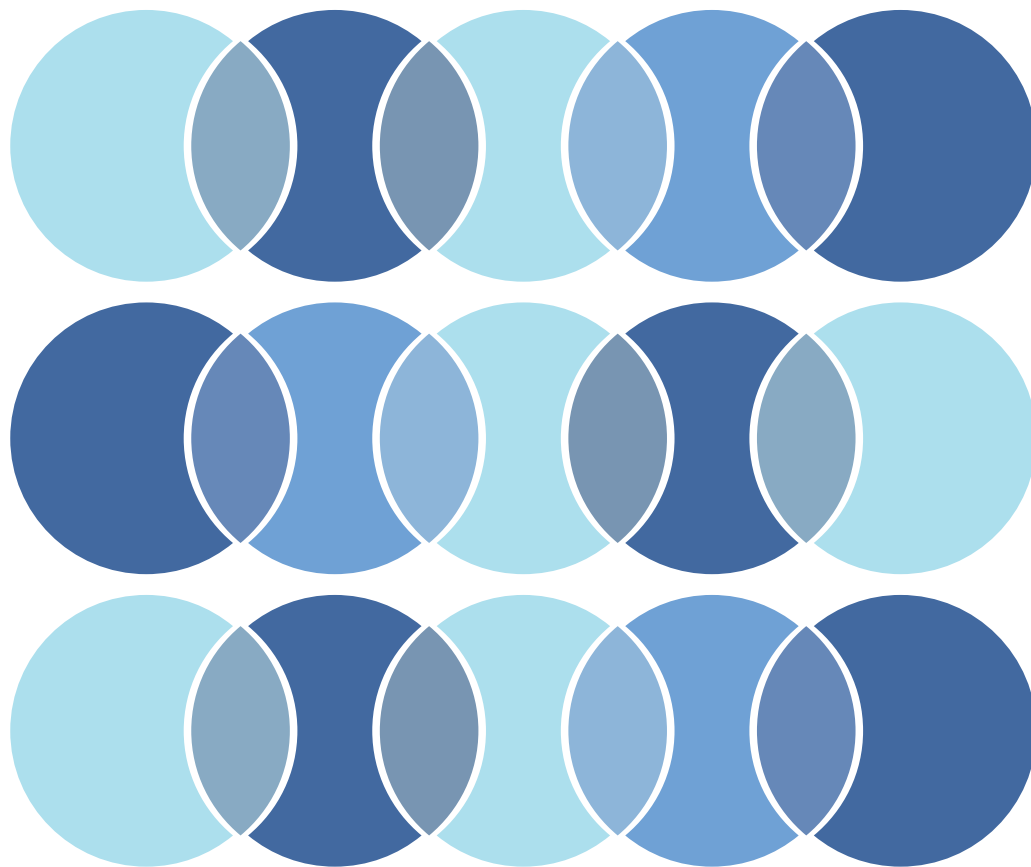


# Early Identification of Psychosis

A Primer



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# INTRODUCTION

Psychosis is a condition characterized by loss of contact with reality and may involve severe disturbances in perception, cognition, behavior, and feeling.

Approximately 3% of people will experience a psychotic episode at some stage in their life. Usually a person's first episode occurs in adolescence or early adult life, an important time for the development of identity, relationships and long-term vocational plans.

The initial episode of psychotic disorders can be particularly confusing and traumatic for the person and their family. A lack of understanding of psychosis often leads to delays in seeking help. As a result, these treatable illnesses are left unrecognized and untreated. Even when appropriate help seeking does occur, further delays in diagnosis and treatment may result from skill and knowledge gaps among professionals.

Increasingly, attention is being paid to strategies that reduce the personal, social and economic strain of these conditions on affected individuals, their families and the community. Early intervention in first-episode psychosis is aimed at shortening the course and decreasing the severity of the initial psychotic episode, thereby minimizing the many complications that can arise from untreated psychosis. It is a strategy that can provide considerable long-term benefits.

This booklet was developed for mental health workers, school counselors, alcohol and drug professionals, and others working with youth and young adults who may be at risk for psychosis.

# PSYCHOSIS AND EARLY INTERVENTION

Psychosis describes a mental state characterised by distortion or loss of contact with reality. Positive symptoms of psychosis include delusions, hallucinations and/or thought disorder.

