PSYCHOLOGICAL EFFECTS OF PRESENT DAY TREATMENT OF EARLY PSYCHOSIS ON PATIENTS, FAMILIES AND STAFF
The Battle or the War?

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OVERVIEW

• Impact on Patient
• Impact on Family and Friends
• Impact on Us (Clinicians)
IMPACT ON PATIENT

• The experience of psychosis
• Becoming a “patient”
• Inpatient Care and Home-based acute care
• Drug therapy
• Psychological and Social Needs
• Key Responses
The psychological impact of acute psychosis

- **Symptoms**
  - The perceived ‘omnipotence’ of voices (Birchwood)
  - The isolation of paranoia
  - Confusion, cognitive impairment
  - Depression and negative symptoms

- **Threat to ‘the person’**
  - Threat to integrity of self (Strauss & Davidson)
  - Negative self schemas (Perris, 1998), self-stigmatisation, demoralization (Birchwood), powerlessness
  - Shame, embarrassment, guilt

- **The treatment**
  - Distress of side-effects of medication

- **Interruptions to the developmental pathway**
  - Education, employment, relationships, poverty, dependency, institutionalisation, addiction
Understand the personal context

• *How rapidly did the prodrome and psychosis evolve?*  
  A slowly-evolving illness may allow the person time to adapt, but also reduce the dysphoria and reduce the perceived need of the patient and family to seek help.

• *What kind of person is being affected by the psychosis and what is their reaction?*  
  Understanding the premorbid personality and other features of the individual will help to interpret the personal meaning of the psychosis.

• *In what kind of environment or culture has the patient’s psychosis arisen?*  
  Sociocultural factors can affect detection of the illness, pathway to care and compliance with interventions that are offered.

• *What kind of family supports exist and what are their reactions to the illness?*  
  These issues will influence decisions about the role of the family in the future care of the patient.
BECOMING A PATIENT
INTRINSIC FEATURES
Premorbid
Gender
Mode of Onset
Comorbidity (Berkson)
Syndromal Pattern
NS, PS, Mood, SA
HLC
Insight
Distrust of Medical Rx
IQ

EXTRINSIC VARIABLES
Social Support
Contact with GP
Stigma
Mental Health Literacy
Family History
Cultural Group

HELP SEEKING
RECOGNITION
ACCESS

DUP
OUTCOME
Treatment
INPATIENT CARE
REASONS FOR INPATIENT CARE

• concerns about safety
• refusal to comply with community assessment or treatment
• lack of appropriate family/social support.
GOALS OF INPATIENT CARE

- Ensure safety.
- Provide comprehensive assessment.
- Provide effective treatment with the lowest possible doses of medication to minimise the side effects.
- Minimise the trauma of admission to a psychiatric unit.
- Instil hope and an expectation of recovery.
- Provide counselling and support to assist the patient come to terms with the illness and hospitalisation.
GOALS OF INPATIENT CARE (contd.)

- Involve the family in assessment, treatment and discharge planning.
- Provide information about psychosis and treatment for the patient and family.
- Involve a case manager as soon as possible, to facilitate engagement with the community team and continuity of care.
- Involve a GP in care as soon as possible.
- Provide activities and group programs which are appropriate for young people and promote supportive social interactions.
Addressing the concerns of patients

When patients with acute psychosis are admitted to an inpatient unit they may be concerned that they:

- will forfeit basic rights
- will be incarcerated indefinitely
- will be injected with chemically-restraining medications
- will be assaulted
- are not unwell like other patients in the unit (Power & McGorry, 1999).
Context of Treatment

• Should be provided in outpatient or home context
• Inpatient care may be necessary. Inpatient care is ideally provided in specialised youth oriented units
• Such units should be small in size and be adequately staffed to allow for nursing of distressed people without locking the unit
• When a separate unit is not possible a special section of a more general unit may be created. This highlights the different needs and prognosis of young people
• Specialised acute, early psychosis day services may be an alternative to inpatient care where they exist
• If attempts to engage fail, and active symptoms remain, in most cases the person has the right to be treated on an involuntary basis.
Characteristics of a Favorable Hospital Environment

• Open design, home-like atmosphere with quality décor
• Color, lighting, space, moderate bed numbers
• Totally flexible visiting hours
• Consumer input and visiting
• Individual dietary control, personal possessions, respect for privacy etc.
• Strong unified clinical leadership and patient-centred value system
• Streaming of patient groups
• Antiboredom strategies
• Zero tolerance for illicit drugs
• Accessible, sociable, low EE clinical staff (No CFs)
LOCATION OF TREATMENT: Home/Community vs Inpatient?

