Trust Me
I’m a Pilot

When Psychosis Masquerades as other things

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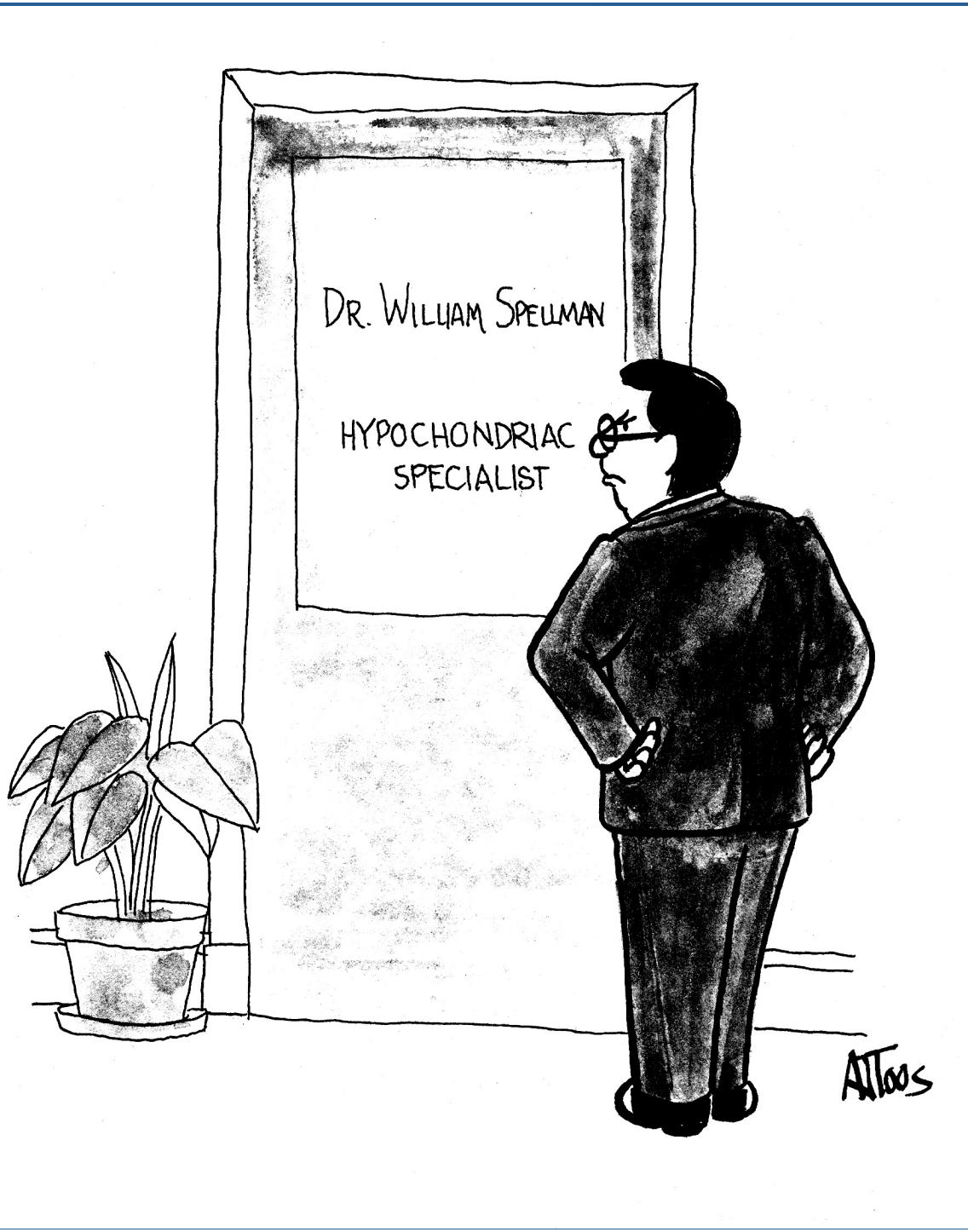
Massachusetts General Hospital Handbook of General Psychiatry: 6th ed.

- The somatic delusions of schizophrenia are generally so bizarre (foreign bodies are inside an organ, or body parts are missing)…as to be easily recognized.
- When a schizophrenic patient presents with symptoms that are not of delusional quality (headache, weakness), psychosis may be missed.
- Making such a diagnosis with a thorough psychiatric history and examination is ordinarily no problem.


DR. WILLIAM SPELLMAN
HYPOCHONDRIAC
SPECIALIST
ATTOOS

Case 1
Mr. A

- 21 year old African-American male facing charges of Burglary in the 2nd Degree. Crime was not in and of itself psychotic.
- Referred for pretrial examination of competency in February, 2011. Attorney had difficulty working with him.
- First pretrial exam found him competent, and found no psychotic illness, only Depressive Disorder, NOS and Personality Disorder, NOS.

