ABSTRACT
Psychosis symptoms (delusions and hallucinations) are multifactorial in origin and, in later life, occur in the context of schizophrenia, delirium, dementia, delusional and schizophrenia-like disorders, mood disorders, and alcohol or substance abuse. The current article provides a clinical overview of very late-onset (after age 60) schizophrenia-like psychosis (VLOSLP), summarizing the literature on treatment options and reflecting on the role of psychiatric–mental health nurses (PMHNs). Increased awareness of the clinical presentation, key features, and evidence-based treatment options will assist PMHNs to confidently recognize this often under-diagnosed disorder and adopt a more assertive role in terms of engagement and follow up. Pragmatic research involving individuals with VLOSLP is required to increase the evidence base for treatment and improve outcomes of care. [Journal of Psychosocial Nursing and Mental Health Services, 56(1), 37-47.]

It has long been acknowledged that psychotic illness can lead to alienation, discrimination, and isolation (Burke & Shone, 1998), and older adults with psychosis represent one of the most disenfranchised groups in relation to health care (Mitford, Reay, McCabe, Paxton, & Turkington, 2010). In the older adult mental health setting, nurses encounter two main groups with a schizophrenia diagnosis: (a) individuals with early-onset schizophrenia (EOS) who have grown old, and (b) those who experience the onset of psychosis in later life, either as late-onset (after age 40) schizophrenia (LOS) or very late-onset (after age 60) schizophrenia-like psychosis (VLOSLP).

Older adults with schizophrenia have been somewhat neglected historically by the scientific research community (Cohen et al., 2008; Folsom et al., 2006), and there is a significant gap between the high prevalence of psychotic disorders in older adults and the availability of evidence-based treatments.
DIAGNOSTIC ISSUES

VLOSIP is described as “schizophrenia-like” as it typically presents with positive symptoms (prominent delusions and multimodal hallucinations) in the absence of formal thought disorder and negative symptoms that are typically seen in EOS, but with greater sensory disturbance (Howard, Rabins, Seeman, & Jeste, 2000; Köhler et al., 2007). In contrast to EOS, VLOSIP occurs more commonly in women (after adjusting for gender differences in mortality) and is less associated with familial occurrences or childhood trauma (Reeves & Brister, 2008). Individuals with VLOSIP typically describe distressing delusional beliefs and hallucinations, often of a persecutory nature, which have a profound impact on their daily life and well-being. Another characteristic of VLOSIP are “partition” delusions, which involve beliefs that structures that normally act as barriers to movement, sight, and sound (e.g., walls, floors, ceilings, and doors [Howard, Castle, O’Brien, Almeida, & Levy, 1992]) become permeable, allowing a person to be observed, harmed, stolen from, and even sexually assaulted.

The exact onset of VLOSIP can be hard to establish. Zarit and Zarit (2012) suggest a two-stage process characterized by initial suspicion, irritability, and ideas of reference, which then erupts into more dramatic visual and auditory hallucinations and delusional interpretation of life events. Cross-sectional studies have found that social isolation (Almeida, Howard, Levy, & David, 1995; Hassett, 1999; Island, Lorenzten, Friis, Hauff, & Vaglum, 1994) and sensory deficits are common (Eissa, Hassan, Hwedi, & Khalil, 2013; Hassett, 1997) in VLOSIP, although no direct causal link has been established, and it is equally possible that the tendency to isolate oneself or failure to acknowledge or correct sensory deficits are part of a prodromal phase. The etiological contribution of neurodegeneration or organic factors to VLOSIP remains unclear (Barak, Aizenberg, Mirecki, Mazeh, & Achiron, 2002; Brodaty, Sachdev, Koschera, Monk, & Cullen, 2003; Jones et al., 2005; Palmer, McClure, & Jeste, 2001), and increased first service contact rates in older adults from ethnic minority groups suggests that psychosocial stressors may be equally important (Mitter et al., 2005; Reeves, Sauer, Stewart, Granger, & Howard, 2001). Historically, the nosology of late-onset and VLOSIP has been contentious (Sharma, Debsikdar, Naphade, & Shetty, 2014). The long history of differing opinions about age of onset, confusion about diagnostic criteria, and challenges of differential diagnosis have resulted in varied and often conflicting findings (Pearman & Batra, 2015). Consensus on diagnosis, nomenclature, treatment guidelines, and future research guidelines was only reached in 2000, following an International Late-Onset Schizophrenia Group Consensus meeting (Howard et al., 2000), in which VLOSIP was defined as a schizophrenia-like psychosis with onset after age 60, which cannot be attributed either to a primary affective disorder or focal or progressive structural brain abnormalities (Table 1).

