Psychosis

Psychosis

Clinical presentation

Acute psychosis represents one of the most severe and complex presentations, and one of the most intrusive when attempting to treat AOD use [520]. During an acute episode of psychosis a person's behaviour is likely to be disruptive and/or peculiar. Psychotic symptoms include [521]:

- Delusions – false beliefs that usually involve a misinterpretation of perceptions or experiences (e.g., thinking that someone is out to get you, that you have special powers, or that passages from the newspaper have special meaning for you).
- Hallucinations – false perceptions such as seeing, hearing, smelling, sensing, or tasting things that others cannot.
- Disorganised speech – illogical, disconnected, or incoherent speech.
- Disorganised thought – difficulties in goal direction such that daily life is impaired.
- Catatonic behaviour – decrease in reactivity to environment (e.g., immobility, peculiar posturing, motiveless resistance to all instructions, absence of speech, flattened affect).
- Rapid or extreme mood swings or behaviour that is unpredictable or erratic (often in response to delusions or hallucinations; e.g., shouting in response to voices, whispering).

It is important to note that mood swings, agitation, and irritability without the presence of hallucinations or delusions does not mean that the person is not psychotic. Workers should respond to these clients in the usual way for such behaviour (described in this chapter), such as providing a calming environment so their needs can be met [123].

Individuals in AOD settings commonly present with sub-acute psychosis, particularly as a result of methamphetamine use. These clients may display a range of low-grade psychotic symptoms such as [123]:

- Increased agitation, severe sleep disturbance.
- Mood swings.
- A distorted sense of self, others, or the world.
- Suspiciousness, guardedness, fear, or paranoia.
- Odd or overvalued ideas.
- Illusions and/or fleeting, low-level hallucinations.
- Erratic behaviour.

Managing symptoms of psychosis

Table 32 presents some strategies for managing acute psychotic symptoms. Some clients may be aware that they are unwell and will voluntarily seek help; others may lack insight into their symptoms and refuse help. Active-phase psychosis can put both the client and others at risk of harm and therefore mental health services should be contacted, whether the client wants such a referral to be made or not.

It should also be remembered that there is much stigma and discrimination associated with both psychotic spectrum disorders and AOD use, and some people may attempt to conceal either one or both of their conditions. Many people with comorbid psychosis and AOD use are frightened of being imprisoned, forcibly medicated or having their children removed. Take the time to engage the person, developing a respectful, non-judgemental relationship with hope and optimism. Use a direct approach, but be flexible and motivational [431].

Table 32: Dos and don'ts of managing a client with symptoms of psychosis

Do:

- ✓ Ensure the environment is well lit to prevent perceptual ambiguities.
- ✓ Ensure discussions take place in settings where privacy, confidentiality, and dignity can be maintained.
- ✓ Try to reduce noise, human traffic, or other stimulation within the person's immediate environment (e.g., reduce clutter).
- ✓ Ensure the safety of the client, yourself, and others.
- ✓ Allow the person as much personal space as possible.
- ✓ Be aware of your body language – keep your arms by your sides, visible to the client.
- ✓ Ignore strange or embarrassing behaviour if you can, especially if it is not serious.
- ✓ Listen attentively and respectfully.
- ✓ Appear confident, even if you are anxious inside – this will increase the client's confidence in your ability to manage the situation.
- ✓ Speak clearly and calmly, asking only one question or giving only one direction at a time.
- ✓ Use a consistently even tone of voice, even if the person becomes aggressive.
- ✓ Limit eye contact as this can imply a personal challenge and might prompt a hostile, protective response.
- ✓ Point out the consequences of the client's behaviour. Be specific.
- ✓ Ensure both you and the client can access exits – if there is only one exit, ensure that you are closest to the exit.
- ✓ Have emergency alarms/mobile phones, and have crisis teams/police on speed dial.
- ✓ If psychosis is severe, arrange transfer to an emergency department for assessment and treatment by calling an ambulance on 000.

