Schizophrenia Diagnosis and Treatment in the Black Community

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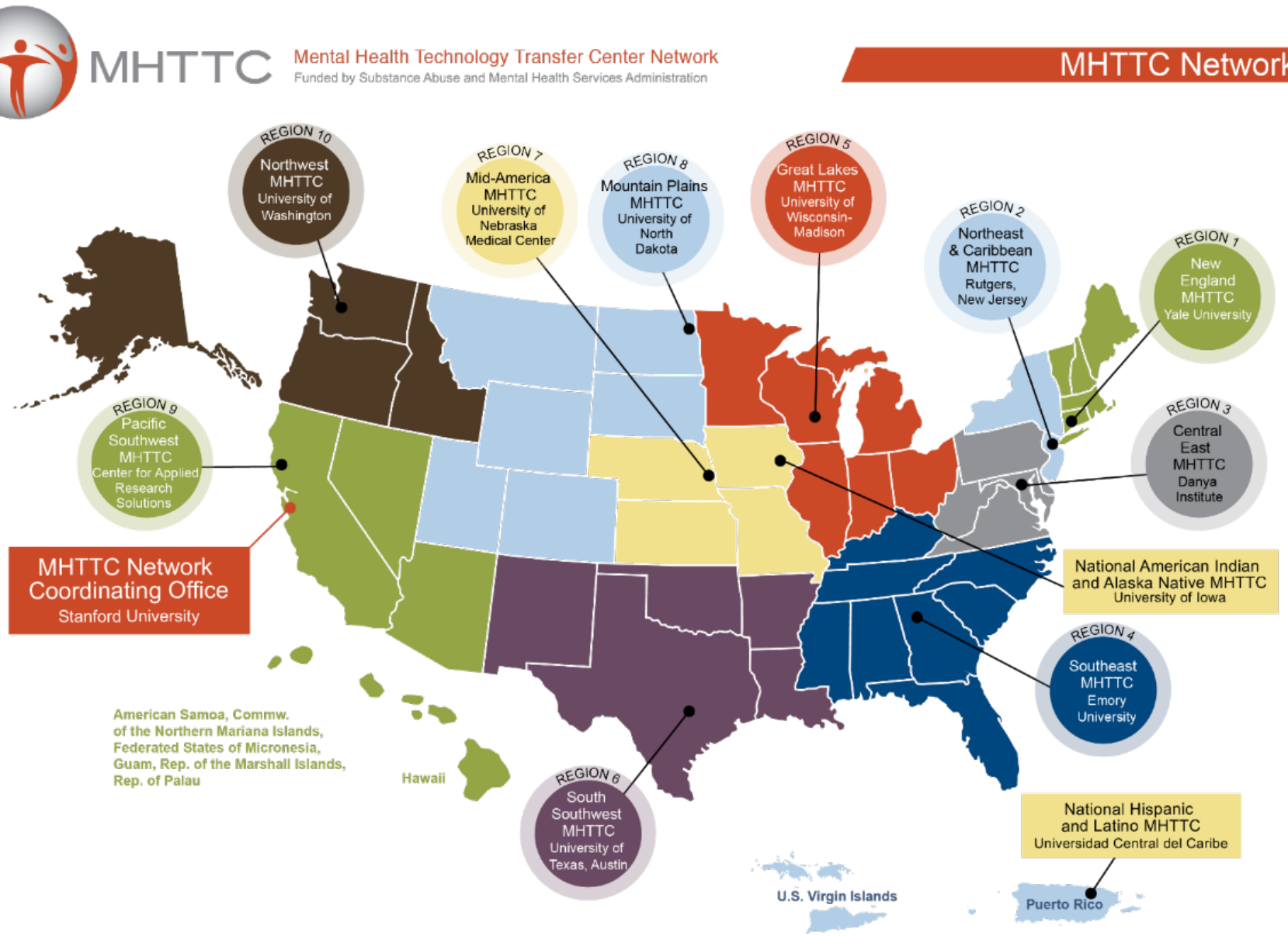
Washtenaw County Community Mental Health

November 18, 2021

Central East (HHS Region 3)
MHTTC
Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

MHTTC Network



MHTTC Purpose

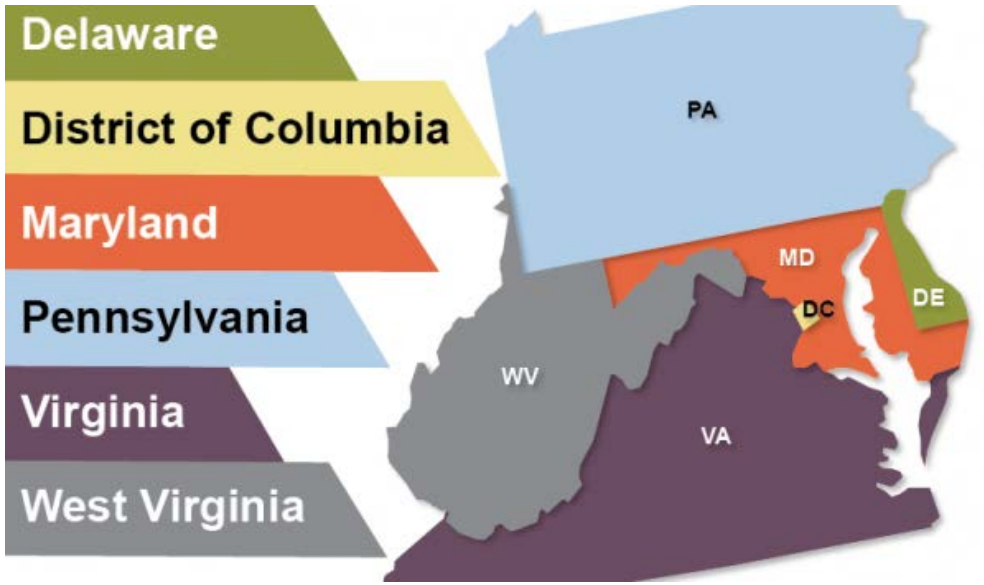
The MHTTC Network vision is to unify science, education and service to transform lives through evidence-based and promising treatment and recovery practices in a recovery-oriented system of care.

