



## THEME

Psychosis



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# The acutely psychotic patient

## Assessment and initial management

### BACKGROUND

Acute psychosis is a medical emergency; apart from distress and behavioural dysfunction, there may be danger to the patient and others. Urgent assessment and management is essential. Although involvement of specialist services is usual, general practitioners may need to initiate initial treatment and, in more remote areas, provide complete care.

### OBJECTIVE

This article aims to update the GP about the initial management of the acutely psychotic patient.

### DISCUSSION

General practitioners will frequently be the initial source of assistance for patients with acute psychosis and their families. The patient with first episode psychosis may pose particular challenges, especially as insight about the need for treatment is often poor. The first step is to establish a therapeutic alliance, enabling history, examination and investigations. While it is necessary to establish the presence of psychosis, precise diagnosis is usually a secondary consideration. Risk assessment must be carried out to decide whether the patient can be managed in the community or needs inpatient care.

**Acute psychosis is the presence of the mental state where appreciation of reality is impaired, as evidenced by the presence of psychotic symptoms such as delusions, hallucinations, mood disturbance, and bizarre behaviour (Table 1).<sup>1</sup>**

In the acute presentation, it is usually more important to establish the presence of psychosis, to establish the symptom characteristics of the patient's illness, and to carry out a risk assessment rather than to make a definitive diagnosis such as schizophrenia or bipolar mood disorder. In any case, the diagnostic boundaries of the various disorders are often unclear and there is considerable overlap between the different entities. Diagnoses also change over time; a patient with early psychosis presenting as schizophrenia may later reveal bipolar mood disorder or schizoaffective disorder.

The diagnosis of psychosis is entirely clinical as there are no diagnostic tests. A number of major psychiatric disorders that present with psychosis are listed in *Table 2*.

It should be noted that psychosis often occurs only briefly during the course of the disorder, and patients suffering from these disorders may not manifest any psychosis, especially if treated. On the other hand, the onset of acute psychosis (or the occurrence of relapse) is often a medical emergency. While most general practitioners will be able to enlist the assistance of specialist services, some rural GPs may need to provide the entire treatment.

### Assessment

Parents often bring in the first episode patient who may be coming reluctantly (see *Case study*). Acutely psychotic patients may be irritable and agitated, as well as unrealistically suspicious about the motives of those around them. They may be perplexed or even hostile. Frequently there is impaired insight so that the patient is not aware that he/she is ill and requires treatment. The first step is to establish a therapeutic alliance and rapport; interest, trust, and a sincere offer

### Case study – Melissa

Melissa, 17 years of age, is a year 11 student who lives with her parents and younger brother. She attends her GP reluctantly in the company of her mother. The mother has previously rung the GP to say that for several months her daughter has been increasingly moody, isolating herself in her room, and losing contact with friends. She has been uncharacteristically angry with her mother. Melissa has also been heard to shout at herself in her room. School results have been deteriorating. The consultation has been precipitated by Melissa's refusal to go to school. The GP sees Melissa by herself. Melissa looks tired, depressed and avoids eye contact. She insists nothing is wrong. Later, she reveals that some students have been picking on her in the school, and she has heard one of them abuse her as she was falling asleep; she is scared of an assault. Melissa flatly refuses to see a psychiatrist. Her physical examination is normal, as are investigations. Melissa agrees to a home visit by primary mental health workers. After discussion with the workers who are concerned that Melissa may have early psychosis, and a telephone consultation with their team psychiatrist, the GP obtains Melissa's agreement to start some antipsychotic medication. She commences aripiprazole 5 mg at night, which causes mild nausea. Three weeks later, Melissa's condition is improving, and she agrees to see a psychiatrist. The diagnosis is psychotic depression. Aripiprazole is increased to 10 mg per day and an antidepressant, venlafaxine, is added at 75 mg mornings. Melissa is seen regularly by the psychiatrist for psychotherapy and psycho-education. She continues to improve and recovers several weeks later while continuing both antipsychotic and antidepressant medication.