Don't:

- × Get visibly upset or angry with the client.
- × Confuse and increase the client's level of stress by having too many workers attempting to communicate with him/her.
- × Argue with the client's unusual beliefs or agree with or support unusual beliefs – it is better to simply say 'I can see you are afraid, how can I help you?'
- × Use 'no' language, as it may provoke hostility and aggression. Statements like 'I'm sorry, we're not allowed to do ____ but I ***can*** offer you other help, assessment, referral…' may help to calm the client whilst retaining communication.
- × Use overly clinical language without clear explanations.
- × Crowd the client or make any sudden movements.
- × Leave dangerous items around that could be used as a weapon or thrown.

Adapted from NSW Department of Health [277], Jenner et al. [123], and UK NICE Guidelines [431].

Some clients with psychotic disorders may present to treatment when stable on antipsychotic medication and thus may not be displaying any active symptoms. These clients should be encouraged to take any medication as prescribed, and ensure they receive an adequate diet, relaxation, and sleep because stress can trigger some psychotic symptoms [522].

Despite the risk of further psychotic episodes, some people decide to keep using substances that may induce psychosis. In such cases the following strategies may be helpful [123]:

- Educate the client about 'reverse tolerance' (i.e., increased sensitivity to a drug after a period of abstinence) and the increased chance of future psychotic episodes.
- Encourage the client to avoid high doses of drugs and riskier administration methods (e.g., injecting in the case of methamphetamine).
- Encourage the client to take regular breaks from using and to avoid using multiple drugs.
- Teach the client to recognise early warning signs that psychotic symptoms might be returning (e.g., feeling more anxious, stressed or fearful than usual, hearing things, seeing things, feeling 'strange'), and encourage them to immediately stop drug use and seek help to reduce the risk of a full-blown episode.
- Inform the client that the use of AOD can make prescribed medications for psychosis ineffective.

Social stressors can be an added pressure for clients with psychotic conditions and the client may require assistance with a range of other services including accommodation, finances, legal problems, child care, or social support. With the client's consent, it can be helpful to consult with the person's family or carers, and provide them with details of other services that can assist in these areas. Family members and carers may also require reassurance, education, and support. See Chapter B4 for strategies on how to incorporate other service providers in a coordinated response to clients' care.

Treating psychotic spectrum disorders

In general, if a person is well maintained on medication for his/her psychotic disorder, then management for AOD use should proceed as usual. Although AOD workers may feel daunted at the prospect of treating this often severe and complex clinical group, it is crucial to remember that treatment and care should reflect an individual's needs and preferences, whilst taking into account the evidence base. People with comorbid psychotic spectrum and AOD use disorders should have the opportunity to participate and make informed choices about their treatment, in consultation and partnership with their health care providers [431]. The UK NICE Guidelines on the management of comorbid psychosis and AOD use recommend that, when planning treatment, workers take into account the severity of both disorders, the individual's social and treatment context, and their readiness to change [431]. There are several treatment options available for the treatment of psychotic disorders, including psychotherapy, pharmacotherapy, and physical activity. The evidence base surrounding each of these treatments is discussed below.

Psychotherapy

A recent Cochrane review of psychosocial treatments for co-occurring severe mental illness (predominantly psychotic spectrum disorders) and AOD use concluded that there is no clear evidence supporting the use of one treatment approach over another [523]. As noted by Lubman and colleagues [524], however, it is difficult to draw any firm conclusions from the current evidence base due to issues with study design (e.g., inconsistent or absent measures of key outcome variables, significant variation within 'treatment as usual' control groups). Integrated psychosocial treatments have shown some promise - in particular, programs in which clients receive treatments addressing both disorders, in combination with case management, vocational rehabilitation, family counselling and housing, as well as medications [525-527].

The majority of studies examining the efficacy of psychological treatments for people with comorbid psychotic spectrum disorders and AOD use have examined MI, either alone or in conjunction with another therapy. Although study findings have been mixed, there is some support for MI in improving AOD use and, when used in conjunction with CBT, improved mental state [523]. One study which added MI, CBT and a family intervention to usual care for clients with schizophrenia comorbid with AOD use found significant improvements in outcomes for both disorders over care as usual [528]. An Australian study which used a 10-session intervention comprising both MI and CBT for this comorbid group also found modest

improvements in outcomes [529]. In contrast to these positive findings, two studies have reported opposing findings in regards to MI. The first examined CBT plus MI, and found no significant differences between the treatment and treatment as usual comparison groups on some key outcome measures (e.g., AOD use, positive symptoms of schizophrenia) [530]. In the second study, conducted among young people with psychosis and cannabis use, the use of MI did not lead to improved outcomes compared to treatment as usual, for AOD use or symptoms of psychosis [531].