There are multiple causes of psychosis, which include substance abuse or withdrawal, exposure to severe stress, inherited and acquired medical conditions or diseases, and mood disorders. However, the most common cause of psychosis is schizophrenia.

Negative symptoms such as poverty of thought or speech, loss of motivation, and restriction in the range of emotional expression can also occur. In addition, there are usually a number of other 'secondary' features, such as sleep disturbance, agitation, behaviour changes, social withdrawal and impaired role functioning. These secondary features can often provide the clue to the presence of psychosis.

Psychosis can be caused by organic causes, intoxication, and “functional” disorders such as schizophrenia, bipolar disorder, schizophreniform psychosis and schizoaffective disorder.

Early intervention involves diagnosis of psychotic disorders at the earliest possible time and ensuring that appropriate specialist treatment is initiated. This should be at the first sign of positive psychotic symptoms, but it may also be possible to intervene during the period prior to development of psychotic symptoms (the prepsychotic or prodromal phase).

Achieving early intervention requires increasing community understanding of these disorders through raising awareness of early signs and decreasing the stigma which can sometimes delay people from seeking help.

Involvement of the family in all phases of the disorder should not be under-emphasized. An educated and committed family is a valuable resource for the individual and the treatment team.

# WHY IS EARLY INTERVENTION NEEDED?

Several studies have shown there is often a major delay in initiating treatment for people affected by a psychotic disorder. These delays vary widely from person to person, but in many studies the interval between onset of psychotic symptoms and commencement of appropriate treatment is more than one year.

## ***Poorer Outcomes***

A psychotic episode commonly isolates the person from others and impairs family and social relationships. Difficulties in school and work performance arise and secondary problems such as unemployment, substance abuse, depression, self harm or suicide and illegal behaviour can occur or intensify.

Some evidence shows that long delays in obtaining treatment may cause the illness to become less responsive to treatment. It has been found that delays in receiving treatment are associated with slower and less complete recovery and that long duration of psychotic symptoms before treatment appears to contribute to poorer prognosis and a greater chance of early relapse.

## ***Delayed Treatment Can Result in:***

- Interference with psychological and social development
- Strain on relationships or loss of family and social supports
- Disruption of parenting role in young mothers/fathers with psychosis
- Distress and increased psychological problems within the person's family
- Disruption of study
- Disruption of employment and unemployment
- Slower and less complete recovery
- Poorer prognosis
- Depression and suicide
- Substance abuse
- Illegal behaviour
- Unnecessary hospitalization

- Increased economic cost to the community

### ***Benefits of Early Intervention:***

- Reduced morbidity
- Preservation of psychosocial skills
- Preservation of family and social supports
- Decreased need for hospitalization
- More rapid recovery
- Better prognosis

## **RISK AND ONSET**

The stress-vulnerability model for psychosis suggests that the onset and course of psychosis are determined by an underlying vulnerability to psychosis which when coupled with the impact of environmental 'stressors' may then trigger active psychotic symptoms.

The major determinants of this vulnerability appear to be biological (genetic and neurodevelopmental) and its expression as disorder is influenced by psychosocial and/or physical stressors.

A positive family history of psychosis is associated with an increased risk of vulnerability to psychosis. For example, the risk of developing psychosis associated with schizophrenia is 1% for the general population vs. 13% for the children of those with schizophrenia.

An estimated 80% of individuals affected by a psychotic disorder experience their first episode between the ages of 16-30 and the median age of first onset of bipolar disorder and schizophrenia is 19 years, with females having a slightly later age of first episode compared to males.

# COURSE OF FIRST-EPIISODE PSYCHOSIS

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

## 1. *Prodrome*

The prodromal phase is the period during which the individual is experiencing changes in feelings, thought, perceptions and behaviour although they have not yet started experiencing clear psychotic symptoms such as hallucinations, delusions or thought disorder. Depending on the type of psychotic condition, the prodrome may or may not be apparent.

Changes in this phase vary from person to person and some people may not experience a prodromal phase. The duration of this phase is also quite variable, although it is usually over several months. In general, the prodrome is fluctuating and fluid, with symptoms gradually appearing and shifting over time. Some prodromal signs and symptoms include:

***Changes in Affect:*** Feelings of vague suspiciousness, depression, anxiety, tension, irritability, anger or mood swings.

