

The background is a solid blue color. Scattered across the top half are several small, white, five-pointed stars. A thin, white, curved line starts from the left edge and arcs across the middle of the page, separating the title area from the lower section.

# The Early Diagnosis and Management of Psychosis

**A Booklet for General Practitioners**



# Contents

---

<b>Theoretical concepts</b> .....	2
What is psychosis .....	2
Who is affected .....	3
Why is early intervention so important?.....	3
Achieving early intervention .....	5
Course of illness .....	5
Continuing care .....	8
<b>Practice considerations</b> .....	9
Principles of intervention .....	9
Detection .....	9
The assessment .....	10
Immediate treatment .....	14
Pharmacotherapy.....	15
<b>The early and late recovery phases</b> .....	22
Psychological management .....	22
Assisting the family.....	25
Continuing care .....	27
<b>Summary</b> .....	29

## Theoretical Concepts

---

### What is psychosis?

Psychosis is the term used to describe a mental state in which the individual experiences a distortion or loss of contact with reality, without clouding of consciousness. This mental state is characterised by the presence of delusions, hallucinations and/or thought disorder. As well as these so called *positive* symptoms, negative symptoms such as affective blunting and loss of motivation can also occur. In addition, there are a number of other *secondary* features such as depression, anxiety, sleep disturbance, social withdrawal and impaired role functioning during a psychotic episode. It is these features which often provide the clue to the presence of psychosis.

Psychosis can be caused by a number of conditions. These include organic causes (such as drug intoxication, metabolic and infective causes) and functional disorders such as schizophrenia, bipolar disorder, schizophreniform psychosis and schizoaffective disorder.

Psychotic mental illnesses are of major social and public health importance. These conditions affect a significant number of individuals in our community. Indeed, if we consider all psychotic disorders together, we find that around 2% of people will experience a psychotic episode at some stage in their life. And, when the impact on the individual's family is also considered, it is apparent that the indirect effects of these conditions are just as great. Clearly, the *cost* of these disorders is considerable.

Increasing attention is therefore being paid to strategies which might reduce the impact of these conditions on affected individuals, their families and the community. A preventive framework has been advocated. Whilst research into primary preventive strategies is on-going, there are as yet no proven strategies for primary prevention. Our efforts,

therefore, need to concentrate on aspects of secondary and tertiary prevention, that is strategies which focus on minimising the impact of these disorders by maximising treatment and rehabilitation efforts.

Early intervention in first-episode psychosis is one such strategy for secondary prevention. Early intervention is aimed at shortening the course and decreasing the severity of the initial psychotic episode, thereby minimising the many complications that can arise from untreated psychosis.

## **Who is affected?**

It is postulated that the onset and course of psychosis is determined by an underlying vulnerability to psychosis coupled with the impact of environmental *stressors* which may then trigger active psychotic symptoms. This is the so-called stress/vulnerability model for psychosis. The major determinants of this vulnerability appear to be biological (genetic and neurodevelopmental) and its expression as frank disorder is influenced by both psychosocial and physical triggers (eg substance abuse).

Whilst the precise identification of individual vulnerability is not possible, it is clear that certain people are at more risk of developing a psychotic illness than others. Risk factors include:

- Family history of psychosis
- Schizotypal, schizoid and paranoid personality disorders
- Adolescence and young adulthood

An estimated 80% of patients affected by a psychotic disorder experience their first episode between the ages of 16-30.

## **Why is early intervention so important?**

The loss of contact with reality characteristic of psychosis can be a very frightening and traumatic experience. A person's first episode of psychosis can be particularly distressing and confusing for the individual, their family and peers, since the experience is so unfamiliar and difficult to understand.

Given that this first episode commonly occurs in adolescence or early adult life, an important time for the development of identity, independence, relationships and long-term vocational plans, the onset of psychosis can therefore cause considerable disruption and numerous secondary problems can develop.

### **Developmental disruption**

A psychotic episode commonly isolates the person from others and disturbs peer relationships. The person's personal and social development will be put on hold, or may even slip backwards. Impairment of school and work performance is common with the potential for profound damage to future vocational prospects and consequent financial insecurity. The impact on the family can cause straining or severing of relationships and increased psychological morbidity amongst family members. In addition substance abuse may begin or intensify and the risk of suicide is increased. The longer the illness is left untreated the greater the risk of permanent derailment of the person's psychosocial development.

### **Biological Toxicity**

There is also evidence to suggest that delayed treatment may cause the illness to become more *biologically entrenched* and less responsive to treatment. It appears that in some way psychosis may be biologically toxic. Indeed, longer periods of untreated psychosis have been related to slower recovery rates and poorer degrees of recovery, greater relapse rates and lower levels of social and occupational functioning and this effect appears to be independent of other prognostic factors. By contrast, early diagnosis and treatment leads to improved recovery and outcome.

It is somewhat disturbing then to find that many individuals experience prolonged periods of untreated psychosis during their first-episode. Numerous studies have demonstrated major delays between the onset of psychotic symptoms and the initiation of appropriate treatment.

These delays, although variable, are often in the order of many months to a year or more.