VLOSIP is estimated to affect approximately 34,000 individuals in the United Kingdom, with 2,800 new service contacts per year (Howard et al., 2000). The prevalence of late-life schizophrenia at age 95 is 2.4%, and the number of individuals with this disorder is likely to increase (Royal College of Psychiatrists, 2012). The Royal College of Psychiatrists (2012) is trying to improve the recognition of schizophrenia in older adults, pointing out that VLOSIP may be regarded as eccentricity or misdiagnosed as dementia. Jeste, Blazer, and First (2005) call for aging-appropriate diagnostic criteria for major disorders such as schizophrenia in later life to improve the accuracy
of epidemiological data, improve diagnosis, and facilitate study of premorbid indicators, neurobiological underpinnings, prognosis, and management.

In VLOSLP, a multi-modal treatment approach involving individual care planning, judicious prescribing of antipsychotic medication, psychological support, education, and family and community resources is essential, but is not yet supported by a robust evidence base (Reinhardt & Cohen, 2015). Individuals who access services are not necessarily served well. A recent UK audit found that 54% of individuals assessed and diagnosed with VLOSLP failed to engage with services or were lost to follow up, with only 28% taking antipsychotic drug treatment at the point of discharge (Lam et al., 2016).

**PRESENTATION**

Individuals with VLOSLP typically lack insight into their illness and, as a result, their presentation to mental health services is largely initiated by others (e.g., general practitioner, neighbor, family, emergency services) and is often an indication that the experience is leading to increased distress and disturbing feelings, thoughts, and behaviors (Byrne, 2007). Individuals experiencing symptoms of VLOSLP can feel frightened, distressed, outraged, or simply overwhelmed by their experiences and referral to mental health services can provoke uncertainty, hostility, and fear. Typical case presentations are illustrated in Table 2.

Experience with this patient group has taught the health profession that subtlety, patience, and tenacity are often required before an individual agrees even to an initial assessment, as the psychotic experiences can hinder communication and lead to a lack of connection for both parties. Several attempts to visit are often required before seemingly therapeutic progress is achieved. Individuals experiencing persecutory delusions and hallucinations can become defensive or antagonistic and frustrated when encountering individuals who disbelieve them. A non-judgmental approach and active listening to complaints about neighbors’ intrusions can diffuse the anger and distress associated with delusional belief and decrease the likelihood of provoking a confrontation or repeated calls to emergency services (Howard, 1999). Relationship building and engagement are integral aspects of a dynamic process associated with, but not limited to, the initial stages of the nurse/patient relationship (Ryrie & Norman, 2013). In patients with VLOSLP, who represent the most difficult-to-engage group of older adults with psychosis, developing a therapeutic alliance is particularly challenging (Lam et al., 2016).

The therapeutic relationship that is so fundamental to psychiatric–mental health nursing requires a complex interplay of specialized skills that need to be continually developed and refined: conveying understanding and empathy, accepting individuality, providing support, being there/being available, being genuine, promoting equality, demonstrating respect, maintaining clear boundaries, and having self-awareness (Dziopa & Ahern, 2008). This valuable skill set should give psychiatric–mental health nurses (PMHNs) confidence to adopt an assertive role in develop-
ing best-practice care for older adults living with VLOSLP and ensure that sufficient time and effort are directed toward the engagement process. Quality therapeutic relationships improve outcomes in terms of mediating care, such as increased treatment adherence but also in terms of direct benefit of the relationship itself (Priebe & McCabe, 2008).

