3-142 Depression in Schizophrenia - Competency

TIPS Question:

My resident has a diagnosis of paranoid schizophrenia. She is 80 years old. After completing the six-question template, my assessment is that on top of the paranoia, she appears to be profoundly depressed. The doctor states her has tried her on several antidepressants and when she starts taking them she becomes very unsteady on her feet and falls. Is there some type of antidepressant that would not make her sleepy and address her depression?

My second question is around competency. This resident scores fairly high on the Folstein, however, due to her paranoia I want to know if a person can be found incompetent to manage their finances and make personal decisions for herself? The doctor states she is competent and my assessment is that her perception of what reality is affected by her paranoia.

Response:

1. Depression in Schizophrenia

   Depressive symptoms in schizophrenia, like anyone else, can be a result of one or a combination of reasons. I should note that one of the problems in clinical practice is a phenomena called "diagnostic overshadowing".

   What does this mean? At times, a diagnosis or label such as schizophrenia or dementia, often results in all symptoms and signs being ascribed to the primary diagnosis instead of looking at other reasons for the change in behaviour, thinking, feeling, and/or judgement.

   In respect to the situation of the individual with schizophrenia with "depression", although it may be associated with the apathy of schizophrenia, a thorough and comprehensive approach to identifying the usual suspects that may cause depressed symptoms is critical, using the P.I.E.C.E.S. framework; i.e.:

   Physical causes such as drugs, disease, discomfort, may in fact be the reason for the presentations.

   Intellectual changes, i.e., co-morbid cognitive disorder.

   Emotional issues; a major depressive disorder or a reaction to the paranoid ideation.

   Capacities: a mismatch between the capabilities of the person and the demands on them; and finally,

   Environment changes in living situations; or

   Social causes. (We do know that high social emotional environments for individuals with schizophrenia are significantly problematic in causing deterioration and depressive symptoms.)

   The bottom line, therefore, is before jumping to ascribing the symptoms to the primary disorder, one needs to look at all the possible suspects across the P.I.E.C.E.S. framework.

   The second part of your question related to selection of antidepressants. I understand that unsteadiness and drowsiness is the problem; selecting or assisting the physician in selecting medication that does not cause orthostatic hypotension and/or instability in terms of balance may be considered, as well as using a medication that does not cause drowsiness. Effexor or bupropion might be considered.

2. Competency

   The pivotal question to ask here is competency "for what". When asking about competency, it is critical to identify—is this for treatment, is it for financial issues, or is it for personal care decisions.

Competency assessment, as you know, is specific to the situation; it is understanding and appreciating the decision that needs to be made, understanding and appreciating the alternatives, understanding and appreciating what would happen if no changes occurred, and showing reasonable judgement in terms of decision-making.

Certainly, schizophrenia is a red flag to review competency, but does not necessarily mean that the person is incompetent. As an example, I might be delusional about some specific issue, that people are stealing and causing fumes to come into my house. However, if the delusion is not affecting my ability to appreciate what are my finances and to enable me to distribute my finances appropriately, etc., then it has no effect on my judgement in this particular situation. I am competent although I may have a significant, severe psychotic disorder.

Please note: *TIPS information should be used similar to the way you would use information from a text book! TIPS is not intended to serve as an individual consultation service! P.I.E.C.E.S. participants should use this information in context and always work closely with the family physician involved in the care of the resident or client and with other Partners In Care to find solutions to individual resident/client issues.*