INVITED ARTICLE

A PRACTICAL APPROACH TO THE MANAGEMENT OF PSYCHOSES

K E Wong

ABSTRACT

The importance of differentiating between the organic and functional psychoses is stressed. The salient features of the different types of functional psychoses are discussed and the management of the psychoses is approached from biological, psychological and sociological angles at the same time. Corroboration of history by concerned relatives or friends is deemed indispensable.

Keywords: psychoses, practical approach management.

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INTRODUCTION

Floridly psychotic patients are easily recognised even by the untrained. For none can miss the unkempt and dirty person wildly gesticulating to himself, quite oblivious of his surroundings. To define accurately the term psychosis however is more difficult. Thus numerous criteria have been proposed to define the term psychoses. One criterion is greater severity of illness but the conditions that fall into this group can occur in mild as well as severe forms. Lack of insight is another criterion for psychosis, but insight is itself difficult to define. Perhaps a simpler criterion is the inability to distinguish between subjective experience and reality, as is the case when the patient obeys the instructions of his auditory hallucinations[1].

The ICD-10[2] however, chooses to explain the term psychoses in a more descriptive manner: "the term 'psychoses' simply indicates the presence of hallucinations, delusions, or a limited number of several abnormalities of behaviour, such as gross excitement and overactivity, marked psychomotor retardation and catatonic behaviour."

DIFFERENTIAL DIAGNOSIS

Once the psychosis is recognised, the patient should be assessed to differentiate between the major categories of psychosis:

A. Organic psychoses

These are psychoses caused by organic illnesses like hyperthyroidism, hypothyroidism, hypoglycaemia, AIDS, syphilis, or drugs of abuse like amphetamine or marijuana. A careful history, mental state examination and physical examination followed by the relevant laboratory tests should give sufficient leads. In every case of psychosis, organic aetiology should be excluded from the outset.

Unit III
Woodbridge Hospital
Jalan Woodbridge
Singapore 1954

K E Wong, DPM (Eng), MRCPsych (UK), FAMS
Consultant Psychiatrist

Correspondence to: Dr K E Wong
Woodbridge Hospital/Institute of Mental Health
Hougang St 51
Singapore 1953

B. Functional psychoses

These are psychoses for which there is no apparent organic cause. The commonest forms to consider are:

(a) Schizophrenia

An illness characterised by a disturbance in perception, thought, emotion and day-to-day functioning, the patient usually experiences auditory hallucinations giving a running commentary on him, instructing him on what to do or discussing him among themselves in the third person. Bizarre delusions are usually present and the patient may also experience a breakdown of his self boundary in that his thoughts, actions and feelings are under external control, or that others are capable of reading his thoughts.

(b) Affective disorders

Also known as Mood disorder or Manic-depression, this condition may demonstrate a high mood state (mania) or low mood state (depression). The cardinal signs of mania are overtalkativeness, overactivity and overcheerfulness while increased irritability, distractability, poor judgement, grandiose delusions and mood-congruent hallucinations may be obvious too. Depression is usually manifested as an intense feeling of gloom associated with sleep disturbances, loss of appetite, loss of weight, loss of libido, inactivity, fatigue, loss of interests and impaired concentration. When severe, suicide is contemplated or even attempted.

(c) Paranoid disorders

These are conditions characterised by intricate, complex and logically elaborated delusional system. The delusions are systematised, firmly knit and more or less isolated so that the rest of the personality remains relatively intact.

APPROACHING THE PSYCHOTIC PATIENT

1. If the patient is calm he may be seated comfortably and spoken to in a calm, reasonable and non-threatening tone of voice. Open-ended questions should be asked of the patient and time should be taken to listen carefully to what the patient says so that the various symptoms may be picked up. Arguments over the irrationality of the patient's delusions should be avoided at all costs.
2. If the patient is disturbed and violent, sufficient staff should be rounded up to assist in physical restraint to prevent harm for everyone concerned. An injection of 5-10 mgm of haloperidol or 5-10 ml of paraldehyde is usually necessary to sedate the patient. Unless there are contraindications, haloperidol is preferred for its action on the psychosis itself.

CORROBORATION OF HISTORY

Psychotic patients tend to downplay or totally deny their symptoms. Some are incapable of giving an account of themselves while others may give a totally irrelevant account. For all these reasons, it is important to verify the history with relatives or friends in the know. The patient should not be present when the history is being taken for he would in all likelihood protest at what is being said, deny it altogether or become outright threatening towards the one giving the history.

TREATMENT

Organic psychoses

The root cause of the organic psychosis should be treated while at the same time neuroleptics are given temporarily till the symptoms abate. For example if it is a case of thyrotoxicosis causing a paranoid psychosis, trifluoperazine will be needed to control the panaroid symptoms till the thyroid status is brought back to normal with anti-thyroid medication.

Functional psychoses

Treatment for functional psychoses goes much beyond the pills and the injections. Working as a team with input from the psychiatrist, psychologist, occupational therapist, nurses and social worker, the ultimate aim is to ameliorate the psychotic symptoms and reinstate the patient in his niche in society. Because there are subtle differences in the needs and outcome of each type of psychosis, it is logical to deal with the psychoses individually from the biological, psychological and sociological point of view.