Comorbid medical problems, particularly cardiovascular and cerebrovascular disease, are common in older adults, which has diagnostic and prognostic implications (Auslander, Perry, & Jeste, 2002; Kennedy & Frazier, 1999). Talaslahti et al. (2015) found higher standard mortality rates in patients with VLOSLP compared to those with EOS, which was largely accounted for by physical comorbidities and accidents in those with VLOSLP. Comorbid medical problems, particularly cardiovascular and cerebrovascular disease, are common in older adults, which has diagnostic and prognostic implications (Auslander, Perry, & Jeste, 2002; Kennedy & Frazier, 1999). Talaslahti et al. (2015) found higher standard mortality rates in patients with VLOSLP compared to those with EOS, which was largely accounted for by physical comorbidities and accidents in those with VLOSLP.

Clinical management of older patients with a new onset disorder (Lubman & Castle, 2002) includes: taking a comprehensive history (including medications), physical examination (including neurological), blood tests, structural imaging, and cognitive screening. Where possible, a collateral history should be obtained from the family, family physician, or other available source. Before a diagnosis of VLOSLP is made, differential diagnoses must be considered and excluded or monitored (Table 3). In old age psychiatry, treatment is guided by the principle of minimum intervention, aiming to identify and reverse components of the illness where possible and reduce the secondary impact of delusional symptoms on an individual’s ability to function (Zarit & Zarit, 2012).

**RISK ASSESSMENT**

Older adults with psychosis are a highly vulnerable group. Florid symptoms may affect capacity and lead them to make unsafe decisions or engage in behaviors that can threaten their personal well-being or endanger others (Talaslahti et al., 2015). The experience of persecutory delusions can lead individuals to isolate themselves, adopt extreme measures to protect themselves (e.g., multiple locks, weapons), or contemplate suicide. Depressive symptoms are frequent in older adults with schizophrenia, an association of depressive symptoms and positive symptoms exists (Zisook et al., 1999), which needs consideration when assessing (suicide) risk regardless of patient age (Meesters, 2014). Nutritional status may be compromised if the patient is experiencing preoccupying symptoms and if there are fears that food and drink have been tampered with. PMHNs should assess for physical signs of illness or self-neglect and/or skin problems, including potential risks of developing pressure ulcers. Persecutory delusions and a perception of a hostile social environment increase anxiety and can disrupt family and social relationships, as delusional beliefs are often directed toward those in close personal or physical proximity (Gwyther & Steffens, 2007). Social isolation, or an overstimulating social environment, can be identified as risk factors.

The comprehensive risk assessment must identify, record, share, and respond to abuse, harm, and neglect. PMHNs have a pivotal role in assessing the safety of the home environment and working in close communication with the multidisciplinary team. Many individuals are best cared for at home, but those who are vulnerable and at risk may require admission for assessment and/or treatment. Based on their case register study of older adults with

### TABLE 3

**DIFFERENTIAL DIAGNOSES THAT SHOULD BE CONSIDERED FOR OLDER ADULTS WITH PSYCHOSIS WITH DISTURBED SENSORY SYMPTOMS OR IMPAIRED COGNITION**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia—Alzheimer’s disease, Lewy Body dementia, Parkinson’s disease, and other dementias, such as vascular and frontotemporal, as well as neurodegenerative diseases and reversible causes of dementia</td>
<td></td>
</tr>
<tr>
<td>Delirium—Occurs in altered consciousness and has rapid onset with a fluctuating course and global disturbance of cognition</td>
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<tr>
<td>Affective disorder—Bipolar affective disorder or psychotic depression</td>
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<tr>
<td>Delusional disorders</td>
<td></td>
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<tr>
<td>Substance-induced psychosis—including delirium tremens in an alcohol-dependent hospitalized patient or withdrawal state from sedative hypnotic agents</td>
<td></td>
</tr>
<tr>
<td>Psychosis due to general medical condition—an extensive list of medical conditions can include symptoms of psychosis including neurological, endocrinological, rheumatological, and metabolic disorders</td>
<td></td>
</tr>
</tbody>
</table>

Adapted from Manepalli, Gebretsadik, Hook, and Grossberg (2007).
VLOSLP, Talaslahti et al. (2016) recommend long-term and comprehensive outpatient care to reduce the need for psychiatric hospitalization with observations of physical illness to reduce the risk of premature long-term residential care.