Mr. A

- Referred for second opinion after defense counsel had continuing difficulties with him.
- Defendant spoke up at hearing, approached the Judge, and complained of various wrongs he had suffered in jail, from racial discrimination to neglect of physical illness.
- When Judge cautioned him to calm down and return to his seat, he publicly accused Judge of drug dealing and smoking “crack” in his chambers.

Mr. A

- Dr. Reynolds sees patient in June of 2011. Initially believes patient is fully grounded in reality, sees no signs of psychosis, and basically considers him “antisocial.”
- Patient denies psychosis in any sphere, shows no signs of attention to internal stimuli, speaks in a calm, measured voice, and shows logical and tightly associated thought patterns.

Mr. A

- Still had records to obtain, but worried little about this one. “Run of the mill defendant.”
- Call from Jail Captain: Patient very difficult to manage. I advised he was antisocial. Capt: “Doesn’t look antisocial, looks mentally ill. Filing numerous grievances, multiple ones per day.
- Had Captain send them to me in original form.
- Very important! Look for the “feel” of letters and grievances, not just the content.

INMATE SPECIAL REQUEST/GRIEVANCE

Complained on 4-18, 4-19, [illegible] Never Received [illegible]

☐ Special Request ☒ Grievance ☒ Appeal	Date Submitted 4-20-11		
Inmate Nam	Pod B	Dayroom B	Cell 08

I am subm … e for consideration and resolution by the appropriate Buchanan … understand that by BCSD policy I am entitled to a response … ve business days of submitting my request to a BCSD staff meml

I also understand that I have the … BCSD staff to the Correctional Administrator

Signatu … Date 4-20-11

Explain in clear and plain langu … and what you want done to resolve this issue

Special requests/grievances that are not clear and understandable or have foul language will NOT be accepted – write legibly

OK, I'm being held on lockdown illegally against my Rights and will. on Friday 4-18-11 4-19-11 I wrote also. I went to Patrick Rob court Room DIV.3. And I told him after he called me to the stand that I have something that I have to say, he said "No". And then I said so your going to denie me my Right of Freedom of speech? he said Yes. So then I stated a Fact in court, that you overdosed off cocaine in your chamber at your Job! And that your a conflict of interest for me. And that you should not even be able to Judge anybody → Flip over

Special Request/Grievance Receipt

Received By – Pod Staff Member	Date	Time	Reviewed ☐ Yes ☐ No
PKH	4-21-11	01:47	
Action Taken: to Capt. Sawyer			

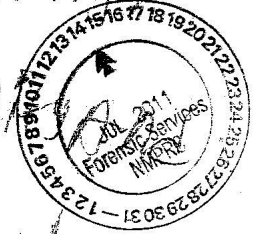
Received By	Date	Time	Reviewed ☐ Yes ☐ No
Action Taken			

Received By	Date	Time	Reviewed ☐ Yes ☐ No

Action Taken: You are lockdown due to the disruption that you caused in court. Your out date of lockdown is on 4/28/11.

Captain or Designee's Review: Capt Sawyer

because of What you did was a Federal Felony
Charge Against you. With that being said, he told
the officer to take me out of his courtRoom. And
I've been locked down For stating Law And
Facts in court. which is Admissable by law
in court. therefore, I'm being Also held Inside
A Jail Facility on lockdown For False Imprisonment.
And everytime my sack lunch comes either
Chips Are a Sandwich Is missing
And I complain but still no Result
And it keeps on happening
this is Inhuman
Against the Law!



Mr. A

- Grievances were disorganized. Illogical. Counter-productive.
- Figured I better look at this case a little closer.
- Patient had reported family hx of schizophrenia.
- Treatment records came in. Patient presented to ER with complaint of hallucinations and that someone had given him brownies with marijuana. This incident was well before his arrest on his index crime.

Mr. A

- At the time, Mr. A was on a 10 year probation for Armed Robbery. It would be very unlikely for a sane, even antisocial young man to self-present with such complaints. No motive to malinger.
- Found patient incompetent.
- Was admitted to a DMH facility where he began from Day 1 filing bitterly worded grievances for a variety of physical complaints.

Mr. A

- Refused psychiatric meds, and was not deemed to need any by treatment team.
- Filed grievances that he was denied care, that he was refused x-rays and CAT scans, and access to expert specialists. However, he HAD been sent to specialists who could find nothing seriously wrong.
- Escalated grievances to DMH Central Office, NAACP, ACLU.

Mr. A

- After three month hospitalization, was discharged as competent, primary diagnosis "Antisocial Personality Disorder," no significant diagnosis on Axis I.
- Patient had consistently "denied" symptoms of psychosis. He was deemed to be "antisocial, drug seeking, and manipulative."
- His supposed history of psychotic symptoms in the past were attributed to drug use.