of assistance are helpful. The GP should avoid colluding with psychotic symptoms, although it is not usually necessary to confront or challenge unusual thoughts

**Table 1. Symptoms of psychoses**

- Positive symptoms
  - delusions and hallucinations
  - formal thought disorder
- Negative symptoms
  - flat affect
  - poverty of thought
  - lack of motivation
  - social withdrawal
- Cognitive symptoms
  - distractibility
  - impaired working memory
  - impaired executive function
- Mood symptoms
  - depression
  - elevation (mania)
- Anxiety/panic/perplexity
- Aggression/hostility/suicidal behaviour

**Table 2. Psychotic disorders (DSM-IV)<sup>2</sup>**

- Schizophreniform disorder
- Schizophrenia
- Schizoaffective disorder
- Bipolar mood disorder
- Unipolar psychotic depression
- Delusional disorder
- Psychoses due to physical condition, alcohol, drugs (stimulants/hallucinogens)

and experiences. The GP should be calm, friendly, and unhurried, while asking questions clearly.

It is always helpful to talk to the patient's family; especially in early psychosis as little may emerge at interview and the presence of illness needs to be inferred from the account given by the family. If not volunteered by the patient, symptoms of psychosis can be elicited through specific questions (*Table 3*).<sup>3</sup> It is best to ask probing questions that may reflect normal experience and do not immediately suggest pathology.

On mental state examination it is important to note whether the patient is agitated (which suggests acuity) and whether affect is depressed, suspicious or perplexed. Thought process may be accelerated in mania, retarded in depression, and illogical or incoherent with loosening of associations. Delusions and hallucinations may be present and insight may be impaired. Some patients retain insight while presenting with a tormenting symptom such as accusatory voices.

Patients with early onset psychosis may not have full blown psychotic symptoms. Prodromal symptoms of psychosis are given in *Table 4*. Detection and treatment of early psychosis without delay is vital as delay in treatment worsens prognosis.<sup>4</sup>

There are a number of physical causes of acute psychoses (*Table 5*). Frequently physical examination is not possible and needs to be deferred until psychosis has been controlled. A number of investigations are also needed (*Table 6*).

Many patients with acute psychosis also abuse cannabis, alcohol and stimulants. Comorbid

**Table 3. Questions for eliciting psychotic symptoms**

Anxiety	Have you been feeling especially nervous or fearful? Have you felt tense and shaky, or experienced palpitations?
Depressed mood	Have you been feeling sad or 'down in the dumps' recently, not enjoying activities as much as before?
Elevated mood	Have you been feeling especially good in yourself, more cheerful than usual and full of life?
Auditory hallucinations	Do you hear voices of people talking to you even when there is no-one nearby?
Thought insertion	Have you felt that thoughts are being put into your mind? Do you experience telepathy?
Thought withdrawal	Have you experienced thoughts being taken out of your mind?
Thought broadcasting	Have you felt that other people are aware of your thoughts?
Thought echo	Have you experienced voices or people echoing your thoughts?
Delusion of control	Have you felt under the control or influence of an outside force?
Delusions of reference	Do programs on the television or radio hold special meaning for you?
Delusions of persecution	Do you feel that you are being singled out for special treatment? Is there a conspiracy against you?
Delusions of grandeur	Do you feel special, with unusual abilities or power?
Delusions of guilt	Do you believe that you have sinned or have done something deserving punishment?

substance abuse will need to be addressed in long term management.

### Risk assessment and hospitalisation

The clinical judgment as to whether the patient constitutes a risk to him/herself or others must be carried out. If there is a danger of suicide or violence, inpatient management will usually be needed. Sometimes it will be necessary to invoke legal procedures to facilitate involuntary hospitalisation.