(a) Schizophrenia

(i) Biological treatment

Medication is the mainstay of treatment. The first-line drugs are usually oral chlorpromazine, trifluoperazine, haloperidol or thioridazine. In uncooperative or resistive patients liquid preparations (such as tasteless and colourless haloperidol drops) or long-acting depot injections will have to be considered. As a general guideline, for the first illness, treatment is usually continued for another 3 months after the symptoms have resolved[3] particularly if the prognosis is thought to be good and the patient is not undergoing any stressful life event like a major examination. During therapy the following side-effects should be watched out for and promptly treated for side-effects are one of the main reasons why patients are non-compliant with medication: acute dystonias, oculo-gyric crises, tremors, hypersalivation, akathisia (an inner restlessness), stiff and robot-like movements, skin rashes, galactorrhoea, secondary amenorrhoea, tardive dyskinesia, etc.

In the case of repeated relapses long-term treatment is inevitable for medication has been shown to prevent relapses significantly[4].

Every case of schizophrenia should be watched carefully for suicide risk for studies have shown that about 10% of schizophrenics die by suicide, especially in patients with persistent auditory hallucinations[5].

Electro-convulsive therapy or ECT, while traditionally prescribed for severe depression, is useful in calming the very disturbed or putting right the disorganised thoughts of the very thought-disordered patient.

(ii) Psychological therapy

As the patient improves he is drawn into groups to discuss his illness, the need for medication and its side-effects as well as his relationship with others. Groups are useful in aiding the patients to learn to interact with one another and to learn from one another with the guidance of the group leader. Group pressure is powerful in bringing about desirable changes in the patient. His family is also counselled on the illness and its treatment, both singly and in groups if the family is so attuned. Education of the families in groups plays a significant role in the families providing group support to one another. The family is also advised against too much face-to-face contact with the patient and advised to avoid passing too many critical comments about him for such an over-involved situation would precipitate relapses[6].

(iii) Sociological therapy

The social worker plays an important role in the psychiatric team management of the patient. Experience has shown that the family tends to be very concerned and supportive during the first illness but the same concern and support wear thin with each subsequent relapse. Thus the team has to work hard with the patient and his family right from the outset on the goals of accommodation, community re-integration and work re-instatement.

At the same time the patient's environment is carefully studied to eliminate as far as possible the stresses that are likely to precipitate further relapses[7].

(b) Affective disorders

(i) Biological treatment

Medication is again the mainstay of treatment. For mania the neuroleptics are important, especially haloperidol, while for depression the antidepressants are important. Lithium is useful both as treatment for the acute attack of mania as well as for the prevention of further relapses of manic-depression[8]. Anti-epileptic drugs like carbamazepine or sodium valproate are also useful in the treatment of acute mania and the prophylaxis of affective disorder[9-11].

ECT is life-saving in cases of severe depression with suicide risk. It is also sometimes needed in cases of severely manic patients who are tired out by their sheer overactivity and restlessness.

(ii) Psychological therapy

Cognitive therapy is a useful adjunct to antidepressants in the treatment of the less severely depressed patients, whereby the patient is led through about 5-20 sessions of structured 20-60 minutes therapy in which his depressive thoughts and assumptions are challenged and cognitive restructuring takes place[12].

Psychotherapy or talk therapy is sometimes indicated for patients with unresolved conflicts in their lives, to be undertaken only when the illness is under satisfactory control.

(iii) Sociological therapy

The same strategies as mentioned for schizophrenia apply equally to affective disorders. Avoidance of stressful life events plays as big a role here as in schizophrenia.

(c) Paranoid disorders

(i) Biological treatment

Medication is again important in the treatment of paranoid disorders. Trifluoperazine is believed to be more efficacious in eradicating the delusions of the patient although the other neuroleptics are also useful when the extra-pyramidal side-effects of trifluoperazine are intolerable. As most paranoid patients are difficult with medication, it is often necessary to resort to the use of haloperidol drops or 2-4 weekly depot injections of fluphenazine decanoate (modecate), flupenthixol decanoate (fluanxol), pipothiazine palmitate (piportil) or clopenthixol decanoate (clopixol). The depot injection can usually be switched from one to another of a different class if the effect is deemed inadequate or if side-effects become intolerable.

(ii) Psychological therapy

As paranoid disorders confer a better prognosis and a more intact personality, less psychological interventions are needed. What is needed is an emphasis on the importance of medication and an understanding of the illness.

(iii) Sociological therapy

The patient with paranoid disorder is often able to return to his previous life and work without much problems. However his environment should still be manoeuvred to reduce his stressful life events and the risk of further relapses.

HOSPITAL AND COMMUNITY PATIENT FACILITIES

Management of the recovering psychotic patient will be incomplete without the support of certain key facilities to assist him in his arduous journey back to the community:

i. The day treatment programme or day hospital accepts patients who require help in social interaction, recreational activities and sometimes medication supervision on an outpatient basis.
ii. The day centres take in better functioning patients who come in for training in various work activities or who work at various tasks in a sheltered workshop environment.
iii. View Road Hospital takes in selected patients for short-term residential job training.
iv. The Halfway House run by the voluntary organisation Singapore Association for Mental Health provides short-term residential rehabilitation to patients who are unable to return home for some reason or other.
v. Community Psychiatric Nurses follow up problematical patients referred to them by the psychiatrists by making periodic phone calls or home visits to ensure their well-being and compliance with medication.

OUTCOME

Generally speaking the outcome for affective and paranoid disorders is better than for schizophrenia as the majority of patients in the former groups function satisfactorily between relapses and are able to obtain gainful employment. A local study[13] demonstrated that out of 330 Chinese schizophrenic patients below the age of 40, only 48% of them were found to be gainfully employed at the end of 15 years.

CONCLUSION

Early diagnosis of organic psychoses with a careful history, mental state examination, physical examination and relevant laboratory investigations is important. The management of all functional psychoses generally follows the same approach with a biological, psychological and sociological intervention. Utilisation of the available hospital and community patient facilities should be maximised for satisfactory patient recovery.

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