Mr. A

- Ward doctor did speculate that a psychotic disorder could not be ruled out, but might require "a longer period of observation." Nevertheless, the patient was returned to jail as competent, on no meds, after three months in the hospital.
- He immediately resumed his frequent bitter complaints.
- He fired a new Public Defender, *before he ever met her*, because she was "racist and in league with the prosecutor."

Mr. A

- Dr. Reynolds was again asked to see him by the Public Defender, with the concurrence of the Prosecutor.
- Patient again presented as pleasant, polite ("yes sir, no sir, please, thank you"), and logical sounding, unless discussing his case.
- More records were obtained.
- Patient was in DOC for 120 days at age 18 on previous conviction.

Mr. A

- He had ZERO write-ups. He was documented as being “no problem whatsoever.” He filed NO grievances! He did seek mental health treatment for “depression and anxiety.”
- He was kept in special population, which staff advised me was an indication he was viewed as “vulnerable.”

Mr. A

- He was again deemed incompetent. Psychological testing presented a range of results deemed "valid" but which showed a high number and severity of symptoms endorsed. However, the pattern of responses did not indicate a picture consistent with malingering.
- Review of every page of the previous DMH facility records showed two instances of clearly documented refusal of controlled substance pain medication, not exactly consistent with a "drug seeking manipulator."

Mr. A

- Mr. A was admitted to NMPRC where he quickly became a serious management problem. He refused voluntary meds, but became aggressive and was given a second opinion under DOR 4.152. Involuntary medication was started in the form of Haldol, later given as Haldol Decanoate.
- Patient denied need for this medication throughout his stay, and made clear he would refuse it if allowed.

Mr. A

- But the results……??

Night and Day

Mr. A

- Mr. A quit filing grievances, within just a few days! He worked effectively in court competency groups, and even voiced willingness to work with his Public Defender, the one he had "fired," sight unseen.

Mr. A

LESSONS LEARNED ?

- We deal with forensic patients now throughout all DMH adult facilities.
- Many of these folks do not work and play well with others.
- It is very easy to get jaded and write off challenging, oppositional patients as "antisocial, drug seeking, manipulative."

Mr. A

- Mr. A appears to be a young man starting in on a lifetime of struggle with schizophrenia.
- He had been incarcerated at age 19 in a high level prison setting, and had an uneventful course. Antisocial personality disorder doesn't generally turn on and off, and antecedents are usually well established before the age of 19.
- By 21, however, he was manipulative and complaining. But his manipulations and complaints were desperate, not calculated, and in many instances self-defeating rather than self-serving.

Mr. A

- Of course, many sociopaths are self-defeating, too. But again, it doesn't turn on and off like a switch. They don't usually seek care from the ER for bizarre reasons, or ask for a drug screen when they don't have to, and are facing a 10 year back-up on a serious prior charge!
- Motiveless "malingering" should be a red flag. As should pointless complaining. And "crazy" writings often show thought disorder more distinctly than conversation.

Mr. A

- Its very difficult to be mentally ill in prison without causing a stir.
- It wigs out the cellmates, it wigs out the guards, and its not something, usually, that a prisoner wants to fake.

Mr. A

- Am I 100% sure Mr. A was psychotic? Well, its hard to say. He does have some criminal mindedness, and some conduct disorder symptoms as a kid, and he is forensic, after all. But when we gave him "Schizophrenia medicine," the acting-out went away. COMPLETELY!
- Until we have a reliable Schizophrenia lab test, that's good enough for me.

Mr. B

- 36 year old Caucasian male committed to DMH in 2009 as NGRI on 2 counts of 1st Degree Assault (severe crimes, just short of murder).
- Committed to maximum security. Diagnosed with Psychosis NOS, treated with antipsychotic meds.
- Responded well to treatment, was described as "motivated, personable, compliant with treatment, and free of psychotic symptoms."

Mr. B

- Transferred in 2010 to minimum security.
- On admission, was stable appearing, and unfortunately advised the treating psychiatrist that he believed his symptoms of psychosis were due to drug abuse.
- With his concurrence, was taken off antipsychotic meds. Diagnosis was changed to drug induced psychosis.

Mr. B

- Did well for a while. Unremarkable treatment course for 6 months.
- In February of 2011, however, he started to isolate himself in his room.
- He became oppositional to treatments and therapies, both physical and psychological.
- He began to refuse groups, meds, even meals.

Mr. B

- Mind, he was prescribed no antipsychotic meds all this time.
- Despite the seeming paradox of refusing physical medications, he began to bitterly complain of various pain sensations, particularly of the neck and back. He voiced fears that he would be paralyzed.
- He spoke of a history of a ruptured disk in his neck, and c/o numbness in the hands.

