Early Psychosis

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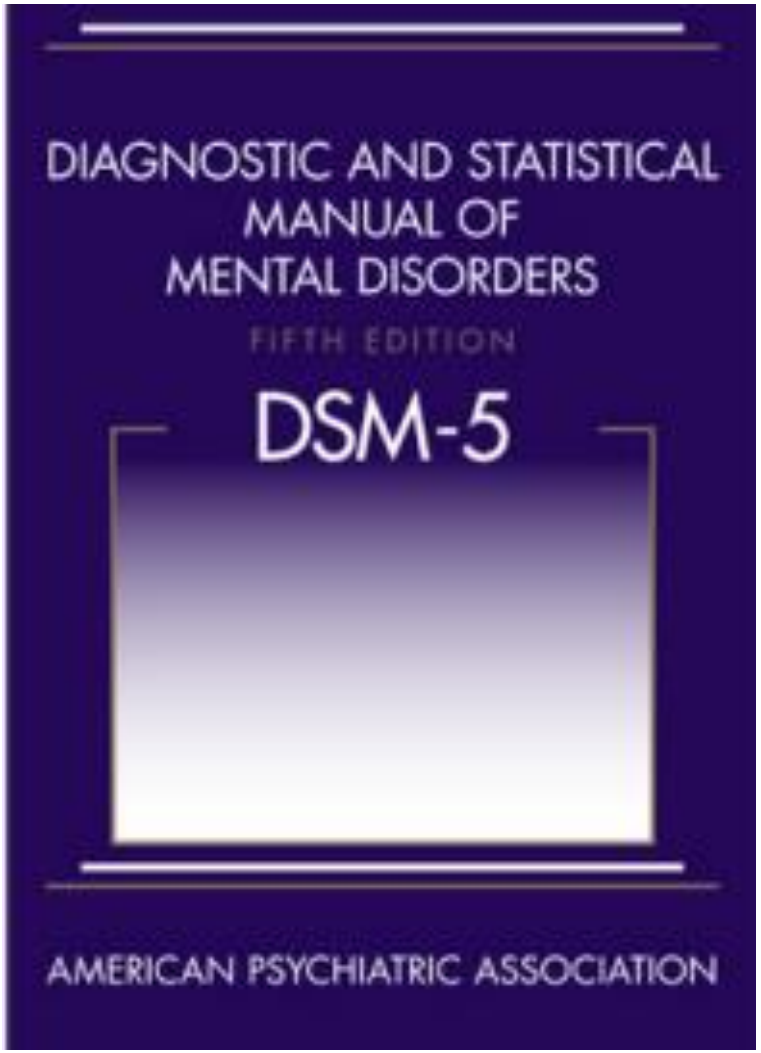
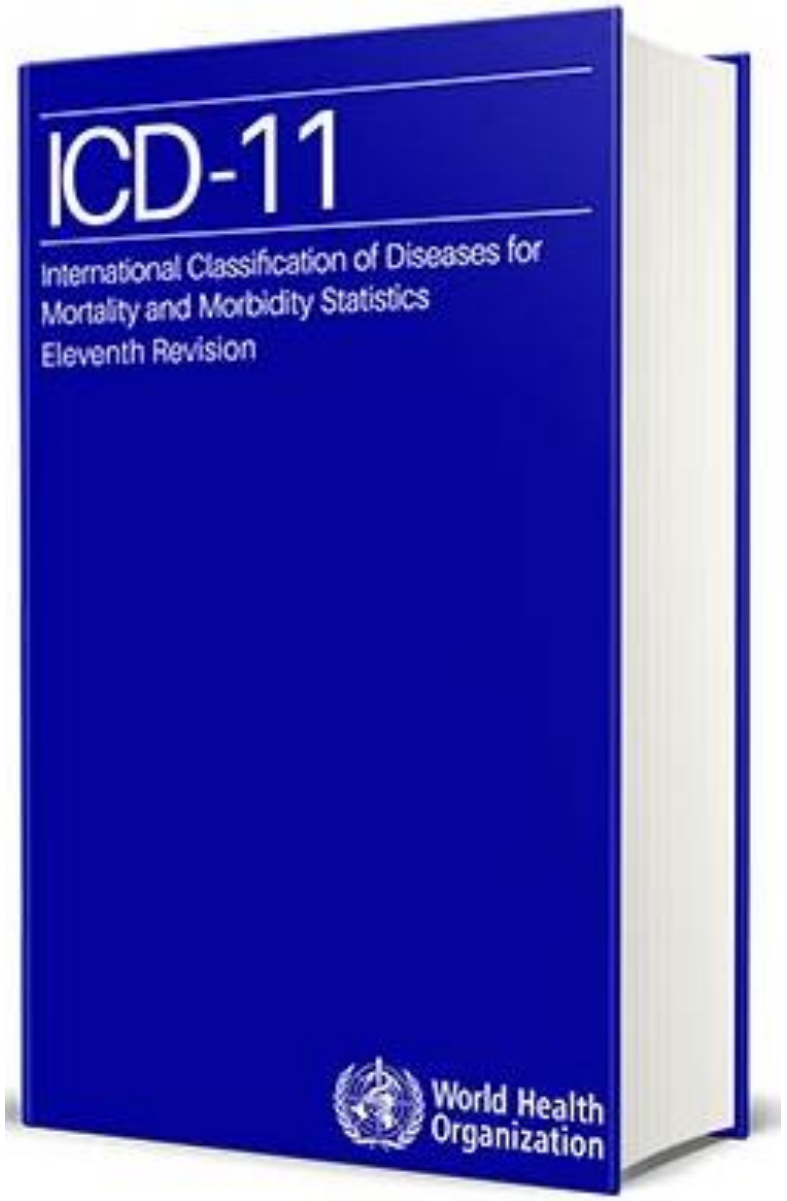
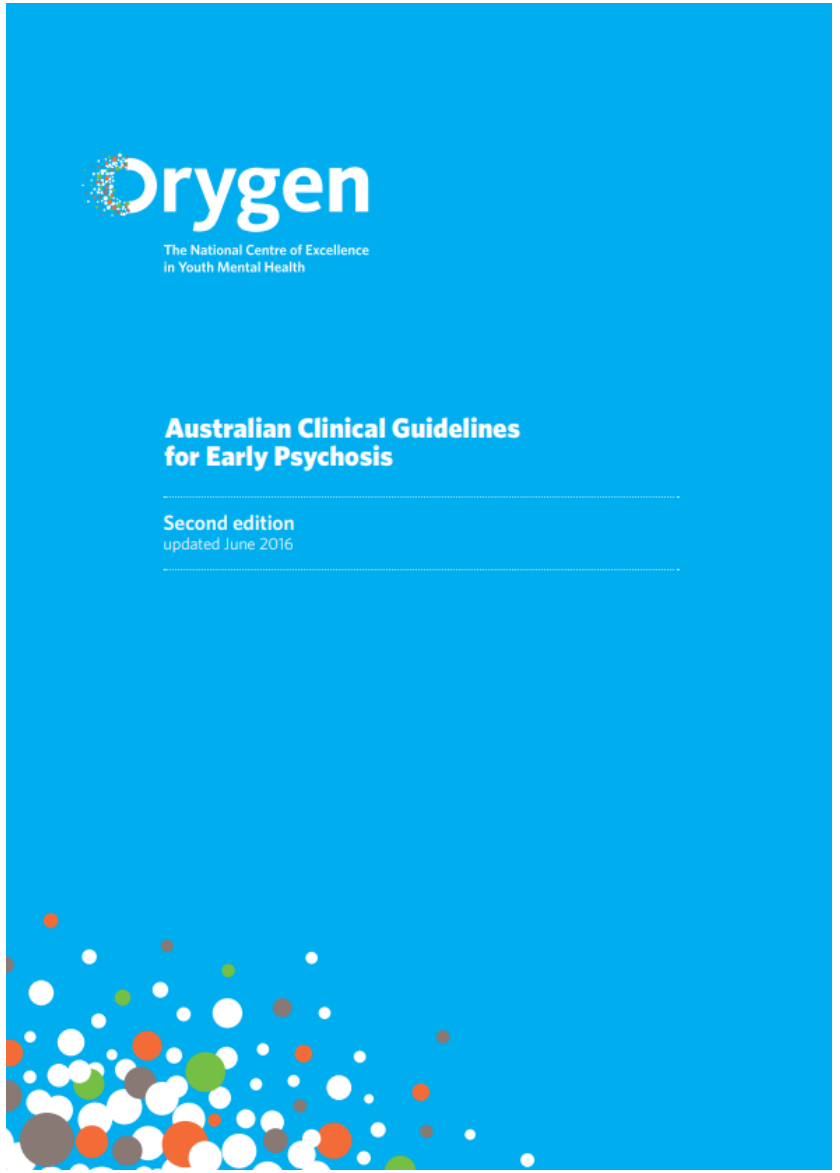
Disclosures

