy, weakness, lethargy, reduced responsiveness are not depression, and do not respond to antidepressants
- Deficits in orientation, concentration, memory, language, and praxis-deficits are absent in affective disorders and schizophrenia

Anxiety
□ Individual has pervasive feelings of tension, apprehension, and worry and/or physical symptoms such as palpitations, sweating, and hyperventilation, without a clear trigger or precipitant, and/or difficulty falling asleep, mildly diminished appetite, and diminished concentration
□ These symptoms occur often enough and with enough intensity to significantly disrupt an individual's function, life, health, safety, or well-being, and cause distress
□ Symptoms of anxiety may coexist with major depression, demoralization, and other psychiatric syndromes
□ Other psychiatric syndromes that may also show excessive worry without a clear or actual stimulus, generalized muscle tension, or vague "nervousness" have been considered and ruled out

Key Points
- Any of the anxiety disorders can occur secondarily with major depression. A secondary anxiety state can be recognized by its occurrence episodically only when episodes of depression occur.
- Anxiety disorder should be distinguished from objects or events that cause dislike or upset but do not interfere with everyday life.

Anxiety / Panic disorder
□ Episodic fearfulness and apprehension lasting several or many minutes, associated with palpitations, shortness of breath and/or the experience of being unable to "catch my breath," tremulousness, and perioral or fingertip tingling
□ Episodes are generally stereotyped (i.e., quite similar from episode to episode), are triggered by specific plans (e.g., planning to go outside) or circumstances, and are frightening to the individual
□ Episodes have been distinguished from medical conditions that may cause similar symptoms (e.g., hyperthyroidism, cardiac arrhythmias)

Anxiety / Phobia
□ Individual experiences excessive fearfulness and apprehension that is triggered by a specific event, setting (e.g., tight spaces, going outside, going into a crowded area of the facility), or object (e.g., needles, spiders)
□ Individual acknowledges reaction as excessive, unreasonable, or an overreaction, which actually interferes with function

Key Points
- Phobias should be distinguished from objects or events that cause dislike or upset but do not interfere with everyday life. For example, a dislike of heights or a feeling of anxiety about standing at an edge is not a phobia if the reaction does not interfere with everyday existence. An example of interference is not being able to use the elevator because of a phobia of enclosed spaces.

Obsessive-Compulsive Disorders and Symptoms
□ Individual has repetitive thoughts (obsessions) or repetitive actions (compulsions) that are distressing and resisted
□ Experiences are recurrent and stereotyped and intrusive
□ Individual recognizes his/her obsessions and compulsions as excessive but ultimately cannot resist thinking about them or doing them

Conversion Disorder
□ Behavior suggests a neurologic disorder
□ Individual appears to desire to be in the sick role
□ Neurologic complaint represents something they do (e.g., behave as if they are paralyzed) rather than something they have (e.g., paralysis)
□ There are reasons in personal history and/or current situation to want to be regarded as sick so that others will treat them differently
□ Individual appears to be better able to cope with a difficult relationship or situation when they are more symptomatic

Dementia
□ Adult onset
□ Two or more cognitive impairments
□ Normal and stable levels of consciousness and alertness
□ Individual shows lack of insight
□ Gradual, not abrupt onset or progression
□ Patient cannot care for self due to cognitive impairment
□ Potentially reversible causes of gradually declining cognition have been considered, including medication-induced cognitive decline, hypothyroidism, and normal pressure hydrocephalus
□ Other causes of any psychiatric and behavioral symptoms have been considered and ruled out
□ Individual has catastrophic reactions (sudden emotional outbursts usually precipitated by minor environmental stressors)
□ Despite abnormalities in multiple cognitive domains, individual is alert and lacks clouded consciousness seen in delirium
Key Points
- Onset in adulthood distinguishes dementia from congenital or early-life onset impaired cognition
- Criterion of multiple cognitive impairments distinguishes dementia from focal cognitive syndromes such as the amnestic syndrome and aphasia.
- Requirement of normal levels of consciousness and alertness distinguishes dementia from delirium.
- Irreversibility or progression are not essential to the diagnosis, although most degenerative dementias (e.g., Alzheimer's disease, dementia with Lewy bodies, frontotemporal dementia) have both qualities
- If the individual can care for self, situation may more accurately be called mild cognitive impairment
- Psychiatric symptoms are common in dementia, including apathy (approximately 30%), agitation (approximately 25%), depression (approximately 20%), delusions (approximately 20%), and hallucinations (approximately 15%)
- More than 75 diseases can cause the symptoms of dementia, so the differential diagnosis is extensive. Alzheimer's disease is most prevalent, accounting for approximately 60% of cases. Other common causes are vascular dementia (about 15%), mixed vascular dementia and Alzheimer's disease (about 10%), Lewy body dementia (about 15%), and frontotemporal dementia (about 5%).

Catastrophic reaction
□ Sudden expressions of negative emotion out of proportion to the precipitating stimulus
□ Usually last minutes, rather than hours
□ Typically respond to interpersonal interventions (e.g., suspending assessment, reassuring the individual, reducing noise and distractions in the environment)
□ Presence of an identifiable brain disease
□ Triggered by everyday situations (e.g., asked to do several things at once) and/or by care-related ones (e.g., receiving care or bedside assessment).

Key Points
- Individuals with cognitive impairments are vulnerable to outbursts of anger, anxiety, frustration, or sadness when they are faced with a task they cannot master or a situation that overwhelms them. These explosions of affect are called catastrophic reactions, and they can occur in patients with dementias, delirium, traumatic brain injuries, cerebrovascular accidents, and mental retardation.

Adapted from Chapter 2; Peter V. Rabins and Phillip R. Slavney: Overview of Psychiatric Symptoms and Syndromes. In Lyketsos, C., Lipsey, J., Rabins, P., and Slavney, P. Psychiatric Aspects of Neurological Diseases. New York: Oxford University Press, 2008.