Mr. B

- He demanded an MRI to evaluate his self-described “spinal stenosis,” a study not deemed medically necessary by his caregivers.
- He became embittered that he was being neglected, and withdrew more from treatment and socialization.
- He appealed to his mother, who communicated her own reportedly bitter complaints to administration on his behalf.

Mr. B

- In the patient's later words, "the relationship between me and my treatment team was poisoned." Both he and his mother demanded a transfer to another facility where he would be treated "more fairly."
- An MRI was finally obtained in March 2011 which demonstrated "very mild degenerative changes." No significant measures to treat this were deemed indicated.

Mr. B

- Given the bitterness that had now developed between the patient, his mother, and facility administration, a transfer to NMPRC was in the works.
- Around this same time, the patient himself fortunately noticed that his thinking seemed "wrong." He actually approached his then treating doctor and requested antipsychotic medication.

Mr. B

- Zyprexa was begun on March 30, 2011 ,and by April 26th, he was noted to be improving.
- He was “attending groups and participating appropriately.”
- He was “med compliant.”
- He was “pleasant, friendly, and social with others.”
- He was sleeping well, and no longer isolating and withdrawn.

Mr. B

- On admission to NMPRC in June 2011, in contrast with his previous hospital transfer the summer before, he readily admitted a need for antipsychotic medication. He recalled now how he had begun to hear voices when off meds the previous year, voices saying things like “kid killer,” and “rot in hell.”
- He was fully agreeable to continuing his medication, and quickly rose in privilege level by virtue of his good performance.

Mr. B

- In just over two months, he had progressed to our second highest level, and by 5 months was living in a cottage. In less than a year, he was at the highest level and enjoying off grounds supervised privileges.
- Psychological testing revealed that he would likely experience increased physical complaints under stress and anxiety, just as was seen in 2011.

Mr. B

- Interestingly enough, nothing was ever done in terms of a specific treatment to address his "mild" spinal stenosis.
- Dr. Reynolds met with him in late 2012 to perform a Conditional Release evaluation.
- By then, nearly a year and a half had passed at NMPRC. The patient had been on antipsychotic medication, with compliance proven by surprise blood tests, and was doing well.

Mr. B

- Dr. Reynolds inquired about his neck pain, the severity of which had caused quite a stir at the highest levels in the Division of Comprehensive Psychiatric Services.
- Severe chronic pain, of that magnitude, accompanied by dramatic paresthesias, should not have just faded into obscurity.
- Mr. B. shrugged his shoulders, and offered that he just felt better after getting that MRI.

Mr. B

- Dr. Reynolds offered that there was nothing about having an MRI that would treat a skeletal abnormality.
- He shrugged again, and in keeping with this insightful young man's ability to reflect, when his thinking is orderly, he suggested that maybe his mental illness was unstable and it magnified the pain he was feeling.

Mr. B

- He went on to successfully complete a partial release and has now been on full release for more than a year. He continues to take his meds, is an active member of our local RESPECT program, and to my knowledge, is not bothered to this day to any significant degree by his still untreated [mild] neck problem.

Mr. B

LESSONS LEARNED ?

- It is very seductive to listen to the patient explain his history, and give it considerable weight.
- “Confirmation bias” is strong. We in the forensic business tend to see patients with awful drug abuse histories, patients who wouldn’t dream of submitting meekly to swallow a physician ordered med, but who would, at the drop of a hat, gulp any unknown pill offered by a total stranger on the street.

Mr. B

- A person appearing completely normal [isn't that just what we hope to accomplish with our meds?], may seem quite compelling when he excuses his symptoms as drug induced.
- Meds for Schizophrenia come with a host of very real side effects and long term hazards, drawbacks we take lightly at our peril.
- Once labeled "not mentally ill," we may be as blind to reality as one of our patients lacking insight into his own illness.

Mr. B

- Once that label is applied, off baseline behavior, coming back gradually as meds taper from the body, especially if of a character of opposition rather than bizarre, will continue to be seen through antisocial colored glasses.
- Fortunately, no peers or staff were harmed by this decompensated person who had shown himself quite capable of maiming people with his bare hands.