### Community treatment

Many patients with acute psychosis can be treated in the community. The widespread provision of assertive outreach teams has enabled high standard care to be provided to patients in their home. General practitioners often provide critical input to assertive outreach teams in collaborative treatment.<sup>5</sup>

### Management

It is essential to build on the therapeutic alliance, which commenced in the assessment phase. Frightened, suspicious patients lacking insight will need a great deal of support and reassurance from their doctor. A GP, who is known and trusted by his/her patient starts with a significant advantage in this difficult therapeutic situation. Families and carers often require support and psycho-education during their relative's acute illness.

An acutely psychotic patient may be anxious, agitated, overactive, hostile, distressed and sleep deprived. In these circumstances it is appropriate to utilise sedative/anxiolytic medications until the patient has settled. Benzodiazepines are most frequently recommended.<sup>4</sup> Some antipsychotics such as chlorpromazine (Largactil)

**Table 4. Early or prodromal symptoms of psychosis**

Reduced concentration, attention  
Deterioration in role functioning  
Irritability  
Suspiciousness  
Reduced drive and motivation, anergia  
Anxiety  
Social withdrawal  
Sleep disturbance  
Depressed mood

**Table 5. Physical (organic) causes of psychosis**

- Amphetamines/stimulants
- Hallucinogens
- Cannabis
- Temporal lobe epilepsy
- Central nervous system infections (eg. HIV)
- Huntington disease
- Cerebral trauma
- Cerebrovascular disease
- Brain tumours
- Cushing disease, steroids
- Thyrotoxicosis
- Hyperparathyroidism
- Systemic lupus erythematosus
- Wilson disease

and quetiapine (Seroquel) are quite useful as tranquillisers in acute psychosis. A number of other sedative/hypnotic drugs may also be utilised.

Antipsychotic medication is the definitive treatment for acute psychosis. If in addition to psychosis, the

patient presents with mood elevation (mania), it is usual to add a mood stabiliser such as lithium, valproate or carbamazepine. Patients with psychosis and depression are treated with the combination of antipsychotic and antidepressant medication (electroconvulsive therapy is also very useful in this situation).

Antipsychotics are broadly classified into conventional and novel types. Conventional antipsychotics such as chlorpromazine and haloperidol tend to induce extrapyramidal side effects (dystonias, Parkinsonism, akathisia, tardive dyskinesia) at therapeutic doses. Novel or

atypical antipsychotics are therefore usually prescribed as most patients can be treated without any extrapyramidal side effects. Atypical antipsychotics cause a range of other side effects, some of which are critical for the long term physical health of patients who will need periodic physical review by their GP (*Table 7*).

The specific property of antipsychotics is their ability to diminish and eliminate delusions, hallucinations, thought disorder and abnormal mood states. The antipsychotic effect can take weeks to manifest.

Patients with acute psychosis due to relapse may have been poorly compliant with their previous medication. It is important to understand the reasons for poor compliance. Unacceptable side effects contribute to poor compliance and the change in medication may assist in future. Poor control of psychotic symptoms may also be a factor. Some patients will benefit from depot antipsychotic medication such as long acting injectable risperidone.

Supportive psychotherapy, psychoeducation, and cognitive behaviour therapy<sup>6</sup> are also vital components of acute treatment for psychoses. Family intervention and social work assistance may be needed. The overall management of acute psychosis is summarised in *Table 8*.

### Specialist referral

General practitioners will usually seek the input of a consultant psychiatrist in the management of an acutely psychotic patient. At times, specialist input will be attained through psychiatric hospitalisation. Alternatively, referral to community psychiatric services or assertive outreach teams may be undertaken. It is important for the GP to understand that advice from community psychiatric workers does not equate to a consultant psychiatrist opinion.