Barrowclough and colleagues [103] suggest that MI techniques may need to be adapted for clients with psychotic disorders because disorganised thoughts and speech may make it difficult for AOD workers to understand what the client is trying to say, and psychotic symptoms (combined with AOD use and heavy medication regimes) may impair clients' cognitive abilities. For this reason it is recommended that therapists:

- Make use of more frequent and shorter reflections to clarify meaning.
- Use frequent and concise summaries to draw together information.
- Avoid emotionally salient material that is likely to increase thought disorder.
- Provide sufficient time for the client to respond to reflections and summaries.
- Ask simple open questions and avoid multiple choices or complicated language.

Several studies have examined the efficacy of CBT on symptoms of psychosis and AOD use [532, 533]; again evidence regarding the efficacy of CBT in treating co-occurring psychotic disorders and AOD problems is mixed. Naeem and colleagues [533] found that although CBT led to better outcomes for symptoms of psychopathology, there were no differences between CBT and treatment as usual groups on AOD use outcomes. Similarly, Edwards and colleagues [532] found no significant differences between the CBT and psychoeducation groups for the key outcomes of cannabis use or psychopathology.

A small number of studies have examined contingency management as a means of treating clients with comorbid psychotic spectrum disorders and AOD use. As discussed in Chapter B5, contingency management involves the use of reinforcement to encourage particular behaviours (and discourage undesired behaviours). In a systematic review of psychosocial interventions for people with comorbid severe mental health (i.e., schizophrenia, schizoaffective disorder, bipolar disorder, or severe depression) and AOD use disorders, Drake and colleagues [534] found that the use of contingency management led to improved outcomes for AOD use. These findings indicate that contingency management may be a useful adjunct to other treatments for psychotic spectrum disorders and AOD use.

Reviews of the literature have also highlighted that residential, 'dual diagnosis' treatment programs may lead to positive outcomes, particularly for people with severe psychosis and AOD use [524, 534]. Long-term residential programs (at least one year) are more likely to be associated with positive outcomes than short-term programs, in terms of increased abstinence from substances, and decreased risk of homelessness [535].

Pharmacotherapy

Despite the high rates of comorbid AOD use among people with psychosis, most trials of pharmacotherapy for psychotic spectrum disorders have excluded individuals with AOD use disorders [524]. The UK NICE Guidelines for comorbid psychosis and AOD use recommend the use of antipsychotics, in line with the UK NICE Guidelines on schizophrenia [536] or bipolar disorder [537], due to the lack of evidence of any differential benefit for one antipsychotic over another for people with this comorbidity. Table 33 lists the names of some of the more common antipsychotics.

It has been theorised that the increased AOD use found amongst those with psychotic disorders relates to dopamine dysfunction which is better addressed by the newer (atypical) antipsychotic agents than the

older (typical) agents [538]. There has been considerable research on the effects of clozapine on AOD use, with generally positive outcomes [539]. Results for other newer antipsychotics in terms of impact on AOD use have been equivocal [540].

There are several reasons why pharmacological interventions for the comorbid AOD use disorder may prove more effective for this group than psychosocial treatments. Problems associated with negative symptoms such as amotivation and cognitive impairment may restrict involvement and outcomes in psychosocial interventions. On the other hand, greater tolerance of medication regimes may render clients with this comorbidity more amenable to pharmacotherapy for AOD use. Caution should be taken when selecting pharmacotherapies for AOD use and some are contraindicated in individuals with psychotic disorders as they may exacerbate symptoms (e.g., disulfiram).

Table 33: Antipsychotic medications

Newer (atypical) antipsychotics		Traditional (typical) antipsychotics	
Drug name	**Brand names**	**Drug name**	**Brand names**
Clozapine	Clozaril, Clopine	**Chlorpromazine**	Largactil
Olanzapine	Zyprexa	**Droperidol**	Droleptan
Quetiapine	Seroquel	**Fluphenazine**	Anatensol, Modecate
Risperidone	Risperdal	**Flupenthixol**	Fluanxol
Amisulpride	Solian, Sulprix	**Haloperidol**	Haldol, Serenace
Aripiprazole	Abilify	**Pericyazine**	Neulactil
Ziprasadone	Zeldox	**Zuclopenthixol**	Clopixol
Paliperidone	Invega	**Prochlorperazine**	Stemzine
Sodium valporate	Epilim, Valpro		
Carbamazepine	Tegretol, Teril		
Lithium	Lithicarb		
Asenapine	Saphris		
Trifluoperazine hydrochloride	Stelazine		

Adapted from the Australian Government Department of Health [541]. For a full list of generic brands available, see the Therapeutic Goods Administration website (https://www.tga.gov.au/).