Mr. B

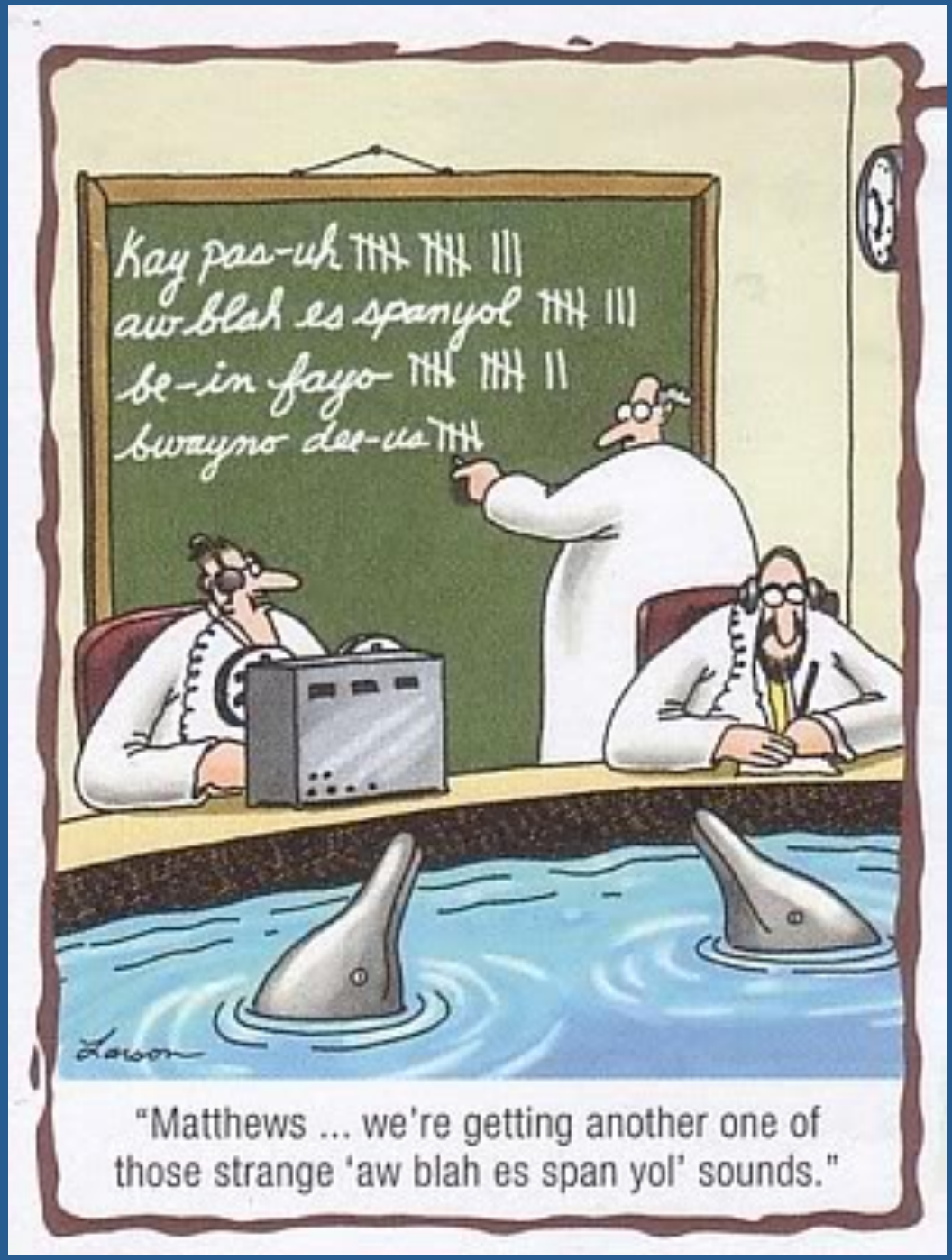
- His “harm” was internal, psychic, no less real to him, but unfortunately, not obvious to others.
- By a miracle, this man possessed a level of insight rather uncommon in untreated Schizophrenia, and himself sought to restart his treatment.
- In the case of Mr. A, that would not have happened.

Mr. B

- Let me reiterate: nothing was done for this man's "pain," but restart his psychotropic meds. As much as our Radiologist friends might dream of the curative power of spinning protons, the cure for this physical pain was in the mind.
- Nothing short of complete records, every progress note, every order sheet, will usually solve a mystery like this.

Mr. B

- Remember the confirmation bias: It infects "summaries," mine and yours, the "summary" of your biases.
- When dictating the chart of a "drug seeker," an "antisocial," a "somaticizer," or yes, even a "borderline," one easily recalls the data affirming that label, while being blinded to data that raise questions.
- The worst "yes man" to beware, is yourself!

