CASES THAT TEST YOUR SKILLS

Hallucinations and suicidal thoughts have long tormented Mr. M. Can you gain his trust, get him to talk honestly, and find out why numerous treatments have failed?

A troubled patient's secret life

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HISTORY THREATENED BY AN 'ANGEL'

Mr. M, age 32, began hearing voices at age 16. He had been diagnosed as having bipolar disorder with psychotic features before presenting to our hospital in 1995. He often experienced hypomania (euphoria, decreased sleep, free spending) followed by depressive periods (lack of energy, tearfulness, decreased concentration), and heard commands to kill himself or saw menacing shadows or "angels."

Several psychiatrists tried various psychotropics across 6 years, but Mr. M's odd behaviors persisted. One night he physically threatened his father, who tried to stop Mr. M from eating a sandwich wrapped in a plastic bag. Mr. M was hospitalized that night, and his diagnosis was changed to schizoaffective disorder based on recurrent auditory and visual hallucinations when mood symptoms were absent.

Mr. M was hospitalized nine times within 6 years for psychotic or depressive symptoms—including twice in 1 month for depression and suicidal ideation. Two months later, he attempted suicide by taking 1,200 mg of ziprasidone (about 10 times the normal daily dosage) and an unknown amount of lorazepam, after which he was treated in the ER and released. He presented to me shortly afterward, frightened by his suicide attempt.

At intake, Mr. M was taking lorazepam, 1 mg tid for anxiety, and ziprasidone, 20 mg bid.

Single and unemployed, Mr. M lived with his parents and a brother, and was collecting disability benefits because of his psychiatric problems. He told me that he had been off cocaine for 3 years but had used marijuana 2 weeks earlier. He also reported ongoing family problems but did not elaborate. He said he did not feel suicidal but described continued depressive episodes.

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Mr. M's symptoms suggest:
- **schizoaffective disorder**
- **substance abuse disorder**
- **psychotic depression**

Dr. Fraser's observations

Mr. M's last six psychiatric hospitalizations and at least 5 years of outpatient notes by other psychiatrists indicated a history of schizoaffective disorder. Mr. M's psychotic symptoms persisted for substantial periods while mood symptoms were absent, thus supporting the diagnosis. By contrast, mood and psychotic symptoms in major depression with psychotic features are almost always simultaneous.

Mr. M's substance use should be considered. Fifty percent of persons with schizophrenia or an affective disorder have a lifetime prevalence of substance abuse disorder.[1] The rate climbs to 60% to 90% for patients with schizophrenia seen in emergency rooms, inpatient psychiatric units, and community settings.[2]

Mr. M's last documented cocaine use was in 1998; subsequent urine drug screens showed only marijuana.

Cocaine abuse could have contributed to Mr. M's psychotic symptoms, and marijuana use could have caused his inertia, lack of motivation, and difficulty concentrating. It is unclear why previous doctors attributed most of his psychotic symptoms to a major mental illness rather than cocaine use.

Ask patients about substance use along with a chronology of psychiatric symptoms. Encourage patients who are regularly using substances to stop for a trial period to see if symptoms abate during abstinence. Refer patients for substance use treatment if necessary.

TREATMENT A WEIGHTY ISSUE

I feared that Mr. M's psychotic symptoms would recur, but he was more concerned about his depression and obesity. He said he gained 50 pounds over 3 1/2 years while taking olanzapine, 10 to 15 mg/d, and divalproex at various dosages. He stopped both agents on his own and lost 35 pounds across 6 months but was still obese (197 lbs., body mass index [BMI] 32.9).

I prescribed bupropion SR—100 mg/d titrated over several weeks to 200 mg each morning and 100 mg at night—because of its association with weight loss. I also:

- continued ziprasidone, 20 mg bid, to prevent psychosis
- continued lorazepam, 1 mg tid, to reduce anxiety stemming from his family problems. I asked Mr. M to slowly taper off the agent—which he had been taking for 8 years—across 6 to 12 months because a protracted benzodiazepine regimen can contribute to depression.
- referred him to a psychotherapist for cognitive-behavioral therapy to help reduce his depressive thinking and suicide risk
- recommended that he stop using marijuana.