Central East MHTTC Goals

Funded by SAMHSA to:

- Accelerate the adoption and implementation of mental health related evidence-based practices
- Heighten the awareness, knowledge, and skills of the behavioral health workforce
- Foster alliances among culturally diverse practitioners, researchers, policy makers, family members, and consumers
- Ensure the availability and delivery of publicly available, free of charge, training and technical assistance

Central East Region 3



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At the time of this presentation, Miriam Delphin-Rittmon served as Assistant Secretary for Mental Health and Substance Use and Administrator of SAMHSA. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by SAMHSA/HHS, or the U.S. Government.

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Schizophrenia Diagnosis and Treatment in the Black Community

Thursday, November 18, 2021

Presenter: Welton Craig Washington, MD
Adjunct Clinical Professor of Psychiatry
University of Michigan Department of Psychiatry

Moderator: Annelle Primm, MD, MPH
Council of Elders, Black Psychiatrists of America

COVID-19: An Unprecedented Disaster

- Disparate levels of death and economic fallout in Black and other racially marginalized communities
- Mental health consequences include anxiety, depression, substance use, grief and loss
- People carrying diagnoses of schizophrenia risk exacerbation of illness and intensification of symptoms, especially paranoid ideas and delusional thinking about the etiology of COVID-19 infection as well as its prevention and treatment

Today's Program

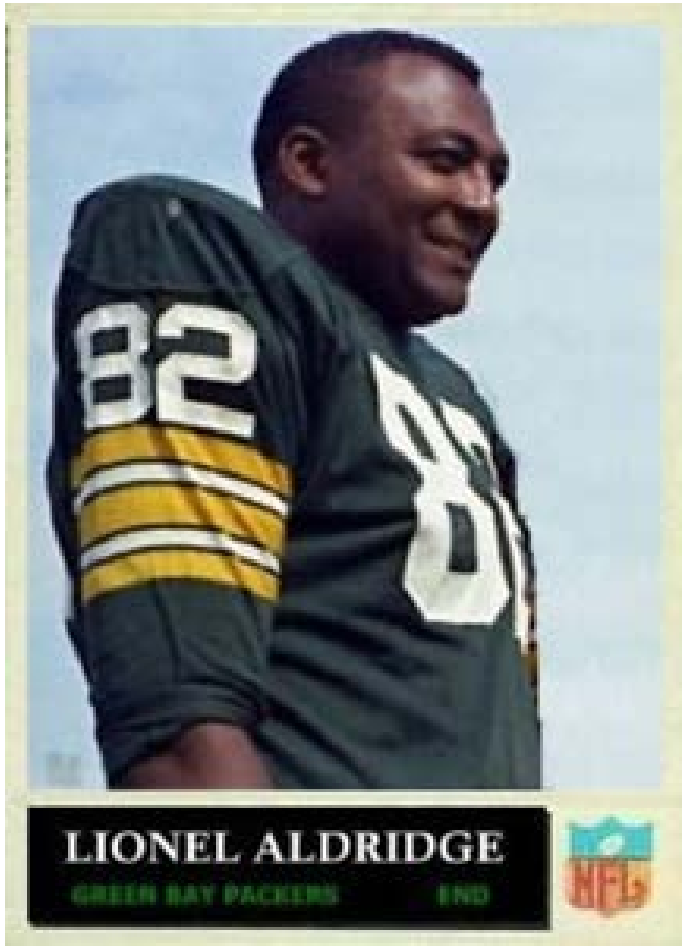
- Special thanks to the CE-MHTTC for its support of this session of the Black Psychiatrists of America Health Equity Webinar Series
- Focus is regional on DE, MD, PA, VA, DC, and WV, yet information has national relevance
- Welton Craig Washington, MD, Board Member, Black Psychiatrists of America, is our featured guest

Overview

- Schizophrenia review
- Disparities in diagnosis and treatment in the black community
- Barriers to care
- Improving quality of care and reducing stigma

Schizophrenia

- Schizophrenia is a psychiatric disorder involving chronic or recurrent psychosis
- Commonly associated with impairments in social and occupational functioning[1]



1. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), American Psychiatric Association, Arlington, VA 2013.

Schizophrenia (cont.d)

- Among the most disabling and economically catastrophic medical disorders, ranked by the World Health Organization as one of the top ten illnesses contributing to the global burden of disease[1]
- Typically includes positive symptoms, negative symptoms, and impairments in cognition