## **Achieving Early Intervention**

Clearly, this problem needs to be addressed. But how do we achieve early intervention? In practice, a number of strategies are required. One important strategy is community education aimed at increasing the public's awareness of these disorders and improving their knowledge of early signs. In addition to increasing knowledge, we also need to lessen the fear and stigma associated with mental illness, which can cause some people to delay seeking help. In conjunction with this, we also have to promote awareness of these disorders amongst service providers working with young people, in particular general practitioners. Although the presentation of first-episode psychosis is a relatively low frequency event in general practice, general practitioners have a crucial role to play. GPs are the first point of contact for the majority of people seeking assistance for their health concerns, whether they are physical or psychological. GPs are therefore quite likely to be the first person in a position to identify what is going wrong.

## **Course of Illness**

The typical course of the initial psychotic episode can be conceptualised as occurring in three *phases*. These are the *prodromal* phase, the *active* phase and the *recovery* phase.

### **The “Prodrome” – Something is not quite right**

Psychotic illnesses rarely present *out of the blue*. Almost always, these disorders are preceded by a gradual change in psychosocial functioning, often over an extended period. This period during which the individual may start to experience a change in themselves although they have not yet started experiencing clear-cut psychotic symptoms, can be thought of as the prodromal phase of the illness.

Changes in this phase vary from person to person and the duration of this phase is also quite variable, although it is usually over several months. In general, the prodrome phase is a fluctuating and fluid process, with symptoms gradually appearing and changing over time. Some of the changes seen during this phase include:

- Changes in affect such as anxiety, irritability and depression,
- Changes in cognition such as difficulty in concentration or memory
- Changes in thought content, such as a preoccupation with new ideas often of an unusual nature
- Physical changes such as sleep disturbance and loss of energy
- Social withdrawal and impairment of role functioning

The person may also experience some *attenuated* positive symptoms such as mild thought disorder, ideas of reference, suspiciousness, odd beliefs and perceptual distortions which are not quite of psychotic intensity or duration. These may be brief and intermittent at first, escalating during times of stress or substance abuse and then perhaps subsiding, before eventually becoming sustained with the emergence of frank psychosis. Clearly many of these changes are quite non-specific and can result from a number of psychosocial difficulties, physical disorders and psychiatric syndromes. However, it is clear that persistent or worsening psychological changes in an adolescent/young adult may herald the development of a mental disorder such as psychosis and this possibility needs to be kept in mind, particularly if other risk factors are present.

### **The “Active” phase**

As already mentioned the *active* phase of psychosis is characterised by the presence of positive psychotic symptoms which include thought disorder, delusions and hallucinations.

Hallucinations are sensory perceptions in the absence of an external stimulus. The most common type are auditory hallucinations. Other types of hallucinations include visual, tactile, gustatory and olfactory.



These are less common and an organic cause may be evident in these situations.

★ Delusions are fixed, false beliefs out of keeping with the person's cultural environment. They may be sustained despite proof to the contrary. These beliefs are often idiosyncratic and very significant to the patient but hard for other people to understand. Delusions often gradually build up in intensity, being more open to challenge in the initial stages, before becoming more entrenched. They can take many forms. Common types of delusions include:

- persecutory delusions
- religious delusions
- grandiose delusions
- ★ delusions of reference
- somatic delusions and
- passivity delusions (thought insertion/broadcasting/withdrawal)

Thought disorder refers to a pattern of vague or disorganised thinking. The person with thought disorder might find it hard to express themselves. Their speech is disjointed and hard to follow.

It is also important to remember that many patients with an underlying psychological/psychiatric disorder will initially present with physical symptoms, which concern them, such as tiredness, repeated headaches or insomnia. An underlying psychological disturbance should always be considered in an individual presenting with persistent or ill-defined somatic complaints in the absence of demonstrable physical pathology on examination or investigation.

## **Recovery Phase**

The majority of young people experiencing their first psychotic episode will make a complete recovery, although a significant minority (around 10-20%) will develop persistent symptoms. The trajectory of recovery, however, is quite variable. Once treatment is instituted, some people will get better slowly, but surely, whilst others will go through a period of seeming lack of progress and then make sudden shifts in well-being.

Slow or partial recovery needs to be managed in an early and assertive fashion and in general requires the use of more sophisticated psychological and pharmacological strategies. Once full recovery is achieved the major focus is on maintaining and promoting wellness and the prevention of relapse. Each relapse represents a potential risk point for the development of more enduring impairment and disability and appears to contribute to treatment resistance. Long-term, assertive follow-up is therefore essential for the vast majority of people with a psychotic illness.

## **Continuing Care**

Recovery is the norm after an initial psychotic episode and around 25% of affected young people will then never experience a further psychotic episode. The rest remain vulnerable to future exacerbations of their psychotic disorder.

Given the importance of continuing care, it is essential that the person's first experience of psychiatric care is managed carefully. Because of the great stigma attached to mental illness, the experience of psychiatric treatment is inevitably traumatic. The greater the trauma attached to the first treatment experience, the greater the risk that the young person will fail to engage with psychiatric care in the long-run.

Overall, the treatment of adolescents and young adults with a psychotic illness requires that the clinician maintain a balance between assertive care in order to promote harm reduction whilst allowing the young person to *run the show*. This also involves striking a balance between acknowledging the reality of the illness, whilst maintaining the focus on the person. The clinician needs to assist the client to work against the trauma and stigma of the illness and gradually share the responsibility for care with the client. Since many young people are overwhelmed by the thought of having a serious mental illness, such collaboration takes time to achieve.