**Table 6. Investigations in acute psychosis**

- Physical examination: general examination including cardiovascular (looking for evidence of arrhythmias and ischaemic heart disease), neurological (tardive dyskinesia), fundoscopic exam through undilated pupil (lens opacities) and weight
- Calculate body mass index
- Random blood glucose – baseline needed due to subsequent increased diabetes risk with some atypical antipsychotics
- Cholesterol and triglycerides – increased risk of cardiovascular disorders that can be exacerbated by metabolic side effects of some antipsychotic medications
- B12 and folate
- Calcium, phosphate
- Full blood examination, erythrocyte sedimentation rate
- Urinary drug screen – looking for illicit drugs, alcohol, benzodiazepines
- Liver function – alcohol, medication effects
- Prolactin
- Chest X-ray

**Table 7. Common antipsychotic medications – dosage and side effects**

Medication	Usual starting and clinical dose (mg/day)	Notable side effects
Chlorpromazine (Largactil)	25–100; 300–600	Sedation, anticholinergic effects, postural hypotension, extrapyramidal side effects (EPS)
Haloperidol (Serenace)	1.5–10; 1.5–20	EPS
Clozapine (Clozaril)	Not initiated in general practice	Sedation, convulsions, agranulocytosis, weight gain, NIDDM, hyperlipidaemia
Risperidone (Risperdal)	0.5–2; 2–8	EPS at supraoptimal doses, hyperprolactinaemia
Risperdal Consta	25–50/2 weekly injections	
Olanzapine (Zyprexa)	2.5–10; 5–20	Sedation, weight gain, NIDDM, hyperlipidaemia
Quetiapine (Seroquel)	25–100; 300–800	Sedation
Amisulpride (Solian)	200–800; 200–800	EPS at supraoptimal doses, hyperprolactinaemia
Aripiprazole (Abilify)	5–10; 10–30	Nausea, headache, insomnia, agitation (initially)

**Table 8. Managing acute psychoses**

- Assess danger to self/others and need for hospitalisation
- Assess physical state and consider possibility of substance abuse
- Consider specialist treatment options (eg. psychiatrist, involvement of mobile community outreach psychiatric services)
- Antipsychotic medication:
  - risperidone 1 mg twice per day, increasing over a few days to 2 mg twice per day
  - olanzapine 5–10 mg at night
  - quetiapine 25 mg twice per day (day 1), 50 mg twice per day (day 2), 100 mg twice per day (day 3), 100 mg morning and 200 mg at night (day 4), 200 mg twice per day (day 5)
  - amisulpride 300–400 mg twice per day
  - aripiprazole 15 mg per day
- If response is inadequate in 3 weeks, the dose can be increased (unless significant extrapyramidal side effects occur) to:
  - risperidone to 2 mg twice per day, up to 3 mg twice per day
  - olanzapine to 20 mg at night
  - quetiapine 400–750 mg per day
  - amisulpride 400–800 mg twice per day
  - aripiprazole 20–30 mg per day
- Treat anxiety, agitation and insomnia with short term diazepam, repeated as required. Quetiapine and chlorpromazine can also be used
- A manic presentation may require addition of a mood stabiliser (eg. lithium, valproate, carbamazepine)
- If depression persists, adjunctive antidepressants may be necessary
- Consider the use of long acting injectable risperidone if adherence is unlikely despite psychosocial interventions, or the patient fails to achieve optimal response from oral therapy
- Engage the patient in supportive psychotherapy and case management. Family therapy and cognitive behaviour therapy may be indicated
- Consider social interventions: housing options, resources, social supports
- Evaluate functional status and consider vocational rehabilitation options

## Conclusion

The initial management of acute psychosis is an increasingly common clinical problem. The majority of patients who suffer from psychotic disorders now live in the community and visit their GP.<sup>7</sup> Such patients are at risk of acute psychotic relapse and will frequently present to their family doctor in crisis, as will families with a child developing prodromal psychosis. Such presentations are usually difficult, complex, and involve the family as well as the patient. General practitioners are in an ideal position to assist with initial management, and then to provide continuity of care over the long term.

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