- the condition of the patient
- the need for particular treatments
- family functioning
- social supports
- preferences of the patient and family
- treatment resources that are available in the community.
HOME-BASED CARE

- less likely to lead to secondary morbidity associated with hospitalisation such as depression and post-traumatic stress disorder (McGorry et al, 1991)
- less expensive than hospital care
- associated with less stigma and dislocation for the patient and family
Checklist for the initiation of home-based treatment (EPPIC, 1997)

- Family member requires treatment.
- Family member is not able to attend appointments at community-based services.
- Clinician’s and family’s risk assessment indicates that home-based treatment is a safe option.
- The collective resources of the treating team and the family enables provision of the required treatment.
- Family understands the tasks involved in home-based treatment.
- Family are willing to take on home-based treatment.
- Good communication can be facilitated through qualified interpreters when needed.
Challenges for clinical staff of home-based care

- a loss of control over the working environment ("Guest" status)
- a lack of access to medical equipment
- diminished access to colleagues
- safety issues

Result: withdrawal from HBC in Australia
Common Fears and Beliefs about Medication

- Fear of side-effects of drugs. Fear of effects of drugs on function, eg work, social, sexual, planning for future. Fears of addiction to medication.
- Concern about stigma attached to taking medication.
- Fear of altered lifestyle due to medication
- Fear of emptiness - if symptoms such as long-standing hallucinations are cured by medication then this may create a vacuum in the patient’s life
- Issues related to family history of psychosis and existing medication of other family members
- Fears of life-long medication
- Fears that medication will not work.
- Sense of weakness and shame for needing medication.
Responses to aggression in an inpatient unit

• Distinguish between normal adolescent behaviour and symptoms of psychosis.
• Redirect energy through sport activities, walks with staff or other physical activity.
• Exert a high degree of self-control despite anxiety in the face of aggressive behaviour.
• Check what the patient wants: the issue might have arisen from difficulty with a simple request such as access to a phone - only control what you need to!
• Avoid looking or becoming nervous: stay calm and self-confident.
• Recognise real threats and withdraw when appropriate: don’t be a hero, and have the confidence to exit safely.
• Use a calm voice at low volume to convey simple messages.
• Adopt a non-threatening posture with some eye contact but avoid staring.
# PRN MEDICATION

## Table 19
Potential advantages and disadvantages of PRN medication

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<tr>
<th>Advantages</th>
<th>Disadvantages</th>
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<tr>
<td>Flexible</td>
<td>Removes control from prescriber - indications (rarely specified), choice</td>
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<tr>
<td>Avoids unnecessary medication</td>
<td>of agent and dose</td>
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<td>Adds to range of nursing approaches</td>
<td>Reactive not proactive</td>
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<td></td>
<td>Can act as substitute for care and containment.</td>
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PSYCHOLOGICAL AND
SOCIAL NEEDS

- Experience of Psychosis
- Social Dislocation - security
- Possible self?
- Lifestyle Change
- Connection
- Meaningful role and trajectory
“It is important to be mindful that the person is attempting to compensate, not only for the cognitive and emotional disruptions wrought by the trauma of psychosis, but also for the assault on self-esteem, identity and disruption to lifestyle resulting from psychosis. Thus the person is grappling, while in a highly compromised state, with the meaning and significance of their predicament”.

(COPE Manual)
The psychological impact of acute psychosis

Symptoms
- The omnipotence of voices
- Isolation of paranoia
- Confusion

Threat to ‘the person’
- Threat to integrity of self
- Trauma of psychosis and associated experiences of treatment (McGorry et al., 1991, Meyer, 1999)

Treatment
- Side effects of medication

Interruptions to the developmental pathway
- Education, employment, relationships, poverty
RESPONSES
Aims of intervention in the acute phase of psychotic illness

General Aims

- Ensure the safety of the individual and others.
- Reduce symptoms of psychosis and disturbed behaviour.
- Build a sustainable therapeutic relationship with the individual and carers.
- Develop a management plan to aid recovery from the acute episode.
Aims of intervention in the acute phase of psychotic illness

Specific aims

- Monitor the patient’s status.
- Prevent harm.
- Minimise trauma.
- Reduce delay in treatment.
- Provide optimal medication to control positive symptoms and disturbed behaviour.
- Prevent or treat negative symptoms and co-existing problems such as depression, mania, anxiety or panic attacks and substance abuse.
Aims of intervention in the acute phase of psychotic illness

Specific aims (contd.)

- Maintain morale and instil hope.
- Provide an acceptable explanatory model, with education about psychosis and its treatment.
- Support the family to relieve their distress and improve family functioning.
- Promote adjustment and psychosocial recovery.
- Promote functional recovery.
- Promote continuity of care and adherence with treatment.
- Promote early recognition of further episodes, and identify factors that precipitate or perpetuate episodes.
- Facilitate access to other services in the mental health, general medical and social service systems.
Psychological Interventions in Acute Psychosis

Cognitive strategies can be used quite early in an acute episode to:

- facilitate discussion about distressing symptoms
- challenge patients' thoughts and assumptions about themselves and the future
- enhance self-esteem
- facilitate discussion about stigma.
WHY PSYCHOLOGICAL TREATMENTS ARE NECESSARY IN PSYCHOSIS

• To develop a therapeutic alliance
• To promote adherence to medication
• To provide emotional support in the face of disturbing subjective experiences and stigma
• To specifically target individual symptom complexes, comorbidities and maladaptive schemas
• To reduce treatment resistance
WHY PSYCHOLOGICAL TREATMENTS ARE NECESSARY IN PSYCHOSIS (contd)