## Practice Considerations

---

### Principles of Intervention

It is worth thinking of treatment as occurring in four main stages. These are:

- Detection
- Immediate management
- Early and Late recovery
- Continuing care

The issues for the person and therefore the treatment focus will differ depending on the particular phase. In addition illness issues are also intimately intertwined with the normal developmental tasks of adolescence including the attainment of a stable sense of identity, a move towards adult independence, decisions regarding study and work decisions and the building of friendships and intimate relationships. These developmental tasks form the background against which all treatment needs to be framed.

At each stage, a respectful and collaborative therapeutic relationship is required and key principles include:

- Explanation and education for the client and their family
- Combined pharmacological, psychological, family and social interventions, which focus on managing triggers and promoting resilience.

### Detection

Since the diagnosis of psychosis is purely a clinical one, it is important to be familiar with the possible presenting patterns of psychosis and the natural history of a psychotic episode. The manner in which a person experiencing their first episode of psychosis may come to your attention

is quite variable and depends on the phase of illness they are in, but as a rule psychotic symptoms are usually not spontaneously volunteered. We have to ask about them.

## **Setting the scene**

Adolescents and young adults (particularly males) are relatively infrequent attenders in general practice. This under-representation is due to a number of factors in particular, young people's relative good physical health compared with children and older people. However a number of structural obstacles may also discourage young people from making use of GP services. Encouraging adolescent help-seeking therefore requires the adoption of a *youth friendly* approach characterised by:

- Flexible appointments, with some provision for drop-in appointments
- Minimising cost (this may include assisting young people 15 and over to apply for their own Medicare card)
- Non-judgmental attitude by practice staff and GP
- Due regard for confidentiality

## **Discussing Confidentiality**

With any new adolescent patient, it is useful to reassure the patient about the confidentiality of your discussions with them, whilst explaining the limits of confidentiality. Limits to confidentiality include instances where the GP has serious concerns about abuse, concerns about patient self-harm or suicide, or concerns about their potential to harm others.

## **The Assessment**

In dealing with this age group, it is worth remembering that some adolescents/young adults may have difficulty relating to doctors. It is necessary therefore, to spend some time establishing rapport and trust. If the patient attends with her/his parents greet the patient and family, but see the young person first and then their family.

Although most young people will usually be attending with some fairly straightforward, acute problem, as in any other life stage, more complex problems can arise. Within adolescence, many of these more complex problems have a significant psychosocial component and in a number of instances this may be the prime “diagnosis”. When interviewing an adolescent patient, it is helpful to have some sort of framework, to assist you in exploring potential problem areas, as well as giving you a structure for more preventive interventions.

### **An Assessment Framework**

One commonly used framework, is the HEADSS checklist. The letters of this mnemonic stand for the various *worlds* of the young person which need to be assessed.

- **H** – stands for home and family relationships
- **E** – stands for education and employment
- **A** – stands for activities (ie the young person’s hobbies and interests and social network)
- **D** – stands for drugs like cigarettes, alcohol, marijuana and other illicit drugs
- **S** – stands for sexuality and intimate relationships
- **S** – stands for suicide and other mental health issues

### **Mental state examination**

If it is clear that the young person is exhibiting psychosocial difficulties, it is imperative to ask specific questions to assess for the presence of particular syndromes such as depression, anxiety disorders, gradually building up towards questions about psychotic experiences. Whilst statistically speaking, anxiety and mood disorders are far more likely, it is still important to check for psychosis, even if just to exclude the possibility. Remember depression and anxiety are common co-morbid or precursor symptoms to psychosis. Patients are unlikely to volunteer specific psychotic symptoms without some prompting from the GP.

Screening for psychosis can therefore be considered as a stepwise process, with the following steps:

- ① Is the young person experiencing psychosocial difficulties?
- ② If yes, could this be attributed to a specific mental disorder, in particular depression, anxiety or substance abuse?
- ③ If symptoms of depression, anxiety or substance abuse are present, is there a possibility that such symptoms are part of a psychotic disorder?

Possible screening questions for psychosis may include:

- Have you had any trouble with your thought processes recently? Do they seem speeded up or confused? (Checking for thought disorder)
- Have you been concerned about any unusual events recently, or thought that there were strange things were happening around you, or to you? (Checking for delusions)
- Have you been feeling as if something bad is happening to you, or that people have turned against you in some way? (Checking for delusions)
- Have you experienced any strange or unpleasant experiences involving your senses, for example hearing things or seeing things that others could not? (Checking for hallucinations)

Manic psychosis is likely to be noted by high levels of energy, reduced need for sleep, elevated and/or irritable mood, grandiose plans and ideas, such as a preoccupation with ideas of power or importance. The person will often be highly aroused or agitated, talk quickly and loudly and may well exhibit thought disorder.

## **Risk and Substance Use**

In any psychiatric assessment it is also essential to assess for suicide risk and whether the person is a risk to others. It is also imperative to inquire about possible substance abuse.

## **Keeping in Touch.**

If a *diagnosis* is not immediately apparent to you, but you suspect the patient may have a mental disorder, it is sensible and important to review the patient on a regular basis. It is also worth making some sort of agreement with the patient at the end of the first appointment to enable you to make contact if they *forget* to turn up. Whilst *chasing-up* patients can be quite difficult to do in a busy general practice, it is unlikely to happen very often.

## **Family Concerns**

Apart from assessing the patient it may also be necessary to obtain collateral information about the patient from their family or others, to clarify what is going on. The changes in behaviour or personality characteristic of psychosis are often noted by the family but not realised or volunteered by the patient. This requires discussion with and permission from the patient. You might try to get them to bring a family member with them to one of the appointments.