- Nil relevant financial conflict of interest

Main References







“Psychosis”

- **A syndrome**

- “BREAK IN REALITY”

- **symptoms** in which there is misinterpretation and misapprehension of the nature of reality; primarily –
  - disturbances in perception (hallucinations),
  - disturbances of belief and interpretation of the environment (delusions), and
  - disorganised speech patterns (thought disorder).

What Causes Psychosis?

- Medical Illnesses – usually acute
- Substances – usually acute
- Severe stressors – usually acute
- Part of a specific severe chronic mental illness – for e.g. schizophrenia, or delusional disorder, or psychotic depression

Psychotic symptoms

“Core” symptoms:

- **Delusions**
- **Hallucinations**
- **Disorganized thought and speech (derailment and incoherence)**

Associated symptoms:

- **Catatonia**
- **Disorganized behaviour**
- **Negative symptoms**

Psychotic disorder →	Acute/Brief Psychotic disorder			
Psychotic symptoms				
“Core” symptoms: • **Delusions** • **Hallucinations** • **Disorganized thought and speech (derailment and incoherence)** Associated symptoms: • **Catatonia** • **Disorganized behaviour** • **Negative symptoms**	Acute onset of any one or more of the Positive psychotic symptoms No symptoms →PSYCHOSIS within two weeks Usually not lasting more than a month			

Psychotic disorder →	Acute/Brief Psychotic disorder	Schizophrenia		
Psychotic symptoms				
“Core” symptoms: • **Delusions** • **Hallucinations** • **Disorganized thought and speech (derailment and incoherence)** Associated symptoms: • **Catatonia** • **Disorganized behaviour** • **Negative symptoms**	Acute onset of any one or more of the Positive psychotic symptoms No symptoms →PSYCHOSIS within two weeks Usually not lasting more than a month	Clearly unwell for six months (DSM-5) Including a period of one month of At least two psychotic symptoms (has to include one core symptom)		

Psychotic disorder →	Acute/Brief Psychotic disorder	Schizophrenia	Delusional Disorder	
Psychotic symptoms				
“Core” symptoms: • **Delusions** • **Hallucinations** • **Disorganized thought and speech (derailment and incoherence)** Associated symptoms: • **Catatonia** • **Disorganized behaviour** • **Negative symptoms**	Acute onset of any one or more of the Positive psychotic symptoms No symptoms →PSYCHOSIS within two weeks Usually not lasting more than a month	Clearly unwell for six months (DSM-5) Including a period of one month of At least two psychotic symptoms (has to include one core symptom)	Clear and prominent Delusion(s) For one month or more (ICD 11 says three months)	