ADDITIONAL BARRIERS

When VLOSLP symptoms arise in the context of sensory impairment, remedial action should be taken. In the current authors’ experience, it is not unusual for those presenting with VLOSLP to have neglected routine health visits (e.g., optician, audiologist) (Howard et al., 2000). Delusional persecutory beliefs may provoke individuals to stop using the phone or reduce radio/television or computer use so that channels of communication from the social world are reduced. Being a member of a migrant group is a risk factor for VLOSLP (Mitter et al., 2005; Reeves et al., 2001), and language may act as an additional barrier to communication. Awareness of cultural and ethnic differences in explanatory models of illness, idioms of distress, treatment expectations, and adherence is crucial (National Institute for Health and Care Excellence [NICE], 2014). Key to this process is striving to understand the cultural context of individuals’ experiences and their interpretation (Reeves et al., 2003), respecting diversity and avoiding a one-size-fits-all approach to the therapeutic alliance (Priebe & McCabe, 2008).

MANAGING CARE

Essential PMHN responsibilities include liaison and maintenance of clear channels of communication among the patient (and carers), health professionals, and other agencies involved; accurate reporting and recording of information; and care planning. The specific role of PMHNs will be guided in part by their skill level and competencies. Working with patients experiencing psychotic symptoms can be challenging, and organizational structures need to include adequate clinical training and supervision. The NICE (2014) recommendations for schizophrenia and psychosis, although not specifically targeted at individuals with schizophrenia older than 60, have relevance for nurses working with older adults.

PMHNs should work from individuals’ perspectives to clarify their concerns, understand on what grounds their beliefs are held, and how ideas have developed. Willingness to listen with empathic response and acknowledgement of distress relating to psychotic experiences is required rather than challenging the reality of the experiences. Nonjudgmental active listening provides validity to the experience, allows emotional ventilation, and signals genuine concern. An approach to patients experiencing VLOSLP is usefully informed by the cognitive–behavioral therapy psychosis (CBT-p) model, which adopts a continuum approach to symptoms, thus placing them in a less stigmatizing context and allowing movement on this continuum (Sivec & Montesano, 2012). Particular strategies used in CBT-p designed to strengthen the therapeutic alliance (regarded as critically important) to formulate shared understanding and promote coping with symptoms (Sivec & Montesano, 2013) could potentially benefit everyday clinical practice when supporting individuals with VLOSLP.

PMHNs need to be confident in their theoretical knowledge of psychopathology and ability to elicit and monitor symptoms and associated risks. Assessment and evaluation of symptoms (and treatment response) can be enhanced through the use of validated rating scales, such as the Brief Psychiatric Rating Scale (BPRS; Overall & Gotham, 1962), which has been used in clinical trials of antipsychotic drug treatment in VLOSLP (Howard et al., 2017; Psarros, Theleritis, Paparrigopoulos, Politis, & Papadimitriou, 2009). Clinicians can be trained in less than 1 day to use the BPRS reliably, and its use with this patient group is appropriate, with hostility, suspiciousness, hallucinations, unusual thought content, tension, and uncooperativeness items being particularly relevant to VLOSLP.