E-health interventions

Although research pertaining to the use of e-health interventions for psychosis is in the early stages, findings to date are promising. A review of internet and mobile-based interventions for psychosis concluded that they appear to be acceptable and feasible, and have the potential to improve clinical and social outcomes [542]. Specifically, the interventions reviewed showed promise in improving positive psychotic symptoms, hospital admissions, socialisation, social connectedness, depression, and medication adherence. Interventions included web-based psychoeducation; web-based psychoeducation plus moderated forums for patients and supporters; integrated web-based therapy, social networking, and peer

and expert moderation; web-based CBT; personalised advice based on clinical monitoring; and text messaging interventions. The authors note however, that the poor quality and early state of current research precludes any definite conclusions, and further trials are necessary. Further research examining the use of e-health interventions for co-occurring psychosis and AOD use is also needed.

Physical activity

To date there is no evidence about the use of exercise for psychotic disorders other than schizophrenia, or comorbid psychosis and AOD use disorder. Research conducted among individuals with schizophrenia however, has found that physical exercise may be useful in terms of improving cognitive functioning (e.g., short-term memory), promoting healthy lifestyles, and managing medication side-effects [543, 544]. Studies that have examined the efficacy of exercise interventions among people with schizophrenia have included a range of physical activities, including basketball [545], aerobic exercise [543, 546], and yoga [547, 548]. Based on the evidence to date, aerobic activity has the most support [142, 543, 549-553], but there is also some support for resistance training as an adjunct to other exercise [546, 554, 555]. In particular, endurance programs of at least 12-weeks, 3 sessions per week, of general aerobic endurance training lasting at least 30 minutes duration are recommended [556].

Summary

In summary, existing research suggests that there is no 'one size fits all' approach for treating comorbid psychotic spectrum and AOD use disorders [524], suggesting combinations of different therapeutic approaches may be necessary for each individual client. Further, therapist flexibility is incredibly important in the treatment of this group. Box 14 illustrates the continuation of case study B, following Nick's story after contact was made with the local AOD service for an assessment.

Box 14: Case study B: Treating comorbid psychosis and AOD use: Nick's story continued

Case study B: Treating comorbid psychosis and AOD use: Nick's story continued

Nick's assessment with the AOD worker opened the door for a collaborative approach to his treatment with the community mental health team. The case manager and AOD worker organised an appointment with Nick's psychiatrist to discuss a treatment plan, taking into account both his mental health and AOD use. They also organised for Nick to be seen by a medical doctor to ascertain whether there were any physical conditions that needed to be taken into consideration. With Nick, a plan was devised to address his most pressing needs. This coordinated approach to Nick's care allowed for his needs to be comprehensively addressed and included alterations to his medication regime, psychotherapy, and ongoing support from his case manager. Several physical health problems were identified, leading him to receive treatment for elevated blood pressure. He also attended a dentist for the first time in many years and had some teeth filled and others extracted.

The treatment goals for Nick in the long term were for him to live in supported accommodation, and he began part time work in a supermarket. Improvements in Nick's mental health and AOD use led to improved social functioning, allowing him to engage in a range of activities organised for the supported living complex, which became his permanent home. Nick continued to express bizarre ideas and still hears voices, but he is able to cope better with these phenomena.

Box 14: Case study B: Treating comorbid psychosis and AOD use: Nick's story continued

Key points:

- Chronic illness does not equate to untreatable illness. Psychotherapy may provide symptom relief and improved quality of life, and all treatment approaches need to be carefully integrated.
- Medication compliance needs long-term attention.
- Physical health is often overlooked.
- A holistic approach, assessing a person's accommodation and employment needs in addition to their mental, physical, and AOD use disorders, is vital.