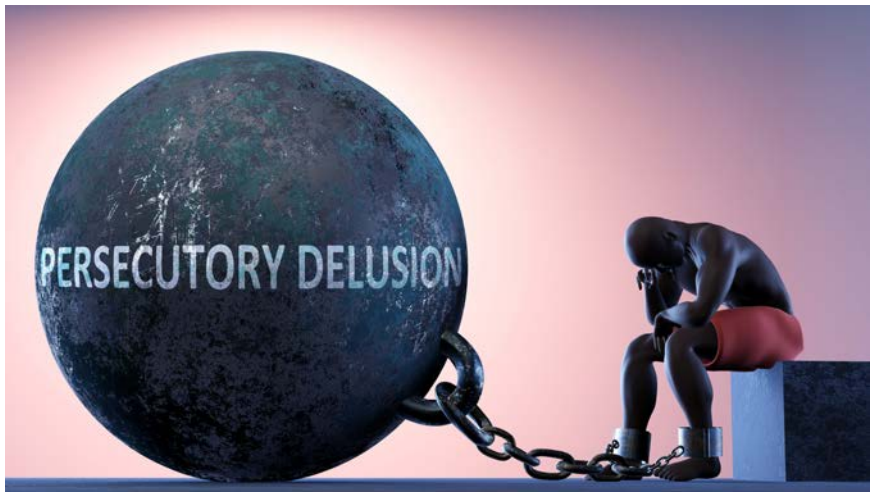
1. Murray CJL, Lopez AD. The Global Burden of Disease, Harvard University Press, Cambridge, MA 1996. p.21.

Hallucinations

- Defined as the perception of a sensory process in the absence of an external source.
- Auditory hallucinations are the most common form of hallucination, with prevalence estimates between 40 and 80% in people with schizophrenia[1]
- Visual hallucinations are often unformed, such as glowing orbs or flashes of color
- Somatic hallucinations can include feelings of being touched, of sexual intercourse, or of pain
- Olfactory and gustatory hallucinations are less common, but occasional patients will report a strange taste or smell

1. Thomas P, Mathur P, Gottesman II, et al. Correlates of hallucinations in schizophrenia: A cross-cultural evaluation. Schizophr Res 2007; 92:41.

Delusions

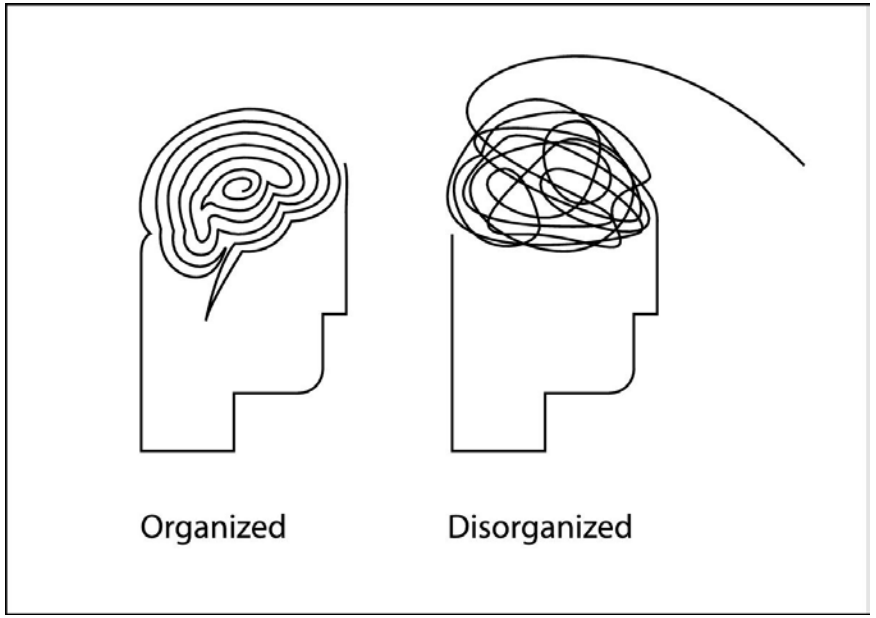


- Defined as a fixed, false belief, are present in approximately 80% of people with schizophrenia[1]
- Bizarre delusions are clearly implausible, i.e., they have no possibility of being true.[2]
- A non-bizarre delusion is one that while not true is understandable and has the possibility of being true.
- Ideas/delusions of reference
- Paranoid delusions
- Nihilistic delusion
- Erotomanic delusions

1. Andreasen NC, Flaum M. Schizophrenia: the characteristic symptoms. Schizophr Bull 1991; 17:27.
2. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, American Psychiatric Association, Washington DC 2000.

Disorganization

- Schizophrenia is a thought disorder. People with schizophrenia typically display some disorganization in behavior and/or thinking.[1]
- Tangential speech
- Circumstantial speech
- Derailment
- Neologisms
- Word salad



1. Andreasen NC, Olsen S. Negative v positive schizophrenia. Definition and validation. Arch Gen Psychiatry 1982; 39:789.

Negative Symptoms

- Negative symptoms are conceptualized as an absence or diminution of normal processes
- Tend to be very resistant to treatment
- Decreased expressiveness, apathy, flat affect, lack of energy
- May be secondary to other manifestations of the illness, such as paranoia