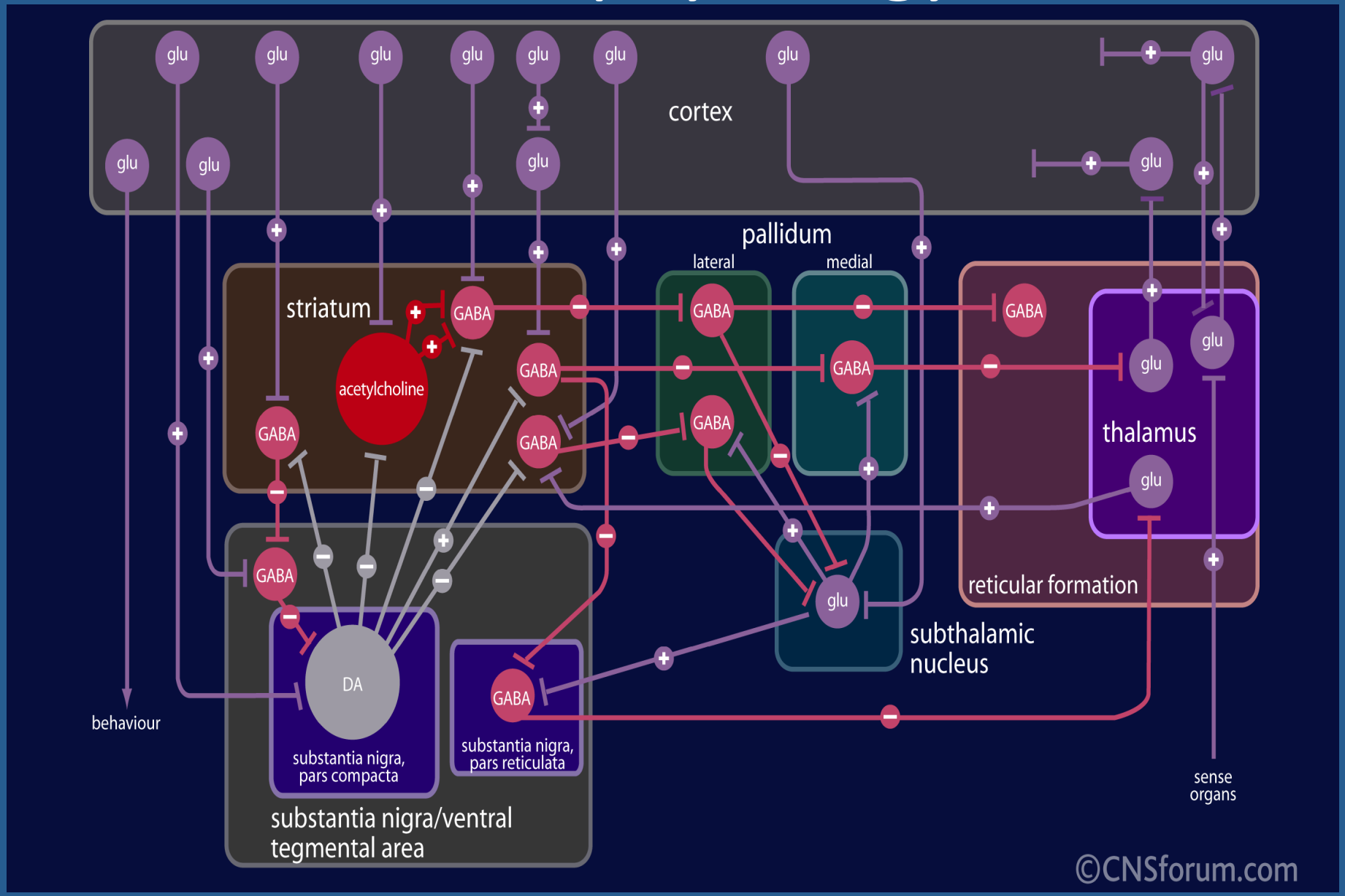


"Matthews ... we're getting another one of those strange 'aw blah es span yol' sounds."