In many instances it may actually be the patient's family who initially recognise that something is wrong and who present on their own, with concerns about their son or daughter. They may have noticed a worrying change in the person's behaviour or personality and may be unsure of what is going on. You may need to be particularly supportive and explore and evaluate the family's concerns thoroughly. The family may be very distressed by the situation and this needs to be recognised.

When talking to the family, whether they have attended to see you or you have contacted them, try to be systematic. Ask them to describe specific examples of behaviour or comments they are concerned about. Assess the degree of change and its duration. The greater the change from usual and the more prolonged it is, the higher the possibility of a psychiatric disorder such as psychosis. Gather information about the patient's premorbid personality and functioning. Clarify the family history. If the family present without the patient try to get a sense of the urgency of the situation. If things can wait, try to encourage the young person to come in and see you or perhaps visit them at home. If the

situation seems serious and urgent than a home visit or urgent referral to psychiatric services might be essential. If a home assessment is contemplated, a preliminary assessment of the person's potential for aggression needs to occur. This requires discussion with the patient's family. If there are clear indications of risk you should enlist the support of experienced community psychiatric workers and a joint assessment may be preferable.

### **Physical Examination**

Finally, do not forget to perform a full physical examination and any appropriate investigations. In suspected psychosis, these would include Es + Us, FBE, LFTs, TFTs, random glucose and a urine drug screen.

### **Immediate Treatment**

The patient experiencing a first-episode psychosis will require specialist psychiatric assistance. Your referral options depend on a number of factors including age (adolescent vs adult specialist), patient preference (public vs private), the degree of urgency and risk, the extent of the patient's social support networks and what is available in your local community.

It is important to present all options to the patient and their family, once it is decided that further assessment or treatment is required. When discussing your concerns or your diagnosis with the patient and their family, it is best to be fairly general in your comments. Patients will feel very threatened if abruptly told they have schizophrenia. They are far more likely to be receptive to obtaining assistance for their *stress, confusion or sleep difficulties*, whilst you *check things out further*. By using this approach, patients can often be encouraged to accept help, particularly in the early stages of psychosis.

### **Handle With Care**

In general, when arranging treatment, you should aim to treat the patient in the least restrictive manner, being mindful to minimise any iatrogenic trauma. In a number of cases, this may mean that outpatient



treatment or home based treatment is a viable option. At other times a “wait and see” approach, with close monitoring via the family, may also be an option. In circumstances where these are not suitable options, it is important to ensure that transport to hospital and the admission itself is also handled with care. Patients often experience a considerable degree of shame and post-traumatic distress if their hospitalisation is coercive.

### **Treatment focus**

The initial focus of treatment is the control of positive psychotic symptoms and secondary symptoms such as insomnia, agitation and poor self-care.

Treatment then gradually progresses to

- Helping the person to make sense of their illness, and overcoming the trauma associated with it
- Making up for developmental delay lost skills (cognitive and social)
- Dealing with negative symptoms
- Dealing with any secondary morbidity such as post psychotic depression or anxiety and
- The prevention of relapse, through decreasing risk factors and promoting protective factors.

### **Pharmacotherapy**

There is now a growing recognition that the treatment approach required for a young person with a newly diagnosed psychotic illness is in many ways different from the approach which may suit a person with more long standing illness. One example of this difference can be seen in the area of psychopharmacological treatment.

### **Initial Drug Free Period**

For instance, it is now becoming common practice in first-episode psychosis, to provide an anti-psychotic free period of one or two days, before commencing specific neuroleptic treatment.

This period gives clinicians a chance to observe and assess the patient more closely, so as to confirm the diagnosis and exclude more transient psychoses (such as a drug-induced psychosis), without the masking effect of medication. Any agitation, irritability or insomnia can be managed by the use of a long acting benzodiazepine (eg diazepam 5mg tds to 10mg tds). In some cases however, this initial *wait and see* approach will be inappropriate and a more rapid treatment response will be required.

### **Start low and go slow**

When the decision to start anti-psychotic medication is made, a few key principles should be kept in mind.

Firstly, it is important to remember that patients experiencing their first psychotic episode are typically very sensitive to the pharmacological effects of these drugs and therefore quite susceptible to possible side-effects. In this group of patients therefore, it is essential to start any anti-psychotic medication at *very low doses*, so as to avoid the unpleasant side-effects that typically occur with these drugs and which contribute to poor compliance in the long-term.

The most problematic side effects are the extra-pyramidal side effects (EPSE). There are three types of EPSE, which may occur in the initial treatment period.

- Acute Dystonic Reactions – Sudden, painful muscle spasms, commonly affecting muscles of the head and neck, the most typical of which is an oculogyric crisis.
- Pseudo-Parkinsonism – Muscle stiffness, tremor and hypokinesia.
- Akathisia – A feeling of motor restlessness, which makes the person feel like they need to keep moving around. It can be mistaken for continuing agitation and lead to an increase in the anti-psychotic medication, making matters worse.

Prescribing low doses of anti-psychotic medication minimises the extent of possible side effects and is just as effective.

The second important principle is to increase dosages gradually. Antipsychotics take time to work. Increasing the dose rapidly offers no particular advantages. As mentioned above, the adjunctive use of a long acting benzodiazepine over the first few weeks will help control agitation and provide sedation, until the anti-psychotic starts having its full effect.