PHARMACOLOGICAL INTERVENTIONS AND MONITORING

In a recovery-based mental health service, medication is one strand of recovery support that can be offered (Slade & Davidson, 2011). The nurse’s role requires awareness and knowledge of the potential effects of aging on how psychotropic drugs are metabolized and cleared from the body, and the nature and prevalence of potential adverse effects (Clibbens, 2005). Decisional capacity about medication can be a complex issue in the context of VLOSLP and needs careful consideration (Folson et al., 2006). Discussing psychotropic agents can create tension within the nurse–patient relationship (Marland, McNay, Fleming, & McCaig, 2011), with most individuals being justifiably wary of taking antipsychotic medication and those experiencing paranoia additionally suspicious. The lack of insight that accompanies VLOSLP means that patients are unlikely to accept that they have a psychotic illness that could respond to treatment. Individual attitudes about medication need to be explored using the individual’s own terminology with a clear rationale for why trying the medication has been proposed (e.g., reducing anxiety levels, sleeping better, providing peace of mind, ability to cope). PMHNs should not shy away from open discussion about antipsychotic drugs involving sharing current evidence, explaining dosage recommendations for older adults, and monitoring of treatment effects, including possible side effects. Conversations should not be hurried and the issue may need to be revisited at a pace set by the patient. The conversation may follow, for example, along the following lines:

- “Do you know why the doctor has asked you to try the medication?” (Listen and discuss)
- “How do you feel about that?” or “What do you think of that suggestion?” (Use genuine curiosity)
- “We know from research and our work with other people who are going through similar experiences as yourself, that sometimes, as well as
having someone to talk to, medication can help…. It’s not always easy to explain but some people find that when they take a tablet like this (known as an antipsychotic) they feel more able to manage the situation they are in.” (Discuss response)

Patients involved in discussions about medication experience less coercion and feelings of powerlessness (Freeman, 2002). Increased adherence to medication in patients with schizophrenia is associated with a perceived stronger alliance between patient and clinician (Dolder, Lacro, Dunn, & Jeste, 2002; McCabe et al., 2012).

Antipsychotic medication should be considered within a clearly defined treatment plan that weighs the risks and (Chahine et al., 2010; Reeves & Brister, 2008). Assessment of renal and liver function is also recommended prior to starting antipsychotic drug therapy (Arbus et al., 2012).

Prescribing for individuals with VLOSLP is particularly challenging, as they are sensitive to antipsychotic drug side effects (Howard, 2008; Reeves et al., 2002), which increases the risk of noncompliance and subsequent disengagement (Lam et al., 2016). The consensus is that doses as low as 20% of those prescribed to individuals with EOS (and 50% of those prescribed to individuals with LOS) are sufficient to relieve symptoms and minimize side effects in VLOSLP (Alexopoulos, Streim, Carpenter, & Docherty, 2004; Howard et al., 2000). This consensus has recently been confirmed in a randomized, placebo-controlled trial in which 100 mg per day of amisulpride was effective and largely well-tolerated in patients with VLOSLP (Howard et al., 2017), which argues for a more assertive approach to engagement and antipsychotic drug treatment.

MONITORING OF SYMPTOMS AND SIDE EFFECTS

Antipsychotic drug–related side effects (e.g., falls, sedation, extrapyramidal side effects, postural hypotension) are greater following the use of first-generation antipsychotic agents (e.g., haloperidol) in older adults, thus second-generation antipsychotic drugs are preferred, particularly for those with VLOSLP who are at greater risk of extrapyramidal side effects than those with an earlier onset illness (Essali & Ali, 2012). However, weight gain, diabetes, and metabolic syndrome can be serious complications of antipsychotic drug therapy (in particular clozapine and olanzapine) and require careful monitoring (Chahine et al., 2010). Vigilance is required when reviewing compliance and side effects. PMHNs should record pulse and lying and standing blood pressure and elicit any signs of dizziness or postural drop. Patients with VLOSLP are second only to those with dementia in their sensitivity to extrapyramidal side effects (Reeves, Eggleston, et al., 2017), and PMHNs should be confident in their ability to identify emergent extrapyramidal side effects by observation of gait, facial expression, and salivation, and direct examination of the wrist and elbow to elicit rigidity (Table 4).