Psychotic disorder →	Acute/Brief Psychotic disorder	Schizophrenia	Delusional Disorder	Psychotic Depression
Psychotic symptoms				
"Core" symptoms: • **Delusions** • **Hallucinations** • **Disorganized thought and speech (derailment and incoherence)** Associated symptoms: • **Catatonia** • **Disorganized behaviour** • **Negative symptoms**	Acute onset of any one or more of the Positive psychotic symptoms No symptoms →PSYCHOSIS within two weeks Usually not lasting more than a month	Clearly unwell for six months (DSM-5) Including a period of one month of At least two psychotic symptoms (has to include one core symptom)	Clear and prominent Delusion(s) For one month or more (ICD 11 says three months)	Primarily Depression Associated Positive psychotic symptom(s) of any duration

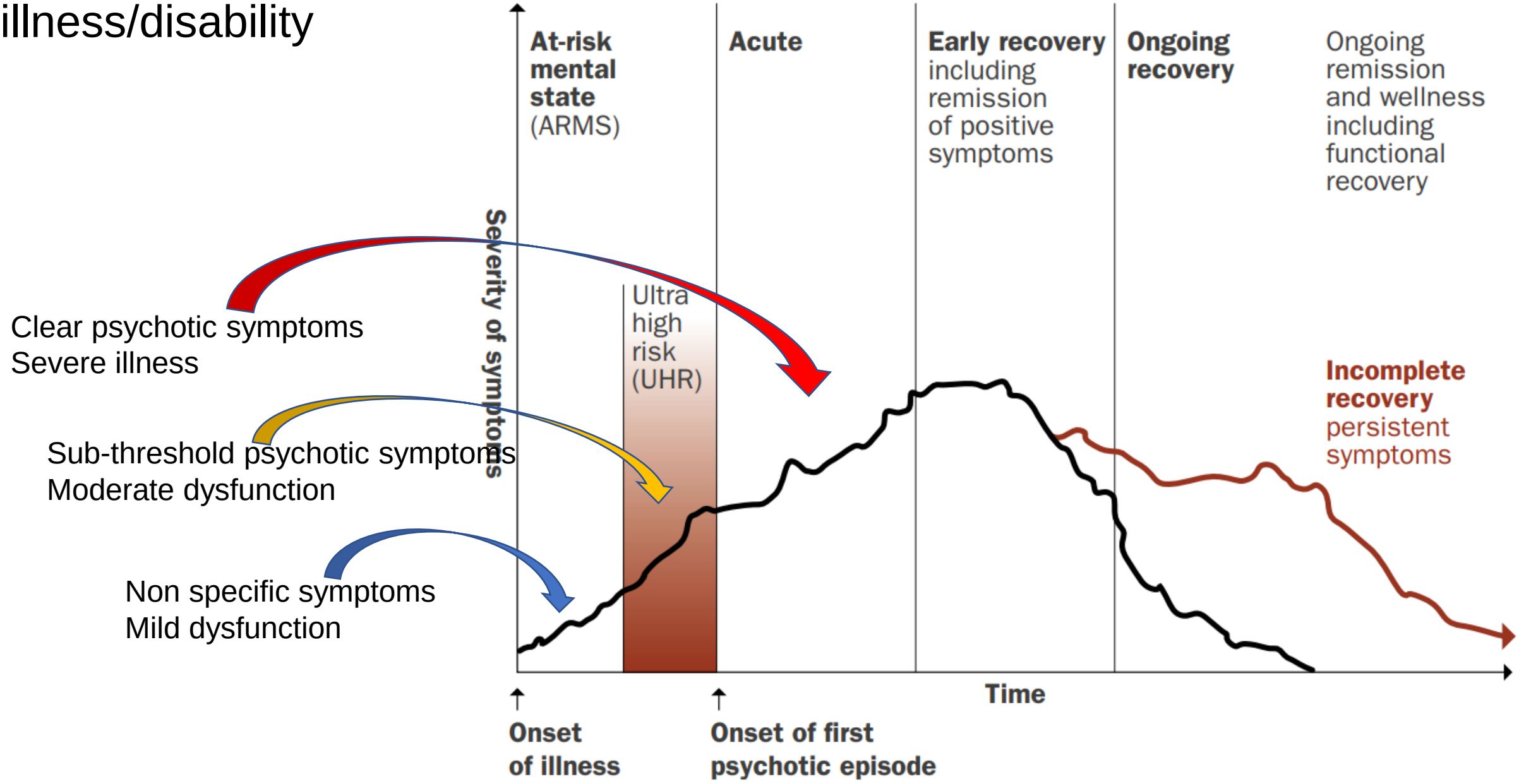
Psychotic disorder →	Acute/Brief Psychotic disorder	Schizophrenia	Delusional Disorder	Psychotic Depression
Psychotic symptoms				
“Core” symptoms: • **Delusions** • **Hallucinations** • **Disorganized thought and speech (derailment and incoherence)**	Acute onset of any one o… Positi… sympt… No sy… →PS… within… Usual… more…	Clearly unwell for six…	Clear and prominent…	Primarily Depression… …ve …m(s)
Associated symptoms: • **Catatonia** • **Disorganized behaviour** • **Negative symptoms**				