### **Which anti-psychotic?**

Over recent years, there has been a substantial increase in the number of medications available to treat psychotic disorders. Along with the traditional medications, a number of newer so-called atypical medications have been added to the range of treatment options.

Traditional typical anti-psychotic medication can be divided into low potency drugs such as chlorpromazine (e.g. largactil) and thioridazine (e.g. melleril) and high potency drugs such as haloperidol (e.g. seranace), trifluoperazine (e.g. stelazine). Low potency drugs are more likely to produce sedation, whilst high potency drugs are more likely to produce EPSE. Since the early 1990s a number of newer *atypical* antipsychotics have become available. Drugs in this category include: Risperidone (Risperdal), Olanzapine (Zyprexa) and Quetiapine (Seroquel) and Clozapine (Clozaril).

Whilst all currently available antipsychotics are efficacious in controlling positive psychotic symptoms (delusions, hallucinations and thought disorder), the atypical medications appear to have the advantage of having a better effect on negative symptoms, mood symptoms and cognitive dysfunction and a reduced incidence of extrapyramidal side-effects.

At the Early Psychosis Prevention and Intervention Centre, patients are therefore commonly commenced on one of the newer atypical antipsychotics such as olanzapine, risperidone or quetiapine. If using risperidone, a common starting dosage would be 0.5–1mg daily or 2.5–5 mg for olanzapine, or 25mg bd of quetiapine, increasing after a few days to 2mg risperidone, 5–7.5mg olanzapine or 200mg quetiapine.

This dose is maintained for a period of at least 2–4 weeks, since it can take some time for the antipsychotic effect to be fully established. If after 2–4 weeks there has not been a reasonable response, then the dosage is increased gradually, up to a maximum of around 4–6mg of risperidone, 10–15mg olanzapine and 700mg quetiapine over the next few weeks. Full remission takes time, but will occur in the majority of patients over the first 12 weeks. If remission is slow or incomplete, or significant side-effects develop, a switch should be made to an alternative antipsychotic.

Mood stabilisers such as lithium should be added if manic symptoms are prominent.

With appropriate treatment, remission will occur in the vast majority of patients, however, around 10–15% of patients may develop persisting positive symptoms. If significant positive symptoms persist despite an optimum trial of two or more antipsychotics and associated psychological and social therapies, a trial of Clozapine should be considered. Clozapine has been found to be effective in controlling symptoms in about a third of patients whose symptoms have not been ameliorated by other first line medications. Because of the risk of agranulocytosis and myocarditis, its use needs to be closely monitored and patients are required to have regular review and pathology tests. Clozapine can only be prescribed by a registered prescriber.

## **Achieving Adherence**

The quality of the therapeutic relationship holds the key to improved adherence. A collaborative approach with the patient, taking due regard of their ideas and beliefs, is more likely to be successful, than mere insistence. In first-episode psychosis, many people are reluctant to accept the idea of mental illness and the use of diagnostic labels such as schizophrenia or bipolar disorder, can be quite threatening.

In this initial period, it is often more useful to talk in a general terms about *stress related illness*, or target acknowledged problems, such as anxiety, insomnia or confused thinking, to make medication use more acceptable. Enlisting the support of the family, can also make initial

compliance more likely with some patients. At any rate, it is essential to provide information about the medications to both patient and family.

## **Length of treatment**

As a rough rule of thumb, the longer the period of untreated psychosis, or the slower the recovery, or the less complete the recovery, the more risk of future problems. At the Early Psychosis Prevention and Intervention Centre, young people are encouraged to continue medication for at least 12 months, or 2 years if they fall into a higher risk group. After ceasing medications, around a quarter of patients will not experience another episode. The remainder will be susceptible to relapses.

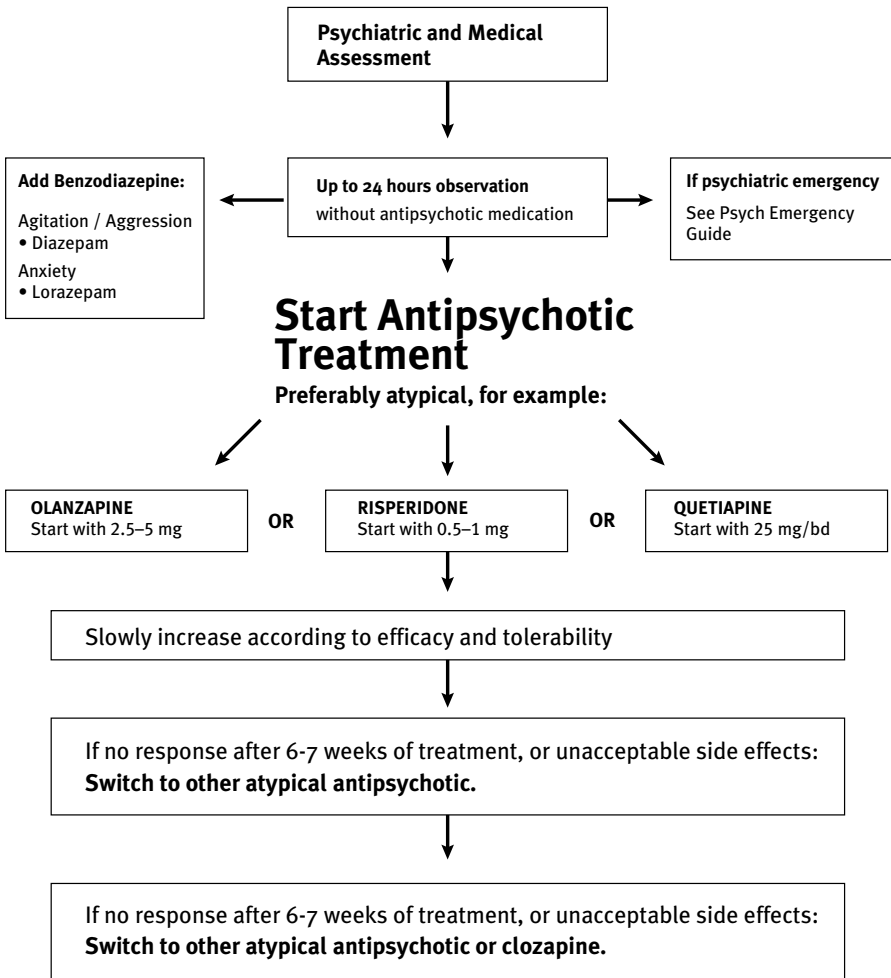
In reality, many patients cease their medication, before these recommended periods. Whilst it is important to try to maintain patients on medications as long as appears required, it is sometimes better to *lose the battle in order to win the war*. If a patient is well and chooses to cease their medication, the most important thing is to try to maintain a good working relationship with them and not have a *falling out* over the issue. In this way, should a relapse occur, the patient would know that the door is always open for them to return to see you and perhaps restart medication.