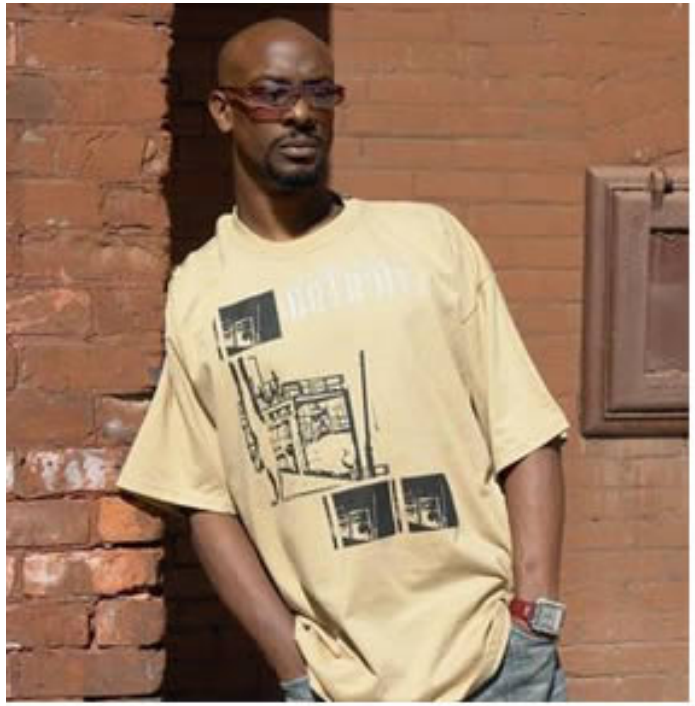
Cognitive Impairment

- Dementia praecox – Arnold Pick 1891
- Problems with processing speed, attention, working memory, verbal learning and memory, visual learning and memory, reasoning/executive functioning, verbal comprehension, social cognition[1]
- Usually precedes the onset of positive symptoms.[2]
- Older individuals with schizophrenia have an increased risk of receiving a diagnosis of dementia.[3]

1. NBora E, Murray RM. Meta-analysis of cognitive deficits in ultra-high risk to psychosis and first-episode psychosis: do the cognitive deficits progress over, or after, the onset of psychosis? Schizophr Bull 2014; 40:744.
2. uechterlein KH, Barch DM, Gold JM, et al. Identification of separable cognitive factors in schizophrenia. Schizophr Res 2004; 72:29.
3. Stroup TS, Olfson M, Huang C, et al. Age-Specific Prevalence and Incidence of Dementia Diagnoses Among Older US Adults With Schizophrenia. JAMA Psychiatry 2021; 78:632.

Neurological disturbances

- May include sensory integration, motor coordination, and sequencing.[1]
- Most neurological disturbances readily observed in people with schizophrenia are likely medication-induced.[2]
- Catatonia can present in schizophrenia as either extreme negativism, mutism, or catatonic excitement, e.g., excessive, purposeless motor activity.



1. Heinrichs DW, Buchanan RW. Significance and meaning of neurological signs in schizophrenia. Am J Psychiatry 1988; 145:11.
2. Torrey EF. Studies of individuals with schizophrenia never treated with antipsychotic medications: a review. Schizophr Res 2002; 58:101.

Cardiovascular and metabolic disturbances

- Schizophrenia is associated with diabetes, hyperlipidemia, and hypertension

The life expectancy of people with schizophrenia is reduced by more than a decade compared with the general population. This is largely related to heart disease[1]

The prevalence of cardiovascular disease is highest in non-Hispanic Black individuals relative to other populations[2]

Schizophrenia, independent of treatment with antipsychotic medication, is associated with altered glucose homeostasis, leading to an increased risk of diabetes[3]

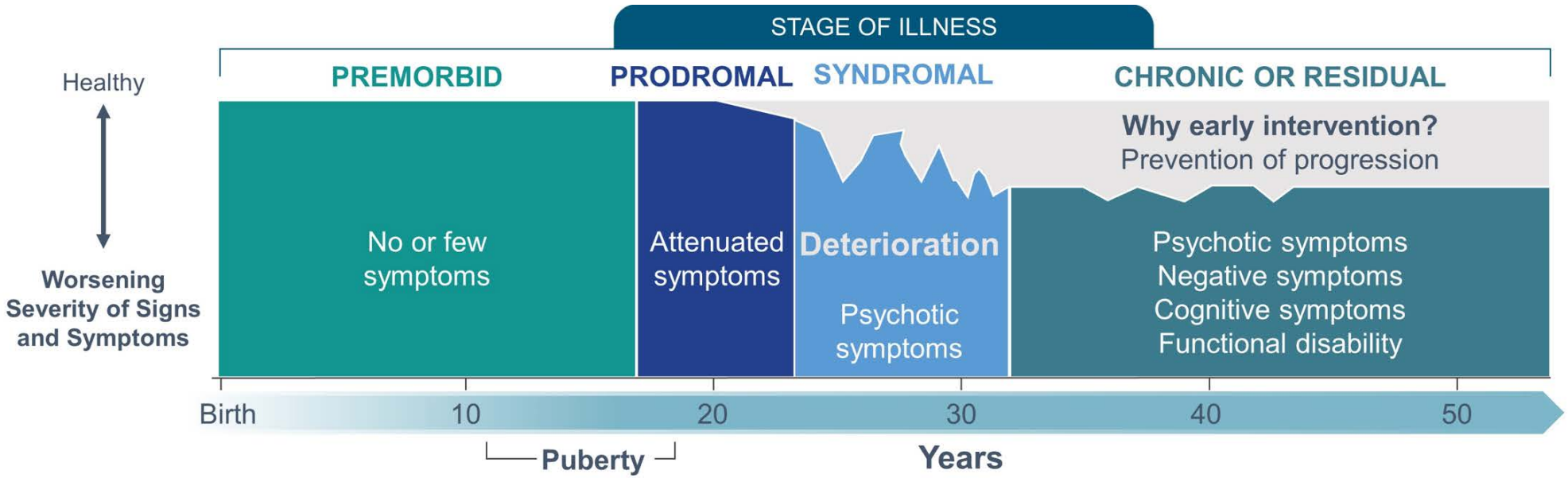
1. Hennekens CH, Hennekens AR, Hollar D, Casey DE. Schizophrenia and increased risks of cardiovascular disease. Am Heart J 2005; 150:1115.
2. Brothers RM, Fadel PJ, Keller DM. Racial disparities in cardiovascular disease risk: mechanisms of vascular dysfunction. Am J Physiol Heart Circ Physiol. 2019 Oct 1;317(4):H777-H789. doi: 10.1152/ajpheart.00126.2019
3. Pillinger T, Beck K, Gobjila C, et al. Impaired Glucose Homeostasis in First-Episode Schizophrenia: A Systematic Review and Meta-analysis. JAMA Psychiatry 2017; 74:261.