• To enhance coping and adaptation
• To improve cognitive functioning
• To improve interpersonal relationships which may be independently problematic or have been disrupted by illness
• To promote vocational recovery
• To provide support and care to family members including siblings
• To reduce risks of suicide and aggression
• To prevent relapse
Engagement techniques
(Edwards & McGorry, 2002)

- Recognise that the patient may be nervous, wary, or not want to see health professionals.
- Be aware that psychosis might distort patients’ interactions and their ability to process information.
- Listen carefully to patients and take their views seriously.
- Acknowledge and respect patients’ viewpoints.
- Identify common ground.
- Find the distress (Othmer & Othmer 1994)
Engagement techniques
(Edwards & McGorry, 2002)

• Consider appropriate body language when interviewing patients who may be paranoid, aroused or manic (sit side-by-side, avoid too much eye contact, allow personal space).
• Be helpful, active and flexible. Negotiate.
• Carefully explain the procedures involved in physical or other assessments.
• Gather information gradually, at the same time as fostering a close relationship.
• Introduce key players who will take part in the patient’s management.
• Provide good continuity of care and good communication between professionals.
Dosing of Antipsychotic medication in acute psychosis

- The optimal dose of the drug should maximise therapeutic benefit while minimising unwanted side effects.
- Starting doses should be very low, particularly in patients who have not previously been treated.
- Dose adjustments should occur in small increments and at appropriate intervals – probably every 3-4 weeks.
Haloperidol - D₂ Occupancy

Haloperidol 2 mg/d
D₂ occupancy predicts EPS/akathisia

D₂ occupancy predicts EPS and akathisia (F₁,₂₀ = 10.54, p < 0.004)

No subject below 78% showed any EPS or akathisia.
Dosing in FE studies

- McEvoy et al 1991
  HPL 2-4 mg
- Emsley et al 1999 (n=183)
  HPL/RIS 5-6mg
- Sanger et al 1999 (n=83)
  OLZ 11.6mg  HPL 10.8mg
- Lieberman et al 2003 (n=263)
  OLZ 9.1mg  HPL 4.4mg
- Merlo et al 2002
  RIS 2-4 mg
- McGorry et al (under review) (n=96)
  RIS 2-4 mg
- Schooler et al (2005) (n=555)
  RIS 3.3mg  HPL 2.9mg
Maximum Daily Dose (HPL eq.) in First 3 Months of Treatment
(n=231)

- Mean maximum daily dose: 4.3 mg/day (sd=2.5)
- 23 patients were not prescribed antipsychotics in the first 3 months
Initial Management

- Low dose antipsychotics will not rapidly affect secondary distress, insomnia or behavioural disturbance
- For this reason, skilled nursing care, a safe and supportive environment and liberal doses of benzodiazepines are essential interim measures
- Treatment of psychosis should be conceptually separated from the need for sedation
- If positive symptoms persist beyond a trial of 2 first line atypical antipsychotics (approx. 12 weeks min.) reasons for persistence should be reviewed
Acute Emergencies in Psychosis

Key goals in managing emergencies

- Primary prevention of emergency situations and the need for restraint.
- Prevention of physical harm to the patient, other patients or staff.
- Prevention of psychological trauma to patients and staff arising from the management of emergencies.
- Prevention of adverse events from physical or pharmacological restraint during emergencies.
- Prevention of sequelae of emergency restraint.
IMPACT ON FAMILY AND FRIENDS
IMPACT ON FAMILY AND FRIENDS

• PARENTS: Grief, anxiety, shame, guilt, conflict, depression, coping and mutual support etc
• SIBLINGS: denial, anxiety, sadness, anger etc
• FRIENDS: concern, denial, detachment, support etc
• TEACHERS, EMPLOYERS etc
Possible fears of families about treatment

• Clinicians will overtly or covertly blame the family for the illness.

• Clinicians will automatically admit the person to hospital without consultation.

• Clinicians will fail to provide adequate follow-up after the assessment process.

• The young person will be turned into a ‘zombie’ by medication.

• The young person will never forgive the family for contacting the service.
FAMILIES AND PHASE OF ILLNESS

- During the prodrome and early stages of a psychotic episode, families might experience some denial and attempt to minimise the problem, until they acknowledge that ‘something is not quite right’ and seek help.

- After psychosis has been identified, they can experience a period of grief and distress. A crisis often precipitates first contact with mental health services and the provision of a diagnosis, although the contact with services might initially be ambivalent. Once the patient is in ‘the system’, families can be faced with an avalanche of bureaucratic procedures and jargon.

- As the patient moves towards recovery, families develop some sense of coping, confidence and adaptive functioning, while recognising that professional help will not always be unlimited. There is a realignment of roles and expectations within the family, accompanied by concerns about the possibility of relapse.
IMPACT ON CLINICIANS
IMPACT ON CLINICIANS

Depends on:

• Factors in the patient(s)
• Factors in the clinician
• Factors in the organisation, system: team, colleagues, leadership, resources, value placed on the work, rewards, status, results etc
CONSEQUENCES

- Morale
- Satisfaction
- Guilt/Anger
- Burnout
- Withdrawal/Retreat
- Advocacy
- Solidarity