The use of depot medication and community treatment orders (involuntary treatment orders), should only be used if the potential risks (to self or others) are high and less restrictive options have been tried.

The following flow charts provide a guide to medication prescription in first episode patients.

# Non-affective First Episode Psychosis

## EPPIC Pharmacotherapy Guide



These are general guidelines and the individual needs of each patient must be considered.

Non-Affective First Episode Psychosis – EPPIC Pharmacotherapy Guide. From EPPIC (2002) *Prolonged recovery in early psychosis: a treatment manual and video* (Early Psychosis Prevention and Intervention Centre: Melbourne).

# Affective First Episode Psychosis

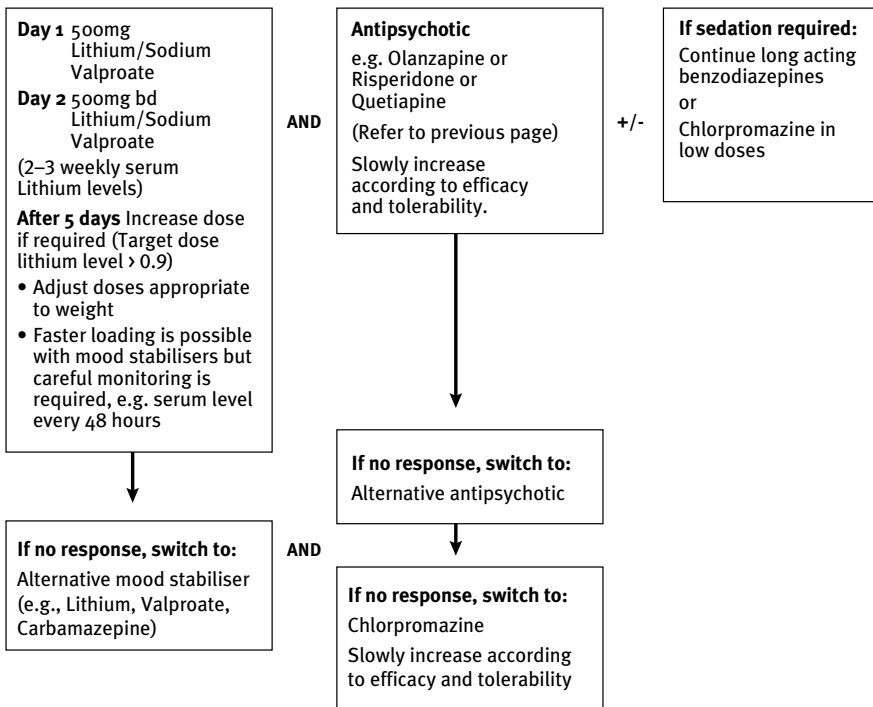
## EPPIC Pharmacotherapy Guide

### Start on benzodiazepine

- Agitation/aggression – Diazepam
- Anxiety – Lorazepam

Up to 24hrs observation without antipsychotic medication

## Commence Mood Stabiliser and Antipsychotic



These are general guidelines and the individual needs of each patient must be considered.

## **The early and late recovery phases**

---

### **Psychological management**

Whilst psychopharmacologic treatments form the cornerstone of treatment for people experiencing a psychotic illness, psychoeducation and psychological therapies, such as cognitive behaviour therapy, remain an essential adjunct. Such therapies have role in the direct treatment of positive psychotic symptoms, help to promote recovery and adaptation and are also particularly important in the prevention of the secondary morbidity associated with psychotic disorders, such as depression and anxiety. Whilst specialist psychological assistance is highly desirable for young people in the early years of illness, the family doctor does have a role to play in promoting the patient's psychological well-being.