At his second visit, Mr. M reported more auditory hallucinations. I increased ziprasidone to 40 mg bid.

By this time, Mr. M was becoming more comfortable in therapy. He began discussing his family problems in more detail, telling me that his brother is addicted to heroin.

I asked Mr. M if he was again threatening family members or other people. He replied that he had not been violent, but that his mother often slaps him and others in his family. I commended him for not retaliating, but warned him that his mother's aggression was perpetuating his depression.

I encouraged Mr. M to find an apartment, but

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Box

Four ways to build an alliance with a chronically ill patient

- **Respect the patient's goals.** You fear psychotic symptoms will resurface, but the patient is more concerned about weight gain or other side effects. When possible, choose an agent that targets symptoms without causing the feared side effects.
- **Enhance motivation for change.** Remind the patient of past successes. Break the broad goal into smaller, achievable goals. Find out the patient's unique motivations for change.
- **Become the patient's advocate.** Accept responsibility for patient care problems. Refer the patient to needed social services.
- **Keep an open mind** about diagnosis and prognosis. Despite being the definitive diagnostic reference, DSM-IV-TR does not neatly fit all patients, nor account for all human suffering.

he said he could not yet afford to live on his own. I referred him to case management services to help him find affordable housing and urged him to avoid his mother's assaults. He seemed to appreciate my concern for him.

Twelve days later, Mr. M made an unplanned visit. He was angry because our pharmacy had not refilled his prescriptions and no one had returned his call asking about the refills. He was irritable but nonthreatening, although he planned to complain to the psychiatric center's medical director.

I had received no phone messages, and my notes indicated the prescriptions were refilled. Nonetheless, my assuming responsibility for this problem was key to preserving our therapeutic alliance (*Box*). I resolved the matter and apologized for the miscommunication. Mr. M accepted my apology and scheduled a return visit.

About 1 month later, Mr. M's self-esteem had increased. He stopped using marijuana, went on a low-calorie diet, and exercised at least 1 hour daily at a local gym. He lost 27 lbs. over 2 months, dropping his weight to 170 lbs. (BMI 28.3). He finished group (15 sessions) and individual (four sessions) psychotherapy, and avoided his mother when she became aggressive.

Before his next monthly visit, Mr. M had called the state vocational rehabilitation department to begin employment. I tapered lorazepam to 0.5 mg nightly while continuing ziprasidone and bupropion. His weight was near normal (150 lbs., BMI 25).

Six months into treatment, Mr. M. applied for a job and moved out of his parents' home to live with another brother, who does not take drugs. He said that he "felt at peace" for the first time in years. His weight stayed in the 140s. I stopped lorazepam and he requested to see me 3 months later.

How would you continue Mr. M's treatment?

- **continue bupropion/ziprasidone regimen**
- **reduce ziprasidone**
- **reduce bupropion**
- **reduce both medications**

Dr. Fraser's observations

Many patients with schizophrenia or schizoaffective disorder struggle with weight gain, substance use, employment problems, and family conflict, and some make slow progress with one or more of these issues. Mr. M's rapid improvement on all fronts was striking, however.

Recovery from schizophrenia has been documented,[3] and the prognosis for schizoaffective disorder is often more positive than for schizophrenia or severe bipolar disorder.[4] Still, Mr. M's apparent recovery seemed incredible.

To prevent symptom recurrence, I left the bupropion/ziprasidone regimen unchanged.

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Table

PTSD symptoms that suggest other diagnoses

PTSD symptoms	Similar to	Diagnosis suggested
Depersonalization, derealization, dissociation	Psychosis	Schizophrenia, schizoaffective disorder
Anxiety, hypervigilance, insomnia	Anxiety	Exacerbations of schizophrenia, schizoaffective disorder, bipolar disorder (mania)
Flashbacks, fear of trauma recurrence	Paranoia	Schizophrenia, schizoaffective disorder

Even after a chronically ill patient responds to medication, I feel dosages should be maintained unless side effects occur or a medication loses effectiveness.