Impact on functioning
- Social
- Occupational
- Personal

Risks

Illness
Disability

Course of Psychotic illness/disability

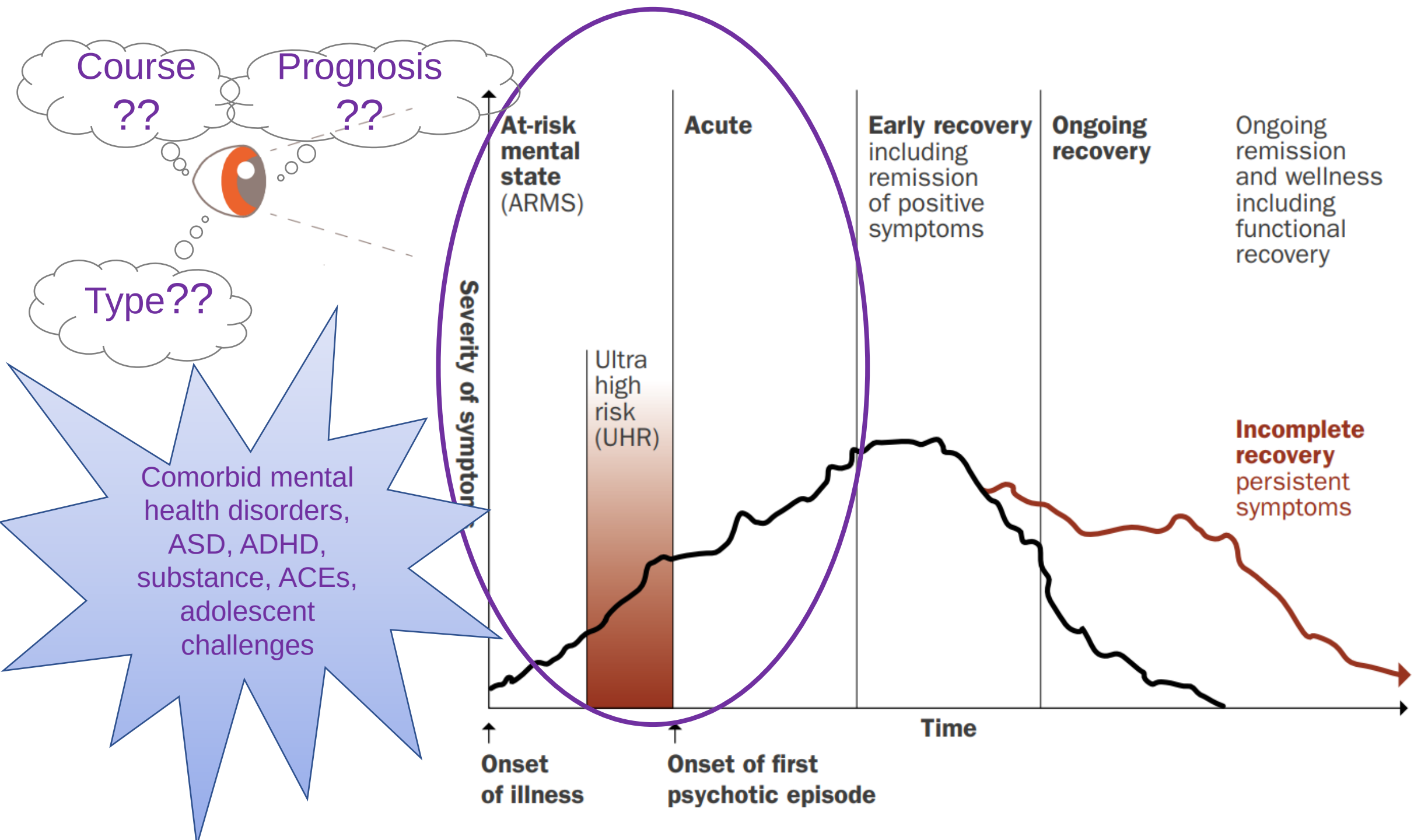


Course ??

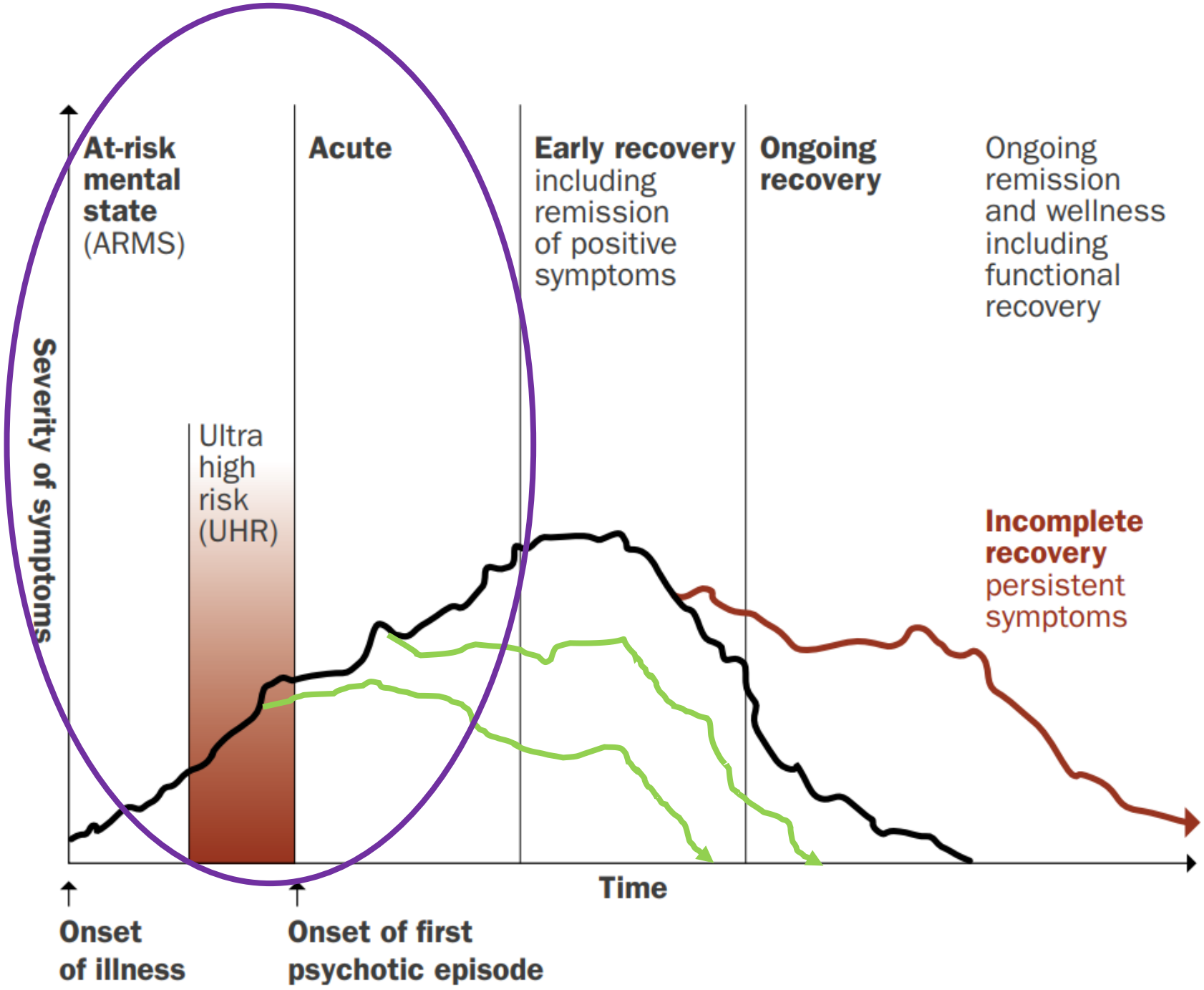
Prognosis ??