Other side effects of antipsychotic medications to be considered include: xerostomia (dry mouth), which is associated with increased risk of dental disease and reduced quality of life (Kisely et al., 2011); constipation and urinary retention associated with medications such as clozapine and olanzapine due to the drugs’ higher anticholinergic properties (Chahine et al., 2010); and unwanted drowsiness or sedation, which can increase fall risk. PMHNs should work collaboratively with patients and the medical team to establish the optimal effective and acceptable treatment. Ritchie et al. (2010) found that older adults with schizophrenia who complied with antipsychotic drug therapy in the first 6 months had increased long-term adherence rates, which supports the importance of engaging individuals in the early stage of treatment. Medication management (of psychiatric and physical health medicines) is an important component of health self-management for older adults with schizophrenia. Informed adherence can be encouraged through the use of open communication and routine patient education (including practical measures such as routine and structure, bubble packs, and updated medication lists) (Leutwyler, Fox, & Wallhagen, 2013).
NONPHARMACOLOGICAL INTERVENTIONS

PMHNs can promote activities that enhance self-esteem and develop coping skills from a positive stance, focusing on personal strengths and ability. In the absence of controlled trial data, it is difficult to draw firm conclusions or evaluate the potential contribution of the non-drug components of patient care, including engagement with members of the community mental health team and social services staff (Howard, 2008). Although the evidence base for effective nonpharmacological interventions for individuals with VLOSLP is yet to be established, randomized controlled trials involving cognitive remediation therapy, CBT, and social skills programs performed in LOS have demonstrated improvement in relation to cognitive deficits, social relatedness, mood, and psychosis (Cohen et al., 2015) and psychological approaches in adjunct with antipsychotic medication have also been acknowledged as beneficial (Clare & Giblin, 2008). An exploratory study, which evaluated the cognitive etiology of persecutory delusion formation and maintenance in VLOSLP, showed evidence of mentalizing errors but not the other cognitive biases described in EOS. The authors argued for the development of new cognitive models for psychotic symptoms, which could be used to guide psychological interventions (Moore et al., 2006).

Studies have shown that nurses and case managers with brief training can deliver CBT-p with positive effects to younger patients with schizophrenia spectrum disorders (Sivec & Montesano, 2012). Such approaches could be trialed and adapted for use with older adults with VLOSLP, as increasing PMHNs’ repertoire of skills to respond effectively to psychotic experiences could be beneficial in terms of continuation of care. Such training would also inform a structured, phased approach to delivering support with attention to the engagement process (using strategies such as normalizing and shared formulation [process examples of clinical practice can be found in Sivec and Montesano, 2012]).

CAREGIVER SUPPORT

Caregivers of patients living with psychosis can face considerable difficulties, including the challenge of dealing with a range of unusual or bizarre symptoms that can be hard to understand and cope with on an emotional and practical level (Kuipers, 2010). Long-standing paranoia can lead to conflict and part of the PMHN role is to support family members and enable them to reframe and deal with such issues (Lubman & Castle, 2002). Alternatively, relatives may need help and support to create distance and mental space between themselves and the individual, to minimize negative interactions and/or reduce risk. Carers’ support plans should include psychoeducation, strategies for coping, and advice about how to respond to delusional beliefs or ongoing hallucinations. Limited

### TABLE 4

**MONITORING ATYPICAL ANTIPSYCHOTIC MEDICATION IN PATIENTS WITH VERY LATE–ONSET SCHIZOPHRENIA-LIKE PSYCHOSIS (VLOSLP)*

<table>
<thead>
<tr>
<th>Health Measurement</th>
<th>Subjective Report on Inquiry</th>
<th>Of Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>How the patient feels overall about taking the medication and his/her experience</td>
<td>Concerns, difficulties in barriers to taking medication as prescribed</td>
</tr>
<tr>
<td>Sleep</td>
<td>Inquire about sleep patterns</td>
<td>Unwanted sedation, disrupted sleep, unusual restlessness</td>
</tr>
<tr>
<td>Movement</td>
<td>Discuss and observe</td>
<td>Falls, dizziness, feeling unsteady, feeling slowed down, restlessness in legs</td>
</tr>
<tr>
<td>Eating and drinking and elimination</td>
<td>Inquire about food and fluid intake, passing urine and bowel movements</td>
<td>Reduced food/fluid intake, thirst, constipation, change in urinary output or difficulty passing urine</td>
</tr>
</tbody>
</table>

Patients should be examined for extrapyramidal side effects before the initiation of antipsychotic medication to determine the possible pre-existence of Parkinsonism or abnormal involuntary movements. Baseline measurements should also note pre-existing joint stiffness from other medical conditions or mechanical injury. Baseline weight should also be recorded, as well as pulse and blood pressure.

