

Geriatric Mental Health: Dementia & Schizophrenia

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Introduction

Mental health is a significant concern in geriatric populations, where both acute and chronic psychiatric conditions are common. For instance, dementia is prevalent among older adults, but its early symptoms are often subtle and may go unnoticed by those around them. Various factors can trigger episodes such as mania, mood instability, and psychosis. It is essential for healthcare providers, particularly APRNs, to differentiate between illnesses with overlapping symptoms to ensure appropriate treatment. This paper reviews the case of E. J., a 67-year-old patient admitted to the hospital with agitation, hallucinations, and paranoia following a course of medication. Notably, this is his first psychiatric episode in his lifetime.

Diagnoses, Differentials, and ICD Codes

In E. J.'s case, his psychosis and mood disorder appeared rapidly after he began treatment with Prednisone, suggesting the medication as the trigger for his current condition. He was prescribed high doses of corticosteroids to treat severe poison ivy, though the exact duration of Prednisone use and his previous medications over the past 11 months are unknown.

Based on this information, E. J. is likely suffering from corticosteroid-induced psychosis, which aligns with the DSM-V criteria (American Psychiatric Association, 2013). His auditory hallucinations began shortly after starting Prednisone, a drug known to cause

such symptoms. He also has no prior history of psychiatric issues, and due to his hallucinations, he requires assistance with daily activities. Under the ICD-11 classification, corticosteroid-induced psychosis falls under the category of substance-induced psychotic disorders, possibly coded as 6C4E.6 or 6C4G.6 (ICD-11 for mortality and morbidity statistics, 2019). This diagnosis must be differentiated from schizophrenia and other related disorders.

Although corticosteroid-induced psychosis is relatively rare, occurring in approximately 5.4% of patients receiving corticosteroids (Kenna, Poon, de Los Angeles, & Koran, 2011), high doses of these drugs increase the likelihood of psychiatric complications, including mania, depression, or delirium (Muzyk, Holt, & Gagliardi, 2010). Risk factors such as gender and dosage have been shown to play a role, with women being more susceptible to these psychiatric side effects (Menon, Sunny, Pereira, Chikkaveeraiah, & Ramesh, 2018). In E. J.'s case, the high dosage of corticosteroids is a probable factor in triggering his psychotic episode.

However, the duration of E. J.'s symptoms—remaining hospitalized for 11 months—does not fit the typical pattern for corticosteroid-induced psychosis, as symptoms usually resolve within days or weeks after discontinuation of the medication (Menon et al., 2018). That said, in rare cases, psychosis can persist months after stopping corticosteroid use (Gable & Depry, 2015), and the patient's symptoms may include delusions, hallucinations, and behavioral disorganization.

Corticosteroid-Induced Psychosis vs. Dementia and Schizophrenia

Given E. J.'s age, dementia is another potential diagnosis, as auditory hallucinations are common in 20-30% of dementia patients (Sadock, Sadock, & Ruiz, 2015). However, dementia is typically characterized by a gradual decline in cognitive abilities, which should have been observed before E. J. started corticosteroid treatment. Symptoms such as memory loss, aphasia, apraxia, agnosia, or impaired executive function are also common in dementia but absent in E. J.'s case, according to his grandson.

Late-onset schizophrenia is another possibility, especially since E. J.'s mother had the disorder. Auditory hallucinations, often persecutory in nature and involving third-person

commentary, are typical of late-onset schizophrenia (Vannorsdall & Schretlen, 2019). Cognitive function tends to remain stable in elderly patients with late-onset schizophrenia, allowing them to perform daily activities (Hussein, El Shafei, Abd El Meguid, El Missiry, & Mahmoud, 2011). However, DSM criteria specify that schizophrenia symptoms must not be induced by substance use (Vannorsdall & Schretlen, 2019), which points to corticosteroid-induced psychosis as the more likely diagnosis in E. J.'s case.