Type??

Comorbid mental health disorders, ASD, ADHD, substance, ACEs, adolescent challenges



“Early” psychosis



Early Psychosis

- early course of psychotic disorder

- specifically refers to the prodrome/At-risk mental state and the period up to five years from first entry into treatment for a psychotic episode

UHR

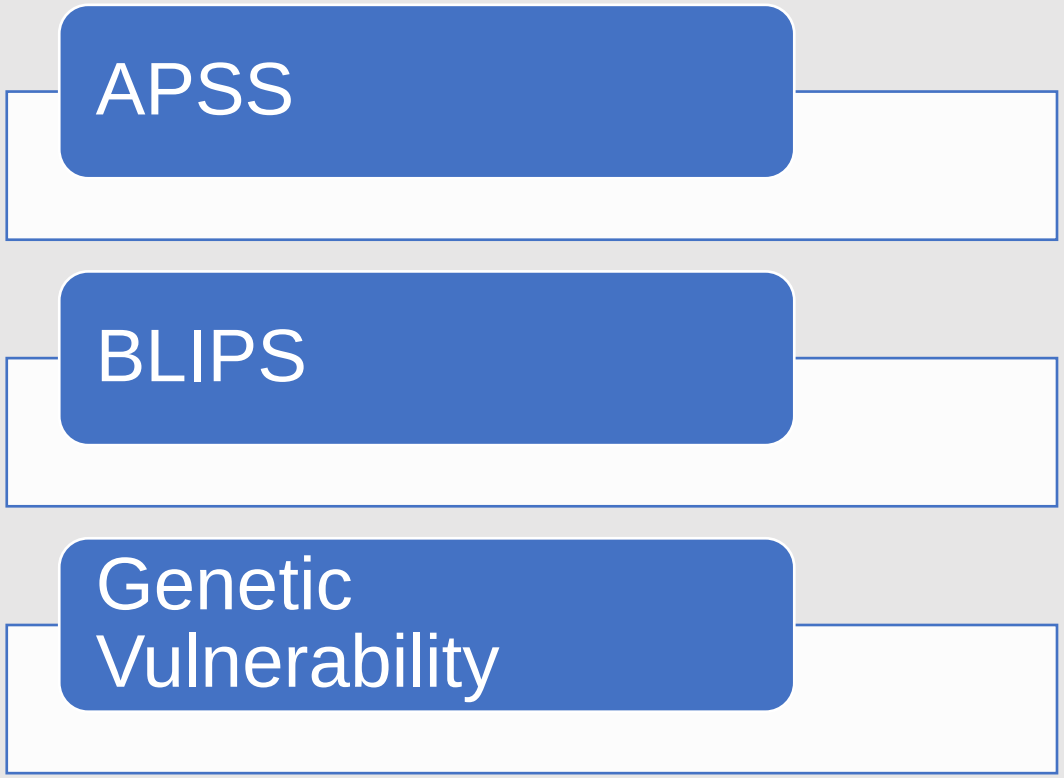
FEP

Criteria for identification of ultra high risk (UHR)

- Age 15 to 25yrs
- Insidious onset of changes over past few months (within past five years)
- Has progressed to a functional decline leading to caseness

(30% or more drop in SOFAS score anytime in the past year OR persistent low functioning SOFAS score of 50 or less for the past year)

- Presents with any one of the three –



APSS – Attenuated Positive symptoms

- Not severe enough

BLIPS – Brief limited psychotic symptoms

- Frank severe psychotic symptoms but lasting less than 7 days

Genetic vulnerability

- Schizotypal disorder or family h/o psychotic disorder in first-degree relative

Figure 1. **Example of the continuum of psychotic-like experiences**

Assessing for UHR

- CAARMS – comprehensive assessment of at-risk mental state
- semi-structured interview
- scales for assessing in detail
  - threshold and subthreshold psychotic phenomena and
  - other symptoms and signs which occur in the psychotic prodrome, including negative, dissociative and ‘basic’ symptoms.
  - SOFAS – social and occupational function assessment scale

*Anti-psychotic use – if frank psychotic symptoms occur for seven days or more

Epidemiology

- Psychotic disorders – 3%, Schizophrenia – 1%

- Psychotic symptoms - a median prevalence of 5%
  - 75% - 90% of psychotic experiences are transitory and disappear with time

- Psychotic disorder usually emerges during adolescence or early adulthood.
  - An estimated 80% experience their first episode between the ages of 16-30yrs

UHR → Psychotic disorder transition

- a recent 2012 meta-analysis comprising 27 studies (n = 2502)

- an overall transition rate of 22%, 12 months after assessment

Why intervene early in psychosis

- Delays can be very damaging to a young person experiencing a psychotic illness because –
  - their maturation is often put on hold (“Developmental gaps”)
  - their social and family relationships are strained or severed and their vocational prospects are derailed
  - secondary problems such as substance abuse, unemployment and behavioural problems may develop or intensify and
  - the illness itself may become more deeply entrenched

Treatment Goals

- Early identification and treatment of the primary symptoms of psychotic illness
- Improve access and reduce delays in initial treatment
- Educate the young person and family about the illness
- Reduce the frequency and severity of relapse
- Reduce the risk of other health-related problems developing
- Reduce disruption to social and vocational functioning
- Promote wellbeing among family members and carers
- Support the young person during their recovery
- Develop a plan for maintaining mental health

Thank you!