Evaluation weekly for a minimum of 2 weeks after medication is introduced and when the dose is adjusted. Reviewing compliance and monitoring side effects is then routinely incorporated in follow-up visits, with ongoing recommendations communicated to the general practitioner on mental health service discharge.

Report and discuss any issues of concern with the team psychiatrist or prescribing physician.

It can be helpful to have the medication packs on hand during the discussion. The psychiatric–mental health nurse should enquire about the patient’s experience with taking the medication.
capacity for interpersonal relationships is noted in individuals experiencing VLOSLP (Hasset, 1999), and care plans should be aimed at promoting a social environment that is not overstimulating or against the individual’s wishes, while avoiding social isolation. Relationships may need to be reappraised and renegotiated between the patient and caregivers (Kuipers, 2010).

<table>
<thead>
<tr>
<th>Health Measurement</th>
<th>Observation and Examination</th>
<th>Rating as Used in Simpson Angus Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gait&lt;b&gt;</td>
<td>Observe walking as the patient walks during the encounter: gait, swing of the arms, general posture.</td>
<td>0 = normal; 1 = diminution in swing while the patient is walking; 2 = marked diminution in swing with obvious rigidity in the arm; 3 = stiff gait with arms held rigidly before the abdomen; 4 = stooped shuffling gait with propulsion and retropulsion</td>
</tr>
<tr>
<td>Arm dropping&lt;sup&gt;b,c&lt;/sup&gt;</td>
<td>The patient and examiner raise their arms to shoulder height and let them fall to their sides. In a normal patient, a stout slap is heard as the arms hit the sides.</td>
<td>0 = normal, fall with loud slap and rebound; 1 = fall slowed slightly with less audible contact and little rebound; 2 = fall slowed, no rebound; 3 = marked slowing, no slap at all; 4 = arms fall as though against resistance, as though through glue</td>
</tr>
<tr>
<td>Elbow rigidity&lt;sup&gt;b&lt;/sup&gt;</td>
<td>The elbow joints are separately bent at right angles and passively extended and flexed, with the patient’s biceps observed and simultaneously palpated. The resistance to this procedure is rated.</td>
<td>0 = normal; 1 = slight stiffness and resistance; 2 = moderate stiffness and resistance; 3 = marked rigidity with difficulty in passive movement; 4 = extreme stiffness and rigidity with an almost “frozen” elbow</td>
</tr>
<tr>
<td>Wrist rigidity or fixation of position&lt;sup&gt;b&lt;/sup&gt;</td>
<td>The wrist is held in one hand and the fingers held by the examiner’s other hand, with the wrist moved to extension, flexion, and ulnar and radial deviation.</td>
<td>0 = normal; 1 = slight stiffness and resistance; 2 = moderate stiffness and resistance; 3 = marked rigidity with difficulty in passive movement; 4 = extreme stiffness and rigidity with an almost “frozen” wrist</td>
</tr>
<tr>
<td>Salivation&lt;sup&gt;b&lt;/sup&gt;</td>
<td>The patient is observed while talking and then asked to open his mouth and elevate his tongue.</td>
<td>0 = normal; 1 = excess salivation to the extent that pooling takes place if the mouth is open and the tongue raised; 2 = when excess salivation is present and might occasionally result in difficulty speaking; 3 = speaking with difficulty because of excess salivation; 4 = frank drooling</td>
</tr>
<tr>
<td>Tremor</td>
<td>Observe the patient during the clinical encounter.</td>
<td>0 = normal; 1 = mild finger tremor, obvious to sight and touch; 2 = tremor of hand or arm occurring spasmodically; 3 = persistent tremor of one or more limbs; 4 = whole body tremor</td>
</tr>
<tr>
<td>Facial expression</td>
<td>Direct observation.</td>
<td>Note any reduction in range of facial expression or mask-like appearance</td>
</tr>
</tbody>
</table>

<sup>a</sup> With attention to extrapyramidal side effects.