Demographics

- Prevalence of schizophrenia and related psychotic disorders in the U.S. range between 0.25% and 0.64%[1,2,3]
- Estimates of the international prevalence of schizophrenia among non-institutionalized persons is 0.33% to 0.75%[4,5]
- Schizophrenia is typically diagnosed in the late teen years to early thirties
- Tends to emerge earlier in males (late adolescence – early twenties) than females (early twenties – early thirties)[6]

1. Kessler RC, Birnbaum H, Demler O, Falloon IR, Gagnon E, Guyer M, Howes MJ, Kendler KS, Shi L, Walters E, Wu EQ. The prevalence and correlates of nonaffective psychosis in the National Comorbidity Survey Replication (NCS-R). Biol Psychiatry. 2005 Oct 15;58(8):668-76
2. Wu EQ, Shi L, Birnbaum H, Hudson T, Kessler R. Annual prevalence of diagnosed schizophrenia in the USA: a claims data analysis approach. Psychol Med. 2006 Nov;36(11):1535-40
3. Desai, PR, Lawson, KA, Barner, JC, Rascati, KL. Estimating the direct and indirect costs for community-dwelling patients with schizophrenia. Journal of Pharmaceutical Health Services Research, 2013 Jul;4(4):187-194
4. Saha S, Chant D, Welham J, McGrath J. A systematic review of the prevalence of schizophrenia. PLoS Med. 2005 May;2(5):e141
5. Moreno-Küstner B, Martín C, Pastor L. Prevalence of psychotic disorders and its association with methodological issues. A systematic review and meta-analyses. PLoS One. 2018;13(4):e0195687
6. McGrath J, Saha S, Chant D, Welham J. Schizophrenia: a concise overview of incidence, prevalence, and mortality. Epidemiol Rev. 2008;30:67-76

Course of illness



1. Lieberman JA, First MB. N Eng J Med, 2018;379(3):270-280
2. Lieberman JA et al. Biol Psychiatry, 2001;50(11):884-897

Differential diagnosis

- Schizophreniform disorder
- Schizoaffective disorder
- Psychotic mood disorders
- Substance induced mood disorders
- Psychosis due to a general medical condition
- Delusional disorder
- Schizotypal personality disorder
- Schizoid personality disorder
- Pervasive developmental disorders

DSM-5 criteria for schizophrenia

- The presence of 2 (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated), with at least 1 of them being (1), (2), or (3): (1) delusions, (2) hallucinations, (3) disorganized speech, (4) grossly disorganized or catatonic behavior, and (5) negative symptoms
- For a significant portion of the time since the onset of the disturbance, level of functioning in 1 or more major areas (e.g., work, interpersonal relations, or self-care) is markedly below the level achieved before onset; when the onset is in childhood or adolescence, the expected level of interpersonal, academic or occupational functioning is not achieved
- Continuous signs of the disturbance persist for a period of at least 6 months, which must include at least 1 month of symptoms (or less if successfully treated); prodromal symptoms often precede the active phase, and residual symptoms may follow it, characterized by mild or subthreshold forms of hallucinations or delusions
- Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out because either (1) no major depressive, manic, or mixed episodes have occurred concurrently with the active-phase symptoms or (2) any mood episodes that have occurred during active-phase symptoms have been present for a minority of the total duration of the active and residual periods of the illness
- The disturbance is not attributable to the physiologic effects of a substance (e.g., a drug of abuse or a medication) or another medical condition
- If there is a history of autism spectrum disorder or a communication disorder of childhood onset, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations, in addition to the other required symptoms or schizophrenia are also present for at least 1 month (or less if successfully treated)

Treatment

- The goal of maintenance treatment of schizophrenia is to minimize symptoms and functional impairments, minimize side effects of pharmacotherapy, avoid relapses, and promote recovery that allows self-determination, full integration into society, and pursuit of personal goals
- Multidisciplinary care
- Patient education
- Antipsychotic pharmacotherapy

Overdiagnosis of psychotic illness in the Black community

- Blacks were 2.7 times more likely than non-Hispanic whites to receive a diagnosis of schizophrenia[1]
- African Americans are almost five times more likely to be diagnosed with Schizophrenia compared with white Americans admitted to state psychiatric hospitals[2]
- Clinicians' own race appears not to alter this diagnostic trend[3]
- This trend has been gaining momentum since the early 1980's[4]

1. Lawson W. Arch Gen Psychiatry. 2012;69:593-600
2. Barnes A. Race, schizophrenia, and admission to state psychiatric hospitals. Adm Policy Ment Health. 2004;31:241–252
3. Trierweiler SJ, Neighbors HW, Munday C, Thompson EE, Jackson JS, Binion VJ. Differences in patterns of symptom attribution in diagnosing schizophrenia between African American and non-African American clinicians. Am J Orthopsychiatry. 2006;76:154–160
4. Bell C, Mehta H. The misdiagnosis of black patients with manic depressive illness. J Health Soc Beh. 1980;72:141–145

Why?