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Early intervention in UHR – potential advantages

- may prevent the entrenchment of such psychosocial disability –
  - subtle yet tenacious disability is possibly laid down during the UHR/ARMS-P phase of illness
- should progression to frank psychosis occur, this pre-existing engagement with mental health services may enhance medication compliance and engagement with outpatient care
- may reduce burden of trauma, stigma, acute or embarrassing behaviour, and the need for hospitalisation, by enabling early intervention if symptoms do progress on to a psychotic disorder
- potentially preventing or delaying transition to psychosis in a subset of people

Treatment for early psychosis Recommendations for the UHR phase

- 3.1.1 The possibility of psychotic disorder should be considered for anyone who is experiencing unexplained functional decline.

- 3.1.2 If subthreshold psychotic features combined with the onset of disability indicating ultra high risk are present, the individual and their relatives should be assessed and mental state and safety monitored regularly (every 2–4 weeks) in a context of ongoing support. CBT is the preferred intervention.

- 3.1.3 Information about the level of risk should be carefully provided taking into account social, educational and cultural factors.

- 3.1.4 Syndromes such as depression and substance use, and problem areas such as interpersonal, vocational and family stress, should be appropriately managed.

- 3.1.5 CBT may reduce psychotic symptomatology and prevent or delay transition to psychosis in the pre-onset phase.

Treatment for early psychosis Recommendations for the UHR phase

- 3.1.6 CBT may improve social functioning in the pre-onset phase.

- 3.1.7 Supportive counselling alone may improve social functioning in the pre-onset phase.

- 3.1.8 Antipsychotic medications should not normally be prescribed unless at least 1 week of frank positive psychotic symptoms have been sustained. The exception may be where briefer or milder positive symptoms are directly associated with risk of self-harm or aggression. E.g. in substance-related psychotic disorder, or when subthreshold positive psychotic symptoms persist in the face of CBT and other psychosocial treatments and are causing distress and or disability.

- 3.1.9 Omega-3 fatty acids may delay or prevent transitions to psychosis.

Some ethical concerns related to “diagnosing” and treating UHR

- In 2011, it was proposed that the constellation of symptoms consistent with increased psychosis risk be considered for inclusion in the *DSM*-5 as attenuated psychosis syndrome.
- Based on concerns about stigma, discrimination and unnecessary exposure to antipsychotics, especially in the context of a high false positive rate, the syndrome was placed in *DSM-5*’s appendix as requiring further study.

- Stigma and “overtreatment with antipsychotics” – threat to nonmaleficence
- Avoid labelling to prevent stigma – Paternalism – threat to patient autonomy

UHR – harms of self-labelling as mentally ill

- studies have found that, after adjusting for age, gender, symptoms, and functioning, self-labeling as mentally ill was associated with
  - greater stigma stress and reduced well-being [27, 28],
  - more suicidal ideation (mediated by social isolation) [29], and
  - higher rates of developing schizophrenia [30],

  - although self-labeling also was associated with more positive attitudes toward treatment [31].

Self-stigma in psychosis label and at-risk label

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Navigating these ethical concerns

- Use of evidence based strategies other than anti-psychotics for UHR. Anti-psychotic regular treatment only if frank psychotic symptoms persisting beyond 7days.

- Taking time to discuss the condition with young people/minors and family members.
- The provision of information to minors themselves, however, must take into account age and developmental sensitivities, such as social context, identity formation, cognitive capacity, and comorbidities.

- the potential stigma of a psychosis risk label can be addressed at the structural or public health level. This strategy has worked in Australia, where ultra-high risk clinical research programs were first located in community centers instead of hospitals or universities and then embedded entirely in nationwide strategies to promote teen mental health and well-being support.

- Carer and consumer involvement in supporting new consumers and carers

Does early intervention work?

- The largest randomised controlled trial (RCT) comparing EI with standard care is the OPUS trial in Denmark
- There are RCTs including the Lambeth Early Onset (LEO) trial, the subsequent Lambeth Early Onset Crisis Assessment Team study (LEO-CAT), and a trial by Leavey *et al*.
- EPPIC trial in Australia (Orygen)

- The evidence is clear that outcomes for patients in EI services are better than for standard care within AMHS.

- However, there is limited evidence in the UK that EI services have any impact on longer-term outcomes for patients with psychosis, and concerns that these patients do not maintain the benefits of EI when discharged from EI services to standard care.
- This has prompted another trial, which is currently ongoing, to prolong the duration of intervention to 5 years.[8] The rationale for this is that the 'critical period' in early psychosis could be much longer than 2 years, and so, by intervening for longer, the positive outcomes may be sustained after the intervention has ended.