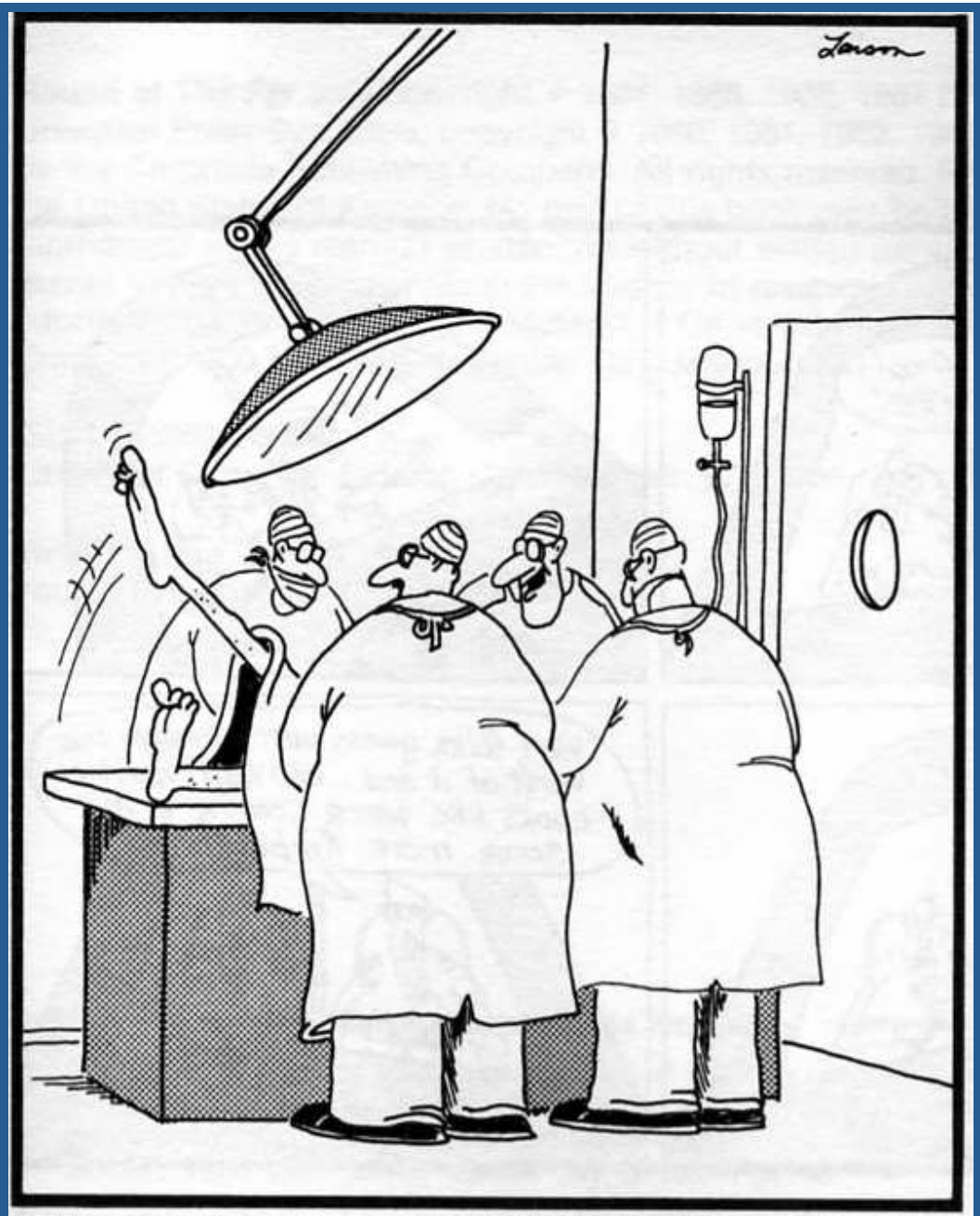
Mr. B

- Thus, ask for the actual notes
- Question the last person's label
- And when something doesn’t fit, keep a critical eye, and listen to your “third ear.”

Pathophysiology



Just Kidding



"Whoa! *That* was a good one! Try it, Hobbs — just poke his brain right where my finger is."

Somatization and Psychosis

- Long known to go hand in hand
- Little research I could find
- Comprises one major section of the BPRS
  - Brief Psychiatric Rating Scale
- When your patient starts complaining of somatic symptoms, not easily accounted for, worry relapse.

Cartoon illustrating a much-simplified cognitive architecture of the frontal and posterior brain systems' utilisation of incoming sensory data.