Medications

The first step in E. J.'s treatment is to reduce his corticosteroid dosage to the minimum required. To address his psychosis and auditory hallucinations, a low-dose antipsychotic treatment is necessary. Olanzapine is commonly used for treating corticosteroid-induced psychosis, with many patients recovering from these symptoms (Muzyk et al., 2010). However, Olanzapine can cause significant side effects, such as weight gain, asthenia, and extrapyramidal symptoms. Rarely, patients may experience drug-induced hypersensitivity syndrome.

Olanzapine should be prescribed cautiously, especially for patients with cardiac issues, as it can exacerbate these conditions (Muzyk et al., 2010). E. J.'s cardiac health must be closely monitored, along with his glucose levels, as antipsychotic medications can lead to fluctuations in blood sugar.

Psychosocial Issues

E. J., at 67, is likely retired and may experience feelings of social isolation, especially if he lacks regular social interactions or community involvement. Mood instability and agitation, which emerged after his corticosteroid treatment, could also stem from environmental factors. Understanding his level of family and social support is crucial for his recovery. Although studies show that older adults with late-onset schizophrenia often lead isolated lives (Hussein et al.), E. J.'s case suggests some level of family support, as his grandson brought him to the hospital.

Variables Related to Aging and Mental Health

E. J. has a family history of psychiatric disorders, with his mother having schizophrenia. Although schizophrenia occurs in only 3% of people over 60 (Vannorsdall & Schretlen, 2019), this family history increases E. J.'s risk. His comorbid conditions—hypertension and coronary artery disease—also pose significant health risks, particularly in the elderly population, where psychotic symptoms are more prevalent (Vannorsdall & Schretlen, 2019).

Recommendations

First, it is critical to ensure E. J. is in a safe environment. His paranoia could lead to dangerous behaviors toward himself or others. APRNs should monitor the suitability of the assisted living facility where E. J. resides, ensuring it meets his care and support needs. Cognitive-behavioral therapy (CBT) should be introduced to help him function in daily life, alongside psychological support to address the fear and insecurity brought on by his psychotic episode. Due to his medical history, cardiometabolic risks should be monitored closely as part of his treatment plan. Strengthening his connections with family and friends is essential for his mental well-being, particularly in geriatric populations.

Conclusion

E. J., a 67-year-old patient, appears to have developed psychosis following high-dose corticosteroid treatment. While dementia can present similar symptoms, it generally develops gradually and involves cognitive decline, which was not observed in E. J. Schizophrenia is also less likely, given that it does not typically result from substance use. E. J. will require antipsychotic treatment, supported by CBT and psychological therapy. His cardiometabolic health should be monitored due to his pre-existing conditions, and family involvement will be crucial in supporting his recovery.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (5th ed)*. Arlington, VA: American Psychiatric Association.

Gable, M., & Dwayne Depry, D. O. (2015). Sustained corticosteroid-induced mania and psychosis despite cessation: A case study and brief literature review. *Journal of Clinical Case Reports*, 5(6), 1-3.

Hussein, H., El Shafei, A., Abd El Meguid, M., El Missiry, M., & Mahmoud, T. (2011). Studying late-onset schizophrenia and non-schizophrenia psychosis in Elderly Egyptian patients. *Middle East Current Psychiatry*, 19(1), 12-22.

ICD-11 for mortality and morbidity statistics. (2019).

Kenna, H. A., Poon, A. W., de Los Angeles, C. P., & Koran, L. M. (2011). Psychiatric complications of treatment with corticosteroids: Review with case report. *Psychiatry and Clinical Neurosciences*, 65(6), 549-560.

Menon, V. B., Sunny, A. A., Pereira, P., Chikkaveeraiah, S., & Ramesh, M. (2018). Steroid psychosis: A case series of three patients. *Indian Journal of Pharmacy Practice*, 11(1), 51-54.

Muzyk, A. J., Holt, S., & Gagliardi, J. P. (2010). Corticosteroid psychosis: Stop therapy or add psychotropics? *Current Psychiatry*, 9(1), 61-68.

Sadock, B. J., Sadock, V. A., & Ruiz, P. (2015). *Kaplan and Sadock's Synopsis of psychiatry: Behavioral sciences/clinical psychiatry* (11th ed.).