Aetiology

- The aetiology of psychosis is generally accepted as resulting from the impact of stress and other risk factors upon a biological predisposition: the ‘stress–vulnerability’ interaction

- genetic, neuronal, life stress and physical vulnerabilities

- The greater the person’s vulnerability, the less stress is required to trigger an episode of psychosis

Table 3. **Risk factors for psychosis onset**

Distal (premorbid) risk factors	Proximal risk factors
Foetal life: • Maternal pregnancy complications/perinatal trauma, (especially foetal hypoxia)[51] • Family history of psychotic disorder (for a review, see Olin & Mednick, 1996 [52]) • Candidate genes (DTNBP1, NRG1, DAOA, RGS4, COMT, DISC1, DISC2, BDNF; for a review, see Weinberger & Berger, 2009 [53]) • Developmental delay (for a review, see Rustin et al., 1997 [54]) • Season of birth (late winter/early spring[55, 56]) • Ethnic minority group membership [57] **Early life:** • Quality of early rearing environment • Trauma (abuse or neglect) [58] • Vulnerable personality (e.g., schizoid personality [59, 60])	**Late childhood/adolescence:** • Age [61] • Urbanicity [62] • Substance (especially cannabis) use [63] • Traumatic head injury (for a review, see Kim et al., 2007 [64]) • Stressful life events (for a review, see Phillips et al., 2007 [65]) • Subtle impairments in cognition (for a review, see Pantelis et al., 2009 [66]) • Poor functioning [67, 68] • Cognitive, affective, and social disturbances subjectively experienced by the individual ('basic symptoms')[69] • Migration [70]