- Racial and ethnic minorities are less likely than Whites to seek mental health treatment
- Diagnostic criteria may not be properly applied.
- Affective symptoms are often ignored
- Underdiagnosis of Major Depressive Disorder and Bipolar Disorder in African Americans could contribute to the overdiagnosis of Schizophrenia[1]
- In people with schizophrenia, psychopathology has been correlated with cultural mistrust
- Cultural mistrust can be interpreted as psychopathology

1. Barnes A. Race and hospital diagnoses of schizophrenia and mood disorders. Soc Work. 2008;53:77–83

Drapetomania

- Madness of the runaway slave
- Conjectural mental illness proposed by American physician Samuel Cartwright in 1851 as the cause of enslaved Africans fleeing captivity
- With "proper medical advice, strictly followed, this troublesome practice that many Negroes have of running away can be almost entirely prevented“
- In the case of slaves "sulky and dissatisfied without cause"–a warning sign of imminent flight– Cartwright mentioned “whipping the devil out of them" as a "preventative measure"

The face of schizophrenia

- The image of schizophrenia has changed over time
- Diagnostic criteria has changed
- Reflects changes in the national culture
- From the 1920s to the 1950s, psychiatric literature often described schizophrenia as a “mild” form of insanity that affected people’s abilities to “think and feel.”
- Assumed that such patients were nonthreatening, and were therefore largely harmless to society[1]

1. Metzl JM, MacLeish KT. Mental illness, mass shootings, and the politics of American firearms. Am J Public Health. 2015 Feb;105(2):240-9.

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severe mental and

emotional stress

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helps relieve anxiety, reduces reaction to pain

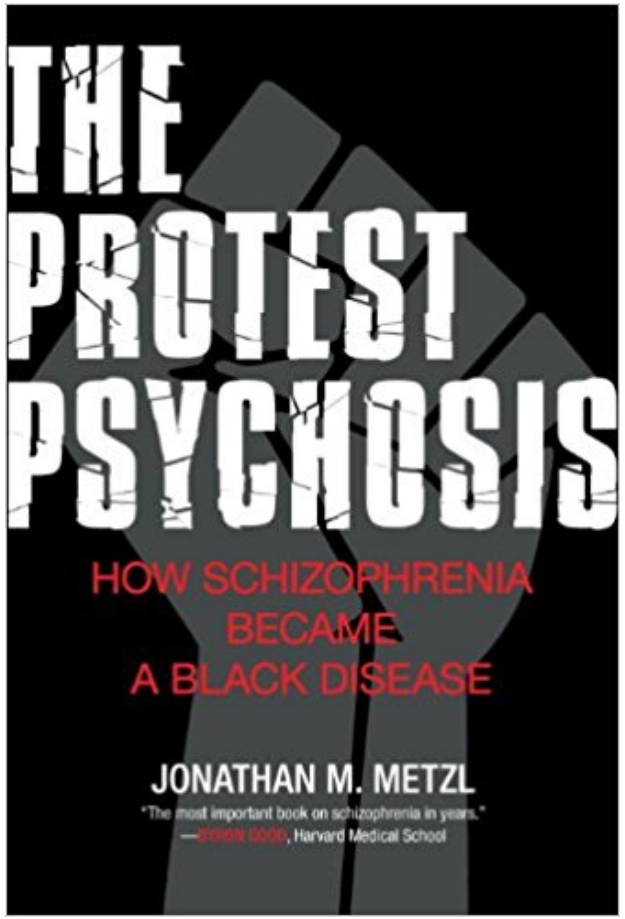
Before prescribing, the physician should be familiar with the complete prescribing information in SK&F literature or *PDR*. The following is a brief precautionary statement. *Contraindications:* Comatose states or the presence of large amounts of C.N.S. depressants. *Precautions:* Potentiation of C.N.S. depressants may occur (reduce dosage of C.N.S. depressants when used concomitantly). Antiemetic effect may mask other conditions. Possibility of drowsiness should be borne in mind for patients who drive cars, etc. In pregnancy, use only when necessary to the welfare of the patient. *Side Effects:* Occasionally transitory drowsiness; dry mouth; nasal congestion; constipation; amenorrhea; mild fever; hypotensive effects, sometimes severe with I.M. administration; epinephrine effects may be reversed; dermatological reactions; parkinsonism-like symptoms on high dosage (in rare instances, may persist); weight gain; miosis; lactation and moderate breast engorgement (in females on high dosages); and less frequently cholestatic jaundice. Side effects occurring rarely include: mydriasis; agranulocytosis; skin pigmentation, lenticular and corneal deposits (after prolonged substantial dosages).

For a comprehensive presentation of 'Thorazine' prescribing information and side effects reported with phenothiazine derivatives, please refer to SK&F literature or *PDR*.

SK&F Smith Kline & French Laboratories

DSM II

- DSM II published in 1968
- Movement away from psychodynamic therapies, schizophrenic reaction
- Move towards more diagnostic validity
- Strong redefinition of schizophrenia to include new terminology, including the terms “projection,” “projected anger,” “anger,” and “hostility”
- “The patient’s attitude is frequently hostile and aggressive, and his behavior tends to be consistent with his delusions.”[1]