***Changes in Cognition (Thinking):*** Difficulty in concentration and memory, thoughts feel slowed down or speeded up, odd ideas, vague speech.

***Changes in Sense of Self, Others or the World:*** Feeling somehow different from others or that things in the environment may seem changed.

***Physical and Perceptual Changes:*** Sleep disturbances, appetite changes, bodily complaints, loss of energy or motivation and perceptual aberrations.

Family and friends may notice when: A person's behaviour changes, their studies or work deteriorate, they become more withdrawn or

isolated, they are no longer interested in socializing or they become less active.

Clearly, these changes are non-specific and can result from a number of psychosocial difficulties, physical disorders and psychiatric disorders.

## **2. Acute Phase**

During this period, which will usually continue until appropriate treatment is initiated, the typical psychotic symptoms occur. This includes *positive* symptoms such as thought disorder, delusions and hallucinations.

Hallucinations are sensory perceptions in the absence of an external stimulus. The most common type is auditory hallucinations or hearing voices. 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 individual 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 or that certain comments or other are cues are specifically directed towards oneself,
- bodily or somatic delusions, and
- passivity experiences such as thought insertion/broadcasting/withdrawal.

Thought disorder refers to a pattern of vague or disorganised thinking which may appear illogical. The person with thought disorder may find it hard to express themselves. Their speech seems disjointed and hard to follow. The person's information processing is impaired. Changes in



cognition may impair insight and judgement. The individual experiencing psychosis may not be able to recognize that something is seriously wrong.

While these symptoms are definitive of psychosis, disturbances of mood, behaviour, sleep pattern and activity also occur.

Many individuals with an underlying psychological/psychiatric disorder will initially present with physical symptoms that 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.

The way an individual may present in this 'active' phase is quite variable. The commonly described scenario of the disturbed psychotic individual is only one possible mode of (usually late) presentation. Just as common is the more 'quietly' psychotic individual who is gradually slipping backwards, losing their place in society and dismissed as being just odd. In fact, negative symptoms such as decreased motivation, energy and interest, blunted affect and a decrease in the richness of inner mental life are common in the acute phase. These symptoms may simply be regarded as indicative of depression thereby increasing the duration of improperly treated psychoses.

### ***3. Recovery Phase***

With available treatments, the great majority of people recover well or fully from their initial episode of psychosis.

The recovery process is dynamic, affected by a number of interacting factors. These include the treatment environment, medication and psychological therapies, factors within the person and factors within the person's family and social environment. The recovery process will vary from person to person and take different lengths of time for each person.

Specific issues to be dealt with in the recovery phase include helping the person and family make sense of the illness experience and see the need for treatment and helping the person to re-establish a confident

sense of themselves, which will allow them to return to their premorbid level of functioning. Problems such as post-psychotic depression, anxiety disorders, altered sense of self, loss of confidence and social withdrawal need to be addressed directly in a preventive manner. Assistance with housing, employment and study may also be required.

To achieve maximum recovery, a supportive and collaborative approach to the person and their family, use of a range of specialist treatments and a comprehensive biopsychosocial approach is essential. All interventions should commence from the time of initial presentation and diagnosis. Medication is usually continued for at least twelve months after a first episode and then slowly discontinued while the individual continues to be monitored.

Following recovery from a first episode, a significant number of people will never experience a recurrence of psychosis. Others will develop recurring episodes of psychosis, but be relatively well in between and continue a productive life especially if they continue on maintenance medication. During the recovery phase, a discussion of these possibilities needs to occur and the person and their family should be provided with information about the risk of relapse. Guidelines for recognizing and seeking treatment for relapses at the earliest possible stage should also be provided as part of the general focus on individual and family psychoeducation. Definitive prognosis is not possible. The number of people who develop significant disability from a first episode is small.

# SUMMARY OF FIRST-EPISODE PSYCHOSIS

- ❖ Most people experience their first episode of psychosis in adolescence or early adult life.
- ❖ The first episode of psychosis is an extremely confusing and traumatic experience for the person and their family and causes considerable distress and disruption.
- ❖ Early appropriate treatment can reduce the degree of disruption and morbidity created by the psychotic illness and can result in more rapid recovery and a more favorable outcome.
- ❖ Current research indicates that early treatment is not occurring in most cases, with symptomatic individuals remaining undiagnosed and untreated for long periods. Delays of up to a year are common. These delays result from multiple factors, but delays in recognition are a critical part of the problem.
- ❖ Increasing awareness of the usual course of first-episode psychosis and the pattern of symptoms that occur is one important way of ensuring early case detection.
- ❖ The first episode can be conceptualized as usually occurring in three phases - prodrome, acute and recovery.
- ❖ Treatment of the first episode requires a comprehensive biopsychosocial approach and a range of specialist treatments aimed at treating the person's primary psychotic symptoms and assisting them in overcoming the secondary personal and social difficulties which the illness often creates. Full recovery from the first episode is the norm.

