Late life paraphrenia in long term care

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Late Life Paraphrenia in Long Term Care

Late life paraphrenia has been described as a subtype of schizophrenia associated with late onset, circumscribed and florid hallucinations or delusions, arid sensory and social losses, although the etiology and validity of the syndrome has been debated (Howard, Almedia, Levy, 1994; Moore, 1981). Elderly individuals with psychotic symptoms whose onset appears to be associated with sensory or social losses may have a better prognosis than those whose symptoms are associated with organic changes (Holden, 1987). In this case study, an elderly man with late onset psychotic symptoms associated with functional losses is described to illustrate this syndrome and possible intervention strategies.

PRESENTING COMPLAINT

The nursing home treatment team received a note from the patient's son stating that the patient believed that nursing home residents were being systematically murdered. This came to the son's attention when the patient would not allow his grandchildren to come into the nursing home after a recent visit, expressing his fear for their lives.

Upon interview the patient described his belief that inmates from prisons in Florida were being transferred to the nursing home and were systematically murdering veterans in the nursing home. He identified the leader of this ring (a large, ambulatory patient with undifferentiated schizophrenia and incoherent speech who frequently paced the halls) and other co-conspirators (other patients). His evidence for this included the following observations. He noted that individuals were transferred to acute medicine and never returned (they died but he believed they were being murdered). He heard individuals calling out at night "help me" and then heard silence (their call lights had presumably been answered, but he believed the silence meant they were murdered). He observed that unusual pipes had suddenly appeared running floor to ceiling in patient rooms (there was construction on the floor above involving running pipes through rooms below), which he believed were used to dispose of bodies. He had a detailed memory for many similar perceptions which formed an elaborate web of evidence for him. He also reported that he thought he heard other patients threaten him if he told of the murder ring, saying, "I'll throw your body in the surf," and "I'll kill you and not leave enough dust to throw away."

Clearly, these experiences were frightening to him. He stated that he had taken to sleeping at night fully clothed, lying on top of the covers with a vase in his hand (for self-defense). Otherwise the patient often kept to himself, as he had trouble initiating social interaction due to sensory losses. However, when approached and spoken to loudly, he easily engaged in one-on-one conversation and was alert, oriented, quick witted, and bright.

HISTORY

The patient was an 89 year-old widowed male, with one son, who served in the Army intelligence motor pool, later worked as a truck

driver and security officer, and, in his retirement, served on the town council and as a nursing home ombudsman. He then suffered vision loss (macular degeneration) and hearing loss, gave up these activities, and developed insomnia which was treated with increasing doses of xanax. He was admitted to the nursing home for decreased ability to care for himself in the community. Records noted he had a brief period of hallucinations when tapered from the xanax too quickly upon admission, but these remitted when he was tapered more slowly.

Neuropsychological testing found no evidence of dementia or delirium. WAIS-R Verbal IQ was in the high average range, with subtest scores from average to very superior. Information and Comprehension were high average and Vocabulary very superior. WMS-R Logical Memory I and II were within normal limits as was FAS. Visual tests were not given due to vision loss. CT scan noted a small old left posterior infarct and diffuse atrophy.

INTERVENTION

Once potential medical reasons for symptoms were ruled out, the patient was treated with a combination of psychotherapy and medications. He was seen two-three times weekly from 3/24/94 to 5/12/94 for approximately 20 minutes each session. These sessions would begin by asking him how he was feeling and how he had slept the previous night. This often led to his revealing his recent experiences with the "murder ring." For example, once he stated "last night when I went into the bathroom I interrupted a group of them discussing their plans; they dropped something on the floor as a signal to stop talking when I entered the bathroom." If this general question did not elicit material, he was asked directly "how are you feeling about your concerns about what is happening in the nursing home?"

During the initial part of the session, response to his beliefs focused on support for his affective experience and assessment of the severity of his current affective symptoms and insomnia. In the later part of the session, alternative explanations were presented in a non-threatening and collaborative manner (e.g., "do you think it might be possible that the men were just discussing something else

when you entered the room and dropped the item accidentally?"). In these instances, if he seemed open to alternative explanations, these were endorsed in moderation by the therapist (e.g., "I think they might have just been having a normal conversation in the bathroom"). Other times potential inconsistencies or problems in his stories were suggested (e.g., "wouldn't the families of patients who were murdered raise questions if this was really happening?"). However, if he did not seem open to alternative explanations or holes in his story, perhaps having had an especially anxious night, the conversation was re-directed back to his emotional experience of the events (e.g., "that sounds very frightening"). The key was balancing respect for his experiences with questioning of the same, both in a supportive fashion.