1. Diagnostic and Statistical Manual of Mental Disorders. 2nd ed. Washington, DC: American Psychiatric Association; 1968.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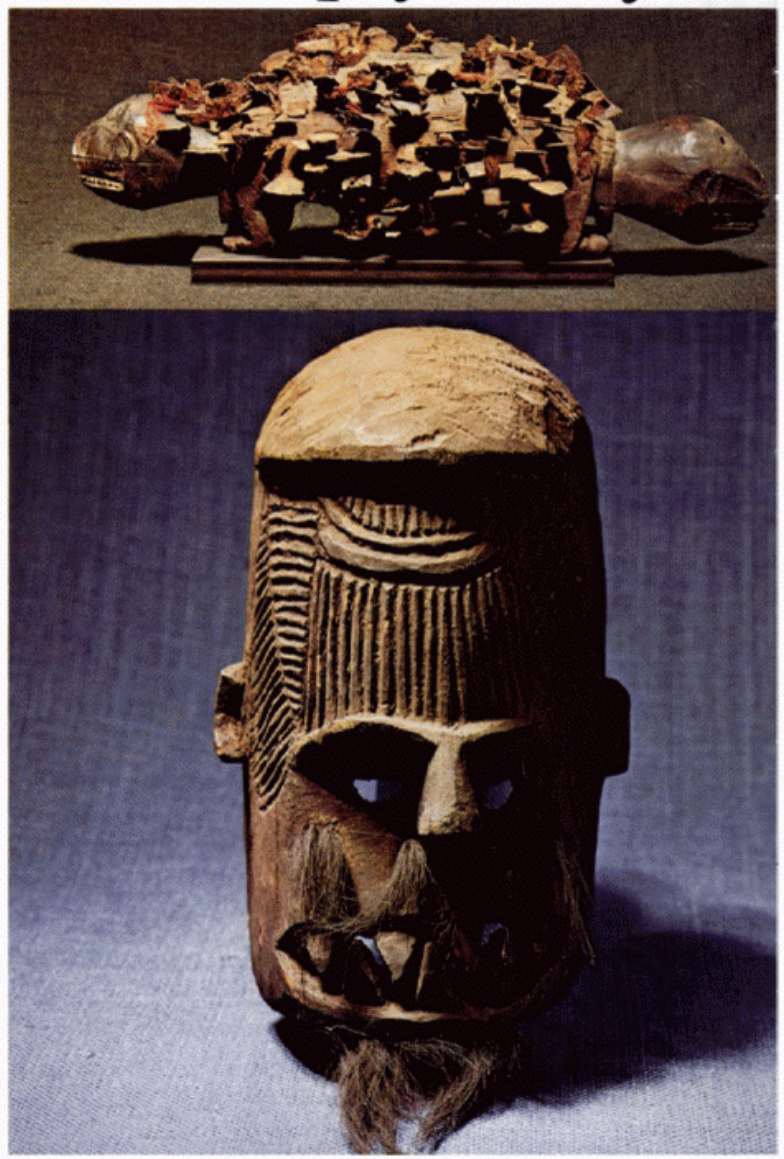
USA

Haldol advertisement. Arch Gen Psychiatry. 1974;31(5):732–733.

Basic tools of Primitive psychiatry



Konde: Incarnation of *Ndoki*, an evil spirit which causes disease. Wish-projection "causes" illness when a nail is driven into the statue. Also used to "drive out" an illness. Bakongo, Zaire.

Mask: Represents the spirit of the underworld. Used by the Ekpo male society, which honors dead ancestors and enforces the law. Anang Ibibio, Nigeria.

Objects from the collection of the Segy Gallery, New York City.

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Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Indications

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: For the management of manifestations of psychotic disorders. For control of the manifestations of manic-depressive illness (manic phase).

Probably effective: For the control of moderate to severe agitation, hyperactivity or aggressiveness in disturbed children.

Possibly effective: For control of excessive anxiety, tension and agitation as seen in neuroses.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Comatose states, presence of large amounts of C.N.S. depressants, or bone marrow depression.

Warnings: Avoid using in patients hypersensitive (e.g., blood dyscrasia, jaundice) to any phenothiazine. Caution patients about activities requiring alertness (e.g., operating vehicles or machinery) especially during the first few days' therapy. Avoid concomitant use with alcohol. May counteract antihypertensive effect of guanethidine and related compounds.

Use in pregnancy only when essential. There are reported instances of jaundice or prolonged extrapyramidal signs in newborn whose mothers had received chlorpromazine.

Precautions: Use cautiously in persons with cardiovascular, liver or chronic respiratory disease, or with acute respiratory infections. Due to cough reflex suppression, aspiration of vomitus is possible. May prolong or intensify the action of C.N.S. depressants, organophosphorus insecticides, heat, atropine and related drugs. (Reduce dosage of concomitant C.N.S. depressants.) Anticonvulsant action of barbiturates is not intensified. Antiemetic effect may mask signs of toxic drug overdosage or physical disorders. Discontinue high-dose, long-term therapy gradually.

Patients on long-term therapy, especially high doses, should be evaluated periodically for possible adjustment or discontinuance of drug therapy.

Adverse Reactions: Drowsiness, cholestatic jaundice, agranulocytosis, eosinophilia, leukopenia, hemolytic anemia, thrombocytopenic purpura and pancytopenia; postural hypotension, tachycardia, fainting, dizziness and, occasionally, a shock-like condition; reversal of epinephrine effects; EKG changes have been reported, but relationship to myocardial damage is not confirmed; neuromuscular (extrapyramidal) reactions; pseudo-parkinsonism, motor restlessness, dystonias, persistent tardive dyskinesia, hyperreflexia in the newborn; psychotic symptoms, catatonic-like states, cerebral edema; convulsive seizures; abnormality of the cerebrospinal fluid proteins; urticarial reactions and photosensitivity, exfoliative dermatitis, contact dermatitis; lactation and breast engorgement (in females on large doses), false positive pregnancy tests, amenorrhea, gynecomastia; hyperglycemia, hypoglycemia, glycosuria; dry mouth, nasal congestion, constipation, adynamic ileus, urinary retention, miosis, mydriasis; after prolonged substantial doses, skin pigmentation, epithelial keratopathy, lenticular and corneal deposits and pigmentary retinopathy, visual impairment; mild fever (after large I.M. dosage); hyperpyrexia; increased appetite and weight; a systemic lupus erythematosus-like syndrome; peripheral edema.