# TIPS FOR HELPERS

## ***Recognizing Psychosis***

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. Because we have to go looking for them the recognition of the first episode of a psychotic illness can present some difficulties.

Even when the individual does reach out for help, it may be unclear what is going on. In the prodromal phase the individual may present with various vague symptoms and concerns. They may express a general sense of feeling stressed or feeling different or not coping. Somatic complaints and preoccupations, particularly sleep disturbances, are often apparent, as they can be in other psychiatric syndromes, such as depression. An underlying psychological disturbance should always be considered in an individual presenting with persistent, ill-defined somatic complaints in the absence of demonstrable physical pathology on examination or investigation.

In the acute phase, psychotic symptoms may be clearly apparent but at times the individual may be suspicious and guarded or attempt to conceal difficulties. Reassurance and gentle persistence may be necessary. Focussing on the concerns raised by individual and respecting their point of view is usually a fruitful approach.

The key to the early recognition of these disorders is to maintain a relatively high index of suspicion when dealing with an adolescent or young adult with persistent psychological difficulties and persistent or worsening changes in their personality or behaviour.

The first step is to enter into a confiding and caring relationship with the individual you are concerned about. The second step is to derive enough information to determine if a referral for an in-depth assessment by a qualified professional is indicated.

## ***Be Straightforward***

When approaching someone you are concerned about, be straightforward about your concerns. It is best to describe your concerns in specific behavioural terms and not speculate about their diagnosis.

## ***Take Time***

Arrange to talk to the individual somewhere private and free from distractions. It is important that you listen and be patient. The initial time you talk to the person may only allow you to establish a feel for the problem. Repeat visits over a couple of weeks can often make things much clearer. It often takes time for the person to build up trust and open up to you.

You can not force an individual to open up to you. If the individual refuses to talk with you, let them know that you will be available if they would like to talk with you in the future.

## ***Establish Rapport***

When talking to an individual who you suspect may be experiencing a psychotic episode, it is essential to remember that they are often likely to be quite distressed and frightened. Acknowledge that the individual may be nervous or wary and try to find some common ground for discussion, gradually building up towards more specific questions about their psychotic experiences. Be supportive and non-judgemental.

## ***Gather Information***

Once you have established rapport, don't be shy about asking direct questions. Ask the individual about their mood and thoughts. Inquire about how things have been going with school, work, and relationships. Ask if they have experienced any stressful events or had any unusual experiences lately. Also, don't be hesitant to ask in a matter-of-fact manner, if they have had any thoughts about hurting themselves or anyone else.

## ***Make the Referral***

The purpose of gathering information is to determine if a referral to a qualified professional is in order.

It is important to convey a message of hope to the individual. Assure them that help is available and things can get better. If you can, prepare the individual for what they might expect when following through with the referral.

You can make the referral with the individual present and/or you can offer to accompany the individual to the first appointment. If the person refuses to get help and follow-through on the referral (and it is not an emergency situation), remain friendly and open to the possibility that he/she may want your help in the future.

If you have determined that the person is in a potentially life-threatening or emergency situation, you must ensure that the individual gets professional help immediately. This may be done by accompanying the individual to the appropriate service or by utilizing emergency resources.

You may want to follow-up with the individual at a later date to show your continued interest, even if he or she did not accept your attempted referral.

# MORE RESOURCES

Canadian clinical practice guidelines for the treatment of schizophrenia.  
Canadian Journal of Psychiatry, 1998, 43(supplement 2).

The Early Psychosis Prevention and Intervention Centre  
<http://www.eppic.org.au/>

British Columbia Schizophrenia Society  
<http://www.bcss.org/>

Internet Mental Health  
<http://www.mentalhealth.com/>

Mental Health Evaluation & Community Consultation Unit  
<http://www.mheccu.ubc.ca>

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