### **A Focus on Recovery**

The first-onset of psychosis is usually a very traumatic experience. It has the capacity to profoundly change a person's usual way of construing themselves, their environment and their future. Overall, the major aims of psychological interventions in early psychosis are to assist the person to understand their condition and to help them regain a sense of mastery over their life, despite the sense of trauma. It is particularly important to protect and enhance the person's self-esteem, which has often been severely threatened or damaged by the onset of the disorder. Interventions need to instil hope, foster a positive yet realistic sense of self and encourage and build on existing strengths.

### **Early Issues.**

During the initial treatment period, the person is still unwell and will generally feel alone, misunderstood, confused and fearful about what is happening. They may feel powerless and that all control has been taken



from them. As a consequence, they may experience anger and frustration at being forced to do something they don't want to do.

In assisting patients at this time, it is important to make an effort to fully understand how the patient sees the situation and try to convey this understanding to them, trying to find some common ground with them about their difficulties, despite their psychosis. Where it becomes necessary to take control and take more assertive action, the emphasis is on conveying a sense of understanding their fear, giving clear information about what to expect and negotiating around the choices that are still possible.

### **Early recovery phase**

With the use of antipsychotic medication, most patients will experience a resolution of their positive symptoms (delusions, hallucinations and thought disorder) over several weeks. Some people will take longer to respond to treatment.

At this stage it is helpful to talk about recovery as a phase – a period of recuperation after a difficult illness – which takes time, emphasising that improvement will continue to occur over the coming months. It may help to describe other peoples' experiences of recovery and the problems that can occur, whilst encouraging discussion of the person's own experience. The overall emphasis is to try to reduce fear and distress evoked by the psychosis by giving clear information about psychosis, assisting the person in making some sense of why it happened and working towards encouraging the patient to separate *self* from *illness*.

It is also useful to explain psychosis in terms of the stress/vulnerability model, highlighting the interaction between biological predisposition and environmental influences, in particular the role of stress in lowering the threshold to psychosis. This can allow you to emphasise the episodic nature of psychosis and to highlight the possibility for the patient to have some control over managing their illness. Another essential task is to discuss the person's medication treatment, making sure they understand what each of their medications are for and proactively dispel common myths about medication.

As their symptoms begin to subside, patients can start to experience profound changes in the way they view themselves. Some will have a sense of extreme loss and grief due to a feeling that everything has changed. Others may make attempts to deny or minimise what has happened, or work hard to find alternative explanations for the episode. It is important to respect the patient's need to deny some aspects of their experience or unwillingness to talk about certain issues. In addition, a number of patients may have experienced their psychotic symptoms, their entry into treatment, or some of the interventions used in the active phase as frightening or even traumatic and may continue to ruminate on these memories.

As recovery progresses it is essential to be on the look out for any possible secondary morbidity, in particular post-psychotic depression and anxiety and tackle any new problems in a proactive way.

### **Late Recovery**

The person at this stage generally feels much better though maybe not quite the same as they used to be. The person may lack confidence, particularly in social situations and other activities requiring their usual level of independence. They may also have some continuing mild cognitive difficulties, particularly with concentration and their level of motivation may still be reduced.

They are usually very aware of stigma and extremely fearful of relapse. They may now wish to really distance themselves from what has happened and express the desire to cease medication. The emphasis is on helping the patient gradually return to their previous activities and reinforcing their sense of identity.

It can be helpful to focus on reducing the person's fear of relapse by looking at the early signs of becoming unwell for them and emphasise the idea of early intervention, should they ever re-experience symptoms. Indeed, it may be useful to create an individual warning signs list, along with a preferred management plan. The current and future use of medications can then be negotiated within this 'early signs monitoring' framework.

For many patients it is also necessary to give information on the ways some illicit drugs and alcohol may interact with their illness and medications. This is part of the broad context of helping the patient to identify ways to stay well, including the avoidance of potential triggers for relapse.

## **Persistent Symptoms**

Whilst most young people will make a full recovery from their first-  
psychotic episode, a significant minority will develop persistent  
symptoms. As mentioned, these young people will need a comprehensive  
multidisciplinary approach to their management, which is best  
arranged through specialist mental health services.

## **Assisting the family**

Assisting the individual in dealing with this experience, is an obvious  
and essential part of treatment. An equally important, but often-neglected  
part of treatment, is to deal with the needs of the person's family. All  
too often, family members complain that they become the forgotten  
casualties of these illnesses, despite the wealth of evidence which  
demonstrates the crucial role played by families in ensuring the continued  
well-being of a person with a psychotic illness. It is important  
therefore, when assisting the patient with a recent onset psychotic  
disorder that due regard is also given to the experiences and needs of  
other family members.

## **Helping families make sense of the situation**

When a son or daughter is first diagnosed with a psychotic illness,  
parents are likely to experience quite a range of emotions. These may  
include feelings of confusion, guilt, anxiety, sadness and anger. Indeed,  
the family's emotions often change quite dramatically during this period.  
Siblings may also experience similar emotions. It is important to convey  
to the family a sense of understanding their distress and to give them  
time to express their feelings.

It is also important to give clear, hopeful, yet realistic information to  
families. Most people in the community have a very limited understand-

ing of mental illness and of psychotic conditions in particular. What they know is through television, film and print media, which often presents a distorted and sensationalised view of mental illness. Accurate information is, therefore, one of the family's key needs. It is important to explore the meaning the family attaches to the illness and actively dispel common myths. Points worth highlighting include:

- That the majority of people recover from their first-episode of psychosis.
- That recovery is a gradual process and may take some time.
- That psychosis is caused by the interaction of a biological vulnerability with environmental stress. It is not caused by bad parenting.
- That antipsychotic medication is a very important part of treatment, but usually needs to be supplemented by psychosocial treatments.