<sup>b</sup> Item taken from the Simpson Angus Scale (Simpson & Angus, 1970), a rating for extrapyramidal side effects that has been used in research with VLOSLP (Reeves, Eggleston, et al., 2017).

<sup>c</sup> In the patient with extreme Parkinson’s syndrome, the arms fall very slowly.

Ongoing Support

PMHNs are required to work alongside patients to develop an understanding of their illness experience, consider how wellness can be achieved,
and evaluate care received. A stress-vulnerability model can be used to help patients make sense of why a psychosis may have developed, and recognizing stress triggers may enable patients to reduce the likelihood of relapse (Freeman, 2002). Although research on relapse prevention is almost entirely focused on those with an earlier onset of schizophrenia, it seems likely that those with VLOSLP would benefit from approaches that empower and respect the individual. Blanchard, Serfaty, Duckett, and Flatley (2009) proposed a reintegrative model for old age psychiatry that enables the individual to come to terms with loss and adapt and emerge with a new concept of self, sense of meaning, and empowerment. PMHNs have a role to challenge assumptions about disability and mental illness in older adults and be assertive in helping develop interventions that recognize and foster personal development for older adults with schizophrenia (Collier & Sorrell, 2011). Service pathways and the discharge process need to be planned and collaboratively discussed with the patient, general practitioner, and relevant agencies (including treatment summary, follow-up advice, warning signs of relapse, crisis plan, and future goals). It is important that patients know how to access help in the future, and a low threshold for referral for patients with VLOSLP should be considered. Patients who remain on antipsychotic medication will require continued monitoring of symptoms, compliance, and side effects. Without effective integrated community-based mental health services, older adults are unlikely to receive much needed treatment. It is important that nurses, alongside other health care professionals, researchers, and policy makers, step up to the challenge and continue to advocate for and develop an improved collaborative age-adapted mental health care system that can address unmet needs in this group (Sorrell, 2016).

CONCLUSION

The consensus on management of VLOSLP is that atypical antipsychotic medication is the cornerstone of treatment, and physical screening, the use of very low doses, and ongoing safety monitoring is advised. However, it is important to remember the therapeutic context that needs to be in place before such medications can be prescribed and monitored effectively. All interventions rely on an alliance between the older adult and clinician. Gaining trust of individuals experiencing psychosis translates into listening to their story, “getting inside their world,” and acknowledging their beliefs and why they hold them (Freeman, 2002). Developing and sustaining this relationship is a crucial part of the PMHN’s role and requires compassion and strong collaborative multiprofessional team work. Medication is never a stand-alone treatment, rather it is an adjunct to good quality mental health care that integrates biopsychosocial aspects of well-being. Much can potentially be achieved with nonpharmacological interventions for older adults experiencing psychosis (Karim & Byrne, 2005). Outcomes for care need to be judged not only on the presence or absence of symptoms but on issues such as quality of life, subjective well-being, and how the individual is able to function socially (Vahia et al., 2007).

Research on schizophrenia has largely focused on EOS (Collier & Sorrell, 2011; Köhler et al., 2007), and the literature on mental health nursing in older adults focuses on dementia and depression, with a relative absence of information on VLOSLP. This discrepancy needs to be addressed to understand the antecedents of VLOSLP, illness course, and successful management and intervention strategies (Hasset, 1999; Reeves & Brister, 2008). Older patients should not be denied the therapeutic optimism or assertive treatment and early interventions that are available to younger patients with schizophrenia (Burke & Shome, 1998; Mitford et al., 2010). PMHNs have a responsibility to challenge ageism and negative attitudes toward older adults with schizophrenia (Collier & Sorrell, 2011). PMHNs play a pivotal role in engaging and supporting individuals with VLOSLP, formulating individualized care plans and working to increase resilience. On a broader level, nurses can endeavor to raise the profile of this highly vulnerable group and collaborate with other professionals to optimize engagement and contribute to much needed clinically meaningful randomized studies that can guide management and service delivery.

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