FOLLOW-UP MR. M'S STORY

Since the mix-up with Mr. M's medications, our therapeutic alliance grew stronger. He told me more about himself with each visit. Four months into treatment, he revealed that he is gay and feels "liberated" after years of keeping it secret.

Five months later, Mr. M confided that an older male partner had physically, sexually, and emotionally abused him for about 10 years, starting when Mr. M was 16—about the time his auditory hallucinations began. The abusive relationship ended when the partner died of an unspecified overdose.

Mr. M's gay friends advised him to seek closure. He visited his ex-partner's grave, placed a rose, said goodbye, and left vowing he'd never again become an abuse victim. He said he had never told any health professional this story.

Mr. M then asked to be tapered off medications. I was afraid his psychotic symptoms could resurface, although I now wondered whether his schizoaffective disorder diagnosis had been correct. We tapered bupropion and ziprasidone over the next month.

Twenty-four months later, his schizoaffective symptoms had not resurfaced. He worked as a security guard, maintained an apartment, and continued exercising and eating right. His weight stayed normal (140 lbs., BMI 23.3). No signs of hypomania were present, and he was finding fulfillment in nonabusive relationships.

Mr. M's symptoms now most closely suggest:

- **schizoaffective disorder**
- **posttraumatic stress disorder (PTSD)**

Dr. Fraser's observations

Some patients progress to schizophrenia's residual "burnout" phase and become asymptomatic. Mr. M, however, was much younger than other patients with residual schizophrenia, and his mental and physical health were more robust.

Instead, Mr. M may have had complex PTSD secondary to 10 years of abuse by a partner and lifelong abuse by his mother, with drug-induced psychotic symptoms. PTSD can mimic schizoaffective disorder and schizophrenia *(Table)*, and DSM-IV trains us to manage the differential diagnosis first. Mr. M's revelation about his abusive mother could have raised suspicion of PTSD, but I was targeting apparent psychotic symptoms.

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Mr. M's shame over being gay and his inability to discuss his guilt with family and friends likely contributed to his isolation and perpetuated both the abuse and psychiatric symptoms. Although his ex-partner's death ended an abusive relationship, his mother's ongoing abuse prolonged its emotional effects.

If Mr. M. had not revealed his mother's aggression—in response to a question about *his* abusive behavior—his psychiatric symptoms may have continued unabated. For years, despite many psychiatric consultations and hospitalizations, Mr. M kept his abusive relationships a secret.

Ask patients about ongoing physical, sexual, and emotional abuse as part of the initial evaluation. Even if the patient denies abuse at first, he or she may reveal this information as the therapeutic alliance develops. As treatment continues—particularly when the patient seems more stressed—ask again about abuse by or toward the patient. If necessary, be direct: "Is anyone hitting or hurting you in any way? Are you hurting someone else in any way?"

BUILDING AN ALLIANCE

Although clinicians often harbor low expectations for chronically ill patients, I believe that recovery from major psychiatric illness is possible.

Whatever his diagnosis, a strong therapeutic alliance hastened Mr. M's recovery. Respecting his treatment goals, enhancing motivation to change, being his advocate, and considering alternate diagnoses helped me gain his trust *(Box, page 64)*. Because I accepted responsibility for Mr. M's prescription problems, for example, he sensed that I was on his side. This trust may have ultimately encouraged him to share secrets with me that he had not told other psychiatrists.

Related resources

- National Center for Post-Traumatic Stress Disorder. www.ncptsd.org
- Heim C, Meinlschmidt G, Nemeroff CB. Neurobiology of early-life stress. *Psychiatric Annals* 2003;33(1):18-26.
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DRUG BRAND NAMES

Bupropion • Wellbutrin
Divalproex • Depakote
Lorazepam • Ativan
Olanzapine • Zyprexa
Ziprasidone • Geodon

DISCLOSURE

The author reports no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

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Bottom Line

When treating chronically ill patients, watch for symptoms that might suggest an alternate diagnosis. An accurate patient history and strong therapeutic alliance are keys to improving outcome. Ask patients about substance use, which can cause psychotic symptoms.