NOTE: Sudden death in patients taking phenothiazines (apparently due to cardiac arrest or asphyxia due to failure of cough reflex) has been reported, but no causal relationship has been established.

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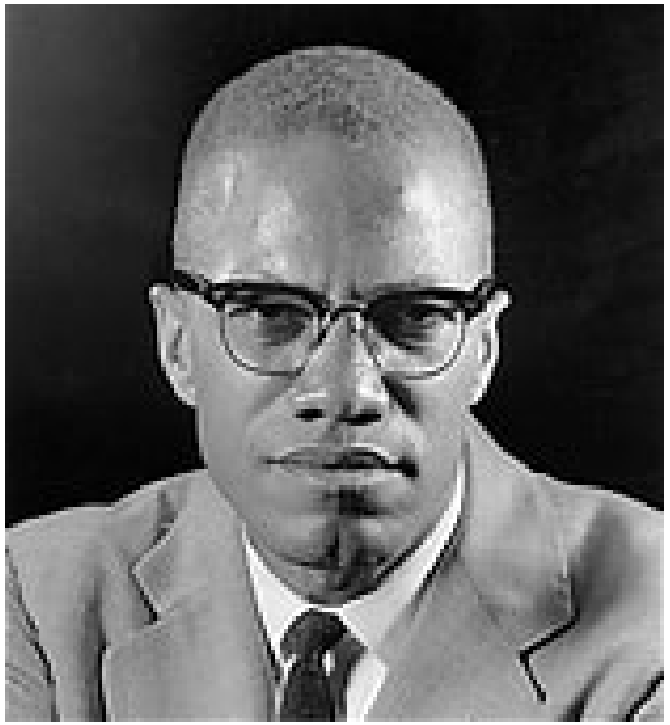
Effective control of psychotic agitation

- The FBI diagnosed Malcolm X with “pre-psychotic paranoid schizophrenia,” and with membership in the Communist Party and the “Muslim Cult of Islam,” while highlighting his attempts to obtain firearms and his “plots” to overthrow the government.[1]
- The FBI also diagnosed Robert Williams, the controversial head of the Monroe, North Carolina, chapter of the NAACP as schizophrenic.[2]



1. Metzl JM. The Protest Psychosis: How Schizophrenia Became a Black Disease. Boston, MA: Beacon Press; 2010.
2. FBI hunts NAACP leader. New York Amsterdam News. September 23, 1961: 1.

Impact of overdiagnosis

- Poorer long-term prognosis associated with primary psychotic illness
- Black people with mental health conditions, particularly schizophrenia, bipolar disorders, and other psychoses are more likely to be incarcerated than people of other races[1,2]

1. U.S. Department of Justice. “Prisoners in 2015.” NCJ 250229 (Bureau of Justice Statistics Bulletin). 2016
2. Hawthorne W, et al. "Incarceration among adults who are in the public mental health system: rates, risk factors, and short-term outcomes." Psychiatr Serv. 2012 Jan;63(1):26-32

Impact of overdiagnosis

- Black patients are significantly more likely to be prescribed first generation antipsychotics[1]
- Although pharmacokinetic research has shown that people of African ancestry metabolize many psychotropic drugs more slowly, Blacks continue to be prescribed higher doses of medications and are more likely to be exposed to polypharmacy[2]

1. Cook TB, Reeves GM, Teufel J, Postolache TT. Persistence of racial disparities in prescription of first-generation antipsychotics in the USA. Pharmacoepidemiol Drug Saf. 2015 Nov;24(11):1197-206. doi: 10.1002/pds.3819
2. Herbeck DM, West JC, Ruditis I, Duffy FF, Fitek DJ, Bell CC, Snowden LR. Variations in use of second-generation antipsychotic medication by race among adult psychiatric patients. Psychiatr Serv. 2004;55(6):677–84

Barriers to care

- Only one-in-three African Americans who need mental health care receives it[1]
- Compared with the general population, African Americans are less likely to be offered either evidence-based medication therapy or psychotherapy[2]
- Physician-patient communication differs for African Americans and Whites. One study found that physicians were 23% more verbally dominant, and engaged in 33% less patient-centered communication with African American patients than with White patients[3]

1. Dalencour M, et al. “The Role of Faith-Based Organizations in the Depression Care of African Americans and Hispanics in Los Angeles.” Psychiatric Services. 2017. 68(4):368-374
2. Wang PS, Berglund P, Kessler RC. “Recent care of common mental disorders in the Unites States: Prevalence and conformance with evidence-based recommendations.” J Gen Intern Med. 2000. 15(5), 284-292
3. Johnson R, et al. “Patient race/ethnicity and quality of patient-physician communication during medical visits.” Am J Public Health. 2004. 94(12), 2084-90.

Barriers to care

- Stigma associated with mental illness
- Distrust of the health care system
- Lack of providers from diverse racial/ethnic backgrounds
- Lack of culturally competent providers
- Lack of insurance, underinsurance

What can we do?

- Cultural sensitivity is imperative
- Cultural formulation Interview
- What concerns the patient most?
- Why they think this is happening?
- What matters most to them?
- How would they like to be helped?

Overcoming mental health stigma

- Shift media narratives
- Tell stories that prove people can lead rich lives
- Increase access to mental health care
- Raise awareness around mental health in young people

Summary

- Schizophrenia is a persistent psychotic illness commonly associated with impairments in social and occupational functioning
- Black Americans are diagnosed with psychotic illness at disproportionately high rates
- Cultural competence may be useful in improving both diagnostic validity and quality of care
- Work must be done to improve access to care and reduce mental health stigma

Questions

Appreciation

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