In addition, the intervention focused on encouraging him to consider how his hearing and vision impairments might be contributing to the situation. He was aware that his hearing and vision were impaired, but had difficulty understanding that these impairments might lead him to misinterpret an event. For example, he once pointed to a bulletin board stating it was a map of how prisoners were being transported from Florida to Massachusetts. On this occasion he was taken to stand close in front of the bulletin board and it was pointed out how the bulletin board in fact illustrated nutrition requirements, again in a supportive fashion (e.g., "I can see now how you might think this is a map, but in fact, if you look here, it really is . . . "). He seemed to be able to see this once it was explained to him. This was used to illustrate how his difficulties with hearing and vision might cause him to misread a situation, and how it could be helpful for his own well-being to develop some skepticism that everything may not be as it first appears.

He was also treated with .25 mg haloperidol bid for 4 weeks, which was increased to .25 mg q am and .5 mg q hs for 2 weeks, and later tapered back to .25 mg bid. Over six weeks of individual psychotherapy he slowly decided that he had been misunderstanding what had been happening and "confusing reality with imagination" (his words).

He was then referred to a weekly men's support group to provide ongoing social interaction and monitoring. The group focused on the experiences of the patients in the nursing home, such as their

concerns and complaints about negotiating care. This group provided him an extremely important outlet for social contact, helping to alleviate his social isolation. From there on he improved though continued to be vulnerable to misperceptions which were monitored in the group format. For example, when group members were discussing their care in the evenings or being awakened in the evening, the therapist asked "and how have your nights been." When, on occasion he reported something that revealed mounting suspiciousness, the therapist intervened by suggesting an alternative explanation and reminding him of what he had learned in individual therapy (e.g., "could this be an occasion when you are confusing reality with imagination?" "could your problems with hearing and seeing have made you misinterpret this?"). The haloperidol was maintained as he continued to present risk for delusions and also reported nightmares, but was eventually discontinued in May '95. The patient died in June '96 of pancreatic cancer.

CONCLUSION

This case illustrates late life onset of circumscribed, florid psychotic symptoms in a bright, cognitively intact elderly man in long term care. Several factors may have contributed to the development of these symptoms: sensory loss, social isolation, environmental changes, and disruption of the sleep cycle. A bright and active mind, excellent memory, and an inquisitive and somewhat skeptical pre-morbid personality may also have contributed. Neuropsychological testing was useful in ruling out dementia. Intensive, time-limited individual psychotherapy in combination with medication allowed him to slowly challenge his beliefs about the Florida-Massachusetts murder ring, but did not altogether eliminate a propensity to see lesser conspiracies. Ongoing group treatment with a trained mental health clinician was critical for monitoring his vulnerable mental status and in replacing social losses.

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Memory Complaints in the Elderly: A Comparative Analysis of Informant and Subject Reports Among Hispanics and White Non-Hispanics

INTRODUCTION

Subjective complaints of memory loss are common among the elderly, with reported prevalence rates ranging from 38% (Grut et al., 1993) to 80% (Bolla, Lindgren, Bonaccorsy, & Bleeker, 1990). Research suggests that memory complaints are associated with depression rather than objective cognitive impairment (Collins & Abels, 1996; Grut et al., 1993); however, in some cases these complaints may herald the onset of a dementing illness such as Alzheimer's disease (Schmand, Jonker, Hooijer, & Lindeboom, 1996). Patients with dementia may be unable to accurately report symptoms of memory loss. Thus, informant reports may demonstrate greater usefulness in the identification of memory disorders in the elderly. It is important to note that no studies have investigated subjective memory complaints among Hispanics. Thus, this study investigated the relation of memory complaints provided by informants and subjects to objective cognitive status among Hispanics and white non-Hispanics.

METHOD

Participants. Research participants included 185 consecutive elderly subjects evaluated at an outpatient memory disorders clinic.