### **Early recovery phase**

Issues in this phase vary according to the speed of recovery. In general, during this phase patients and their families need the opportunity to make sense of their experiences. Whilst relieved to see their family member improving, they may now start to worry about the possibility of future recurrences and want to discuss how to prevent further episodes. It is once again important to provide accurate information. Families should be given some general idea about the risk of relapses and the ways these can be minimised or avoided.

As with patients themselves, it can be helpful to explain psychosis to the family in terms of the stress/vulnerability model and then encourage the family to monitor for any recurrence of symptoms, minimise behaviours which may exacerbate psychosis and develop strategies for managing stress. They should also be given clear information and advice about medications and their potential side-effects.

In working with families, it is also important to highlight the *normal*. Once a diagnosis of psychosis is made, there is often a tendency to label everything in terms of the illness. The clinician needs to separate out the

psychosis from the everyday. In addition, the clinician needs to focus on strengths, not just problems, in a deliberate attempt to tackle the pessimism most people unconsciously have about mental illness.

### **Late recovery**

At this stage, strong emphasis should also be placed on the importance of creating an accepting environment, which allows the individual to continue to develop their own independence, without family members being overprotective or over critical. There is considerable evidence to suggest that the development of a supportive, non-critical environment at home can significantly improve outcome. In addition, the family need to be supported and encouraged to balance their role as care giver to the ill family member, with their own needs. If recovery is slow, families and patients need extra encouragement to remain optimistic.

### **The Special Needs of Children**

Since psychosis usually commences in late adolescence or early adult life, it is possible that the person may have young children themselves. It is important to keep this in mind. In the rush to assist the affected individual, their children are often ignored. Often other family members will take on responsibilities whilst the parent is unwell. At other times, specialist child and family agencies may be needed to offer support. The assistance required will vary according to the child's age, but as with the adult family members, children also need support in dealing with the crisis.

### **Continuing care**

The major aim after achieving remission is to promote wellness and prevent relapse. Continuing care is therefore far from a passive process and requires a structure and purpose for each encounter. Regular appointments spaced one to three months apart are preferable, supplemented by attendance on an as-required basis.

The following issues need to be considered at each appointment:

- Review of general health and well-being

- Assess mental state, including assessment for secondary depression and anxiety (risk assessment if required)
- Review medication (adherence, side-effects, changes required)
- Attend to any practical problems (eg finances, housing)
- Provide supportive counselling or specific counselling (eg stress management through behavioural measures or structured problem solving, counselling re drug use)
- Plan next session and any tasks required in the interim

It is also important the patient and GP agree to an action plan in case of non-attendance (which may signal the onset of relapse) and a relapse action plan. Both of these plans may well require input from the person's family. Elements of the relapse plan should include:

- Possible early warning signs of relapse (these are often, though not always, similar symptoms to those in the previous psychotic episode)
- How long to wait before action
- When and by how much to increase medication
- Who to contact (if non-urgent – the treating GP, if urgent the local CAT team)

Throughout continuing care, the focus is on decreasing risk factors such as

- Stress – financial, housing, work, relationship
- Substance abuse and
- Family conflict

whilst promoting protective factors such as

- Secure accommodation and income
- Structured rehabilitation
- Engagement in work or study
- Strong social networks and family supports and
- Adherence to medication

## Summary

---

In summary then, the early diagnosis and treatment of first episode psychosis can significantly improve the prospects of recovery and reduce longer-term impairment for many individuals. Whilst it may only be one or two patients a year that you see with a developing psychosis, the sooner their illness is diagnosed the better for them and their families.

It is clear that a variety of presenting scenarios exist in first-episode psychosis and this can make diagnosis difficult. We therefore need to maintain an index of suspicion. In practice, if we remember to consider psychotic illness/psychotic prodrome as a differential diagnosis in any individual in the adolescent/young adult age group with persistent changes in functioning, behaviour or personality, especially if other risk factors are present. Whilst conditions such as depression or one of the anxiety disorders are more likely to be the cause, depressive and anxiety symptoms are also part of the clinical picture for psychotic disorders, therefore specific questioning about delusions and hallucinations should be part of every psychosocial assessment.

Treatment requires the integrated use of pharmacological, psychological, family and group interventions. It is essential to start any anti-psychotic medication at very low doses, so as to avoid the unpleasant side effects that typically occur with these drugs and which contribute to poor compliance in the long-term. The adjunctive use of a long acting benzodiazepine (eg diazepam) over the first few weeks allows for sedation and control of agitation, until the anti-psychotic starts having its full effect.

Recovery is the norm after an initial psychotic episode and around 25% of affected young people will then never experience a further psychotic episode. The rest remain vulnerable to future exacerbations of their psychotic disorder.

The major aim after achieving remission is therefore to promote well-ness and prevent relapse. Continuing care is far from a passive process and requires a structure and purpose for each encounter.





# Notes

---



© 2002 ORYGEN Youth Health

This booklet was produced by ORYGEN Youth Health to promote awareness of the benefits of early intervention on the long and short term health of young people with a mental illness.

To find out about early intervention programs in your area, or to obtain extra copies of this booklet, contact the Early Intervention Worker at the Area Mental Health Service for your region.

---





ORYGEN  
Youth Health

© 2002