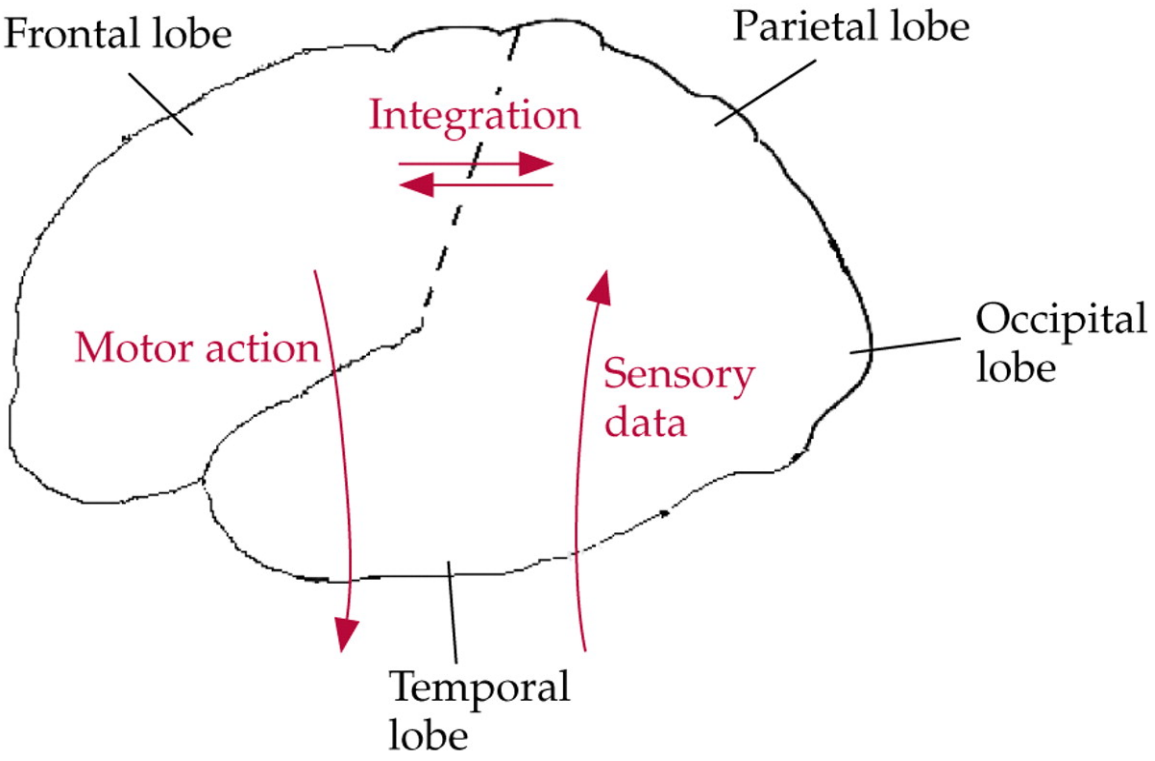
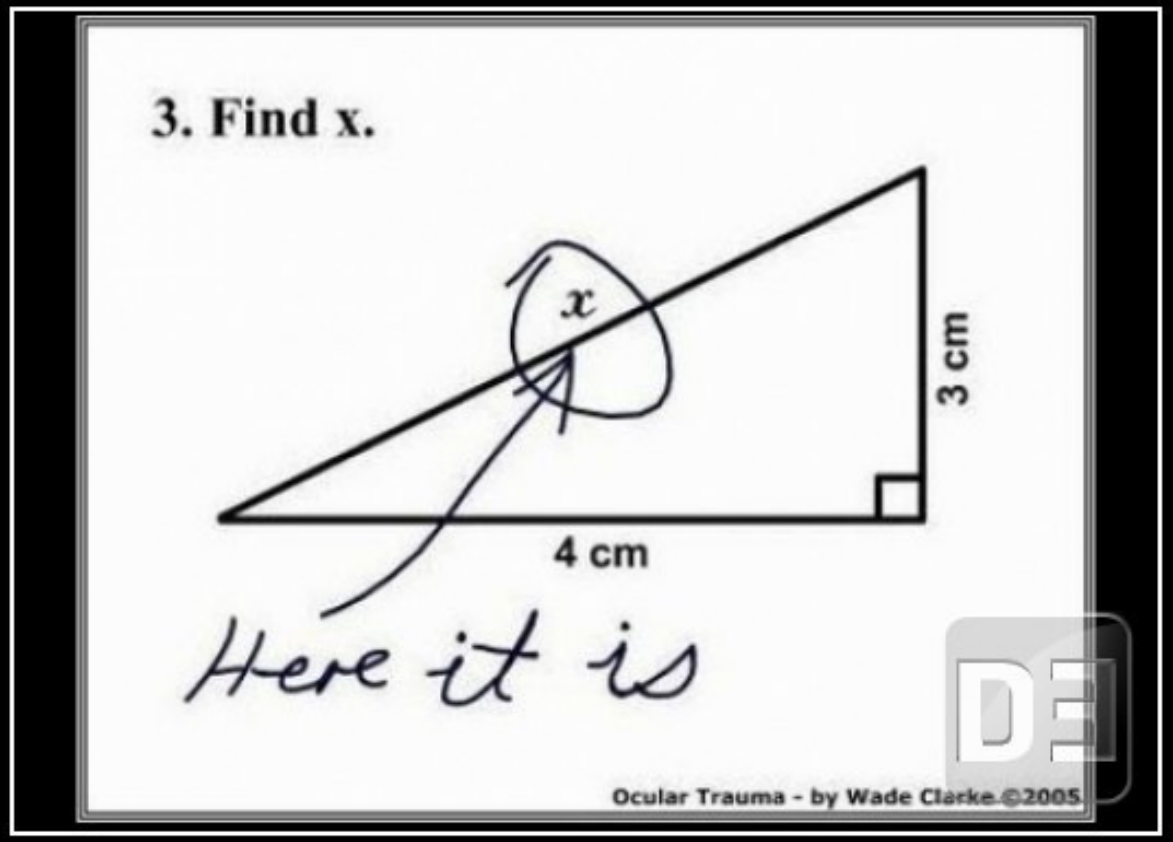


Fig. 1 Cartoon illustrating a much-simplified cognitive architecture of the frontal and posterior brain systems' utilisation of incoming sensory data. The initiation of voluntary actions implicates frontal systems (see text for details).

Questions



All stupid questions

Have simple answers

PILOTS

Looking down on people since 1903.