Figure 2. **Prospective identification of a possible prodrome**

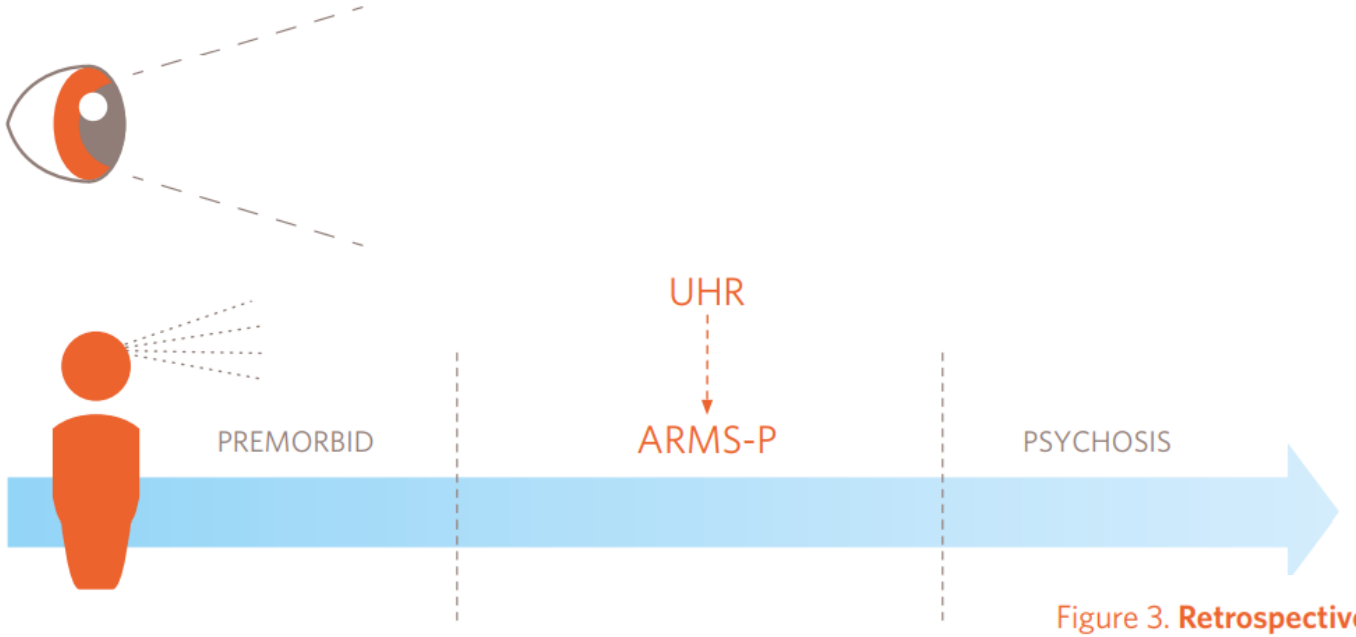
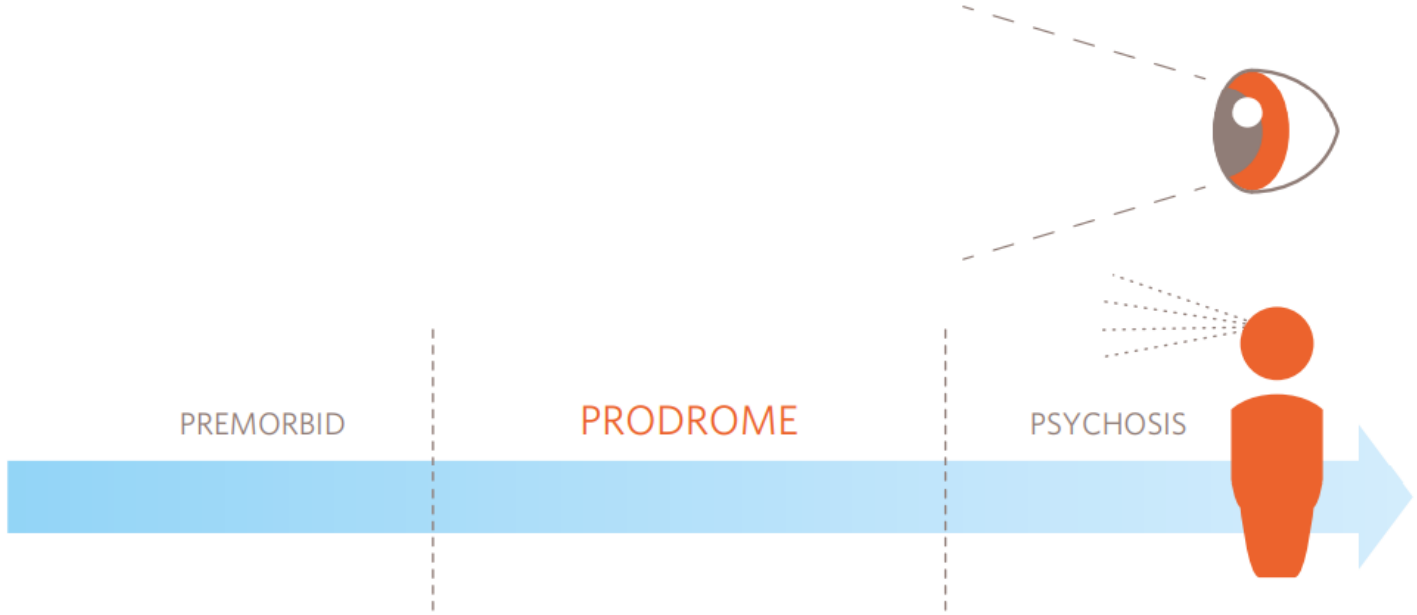
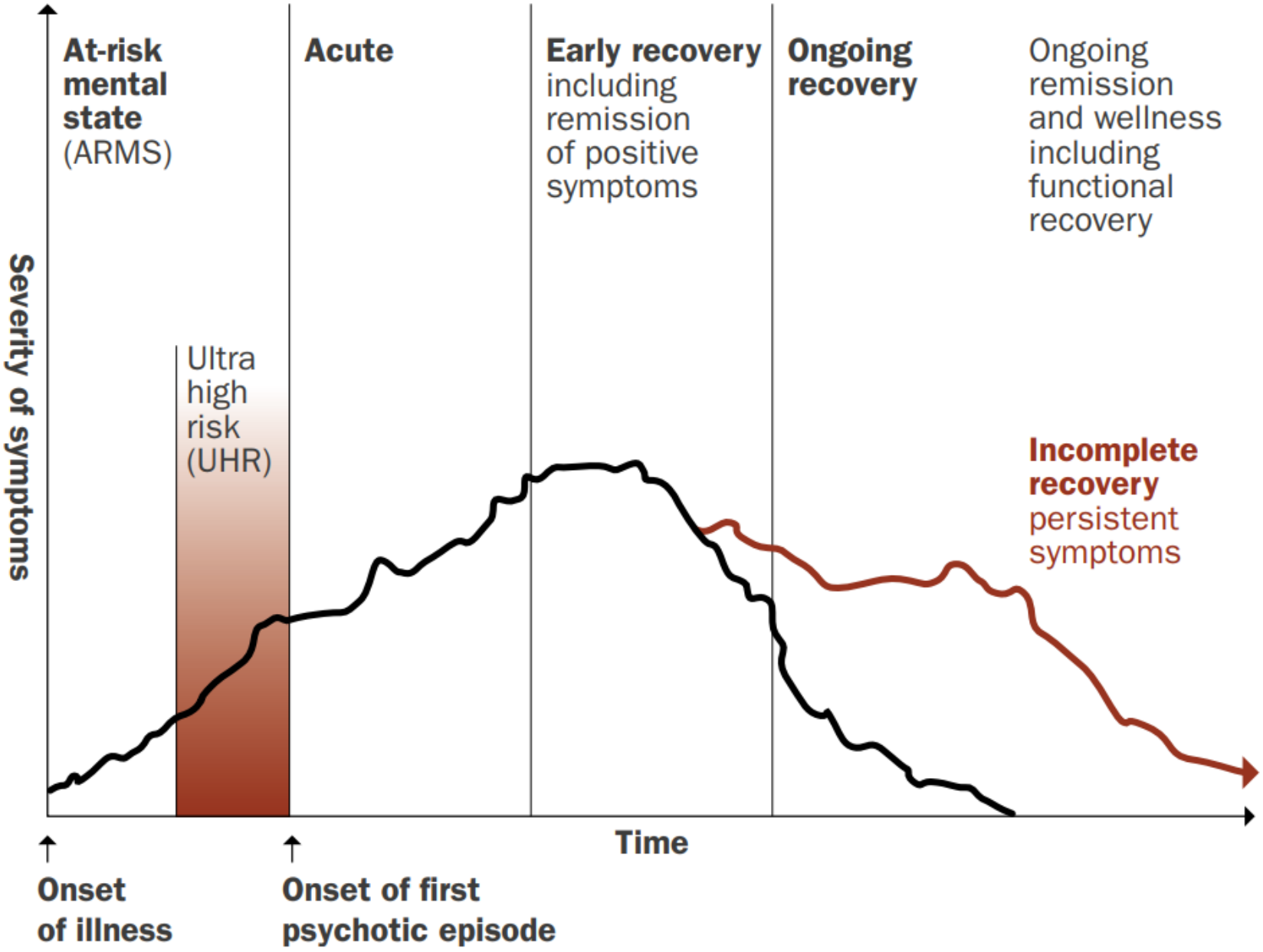


Figure 3. **Retrospective identification of the prodrome**



Common problems of young people with an at-risk mental state

- Neurotic symptoms Anxiety Restlessness Anger, irritability
- Mood-related symptoms Depression Anhedonia Guilt Suicidal ideas Mood swings
- Changes in volition Apathy, loss of drive Boredom, loss of interest Fatigue, reduced energy
- Cognitive changes Disturbance of attention and concentration Preoccupation, daydreaming Thought blocking Reduced abstraction
- Physical symptoms Somatic complaints Loss of weight Poor appetite Sleep disturbance
- Attenuated or subthreshold versions of psychotic symptoms Perceptual abnormalities Suspiciousness Change in sense of self, others or the world
- Other symptoms Obsessive compulsive phenomena Dissociative phenomena Increased interpersonal sensitivity
- Behavioural changes Deterioration in role functioning Social withdrawal Impulsivity Odd behaviour Aggressive, disruptive behaviour


At-risk mental state (ARMS)
Acute
Early recovery including remission of positive symptoms
Ongoing recovery
Ongoing remission and wellness including functional recovery
Severity of symptoms
Ultra high risk (UHR)
Incomplete recovery persistent symptoms
Time
Onset of illness
Onset of first psychotic episode