Psychosis

see also p 227, 271

A 25-year-old man lived in China until the age of 20 when he immigrated to the United States. Initially, he lived with his family and worked in a small Chinese store. Over several months, he began to have difficulty relating to customers, feeling frightened and suspicious. He began to think that the Chinese government was spying on him, and he heard voices telling him he would be killed.

He became more withdrawn at work and was not functioning in his job. At home, he became increasingly agitated and his family was concerned for his safety. They sought urgent medical attention.

Clinical evaluation led to the diagnosis of "psychotic disorder, not otherwise specified." The patient was hospitalized and treated with antipsychotic medication until the acute symptoms abated. He was then released from the hospital. The patient participated in regular weekly group sessions that focused on socialization, stress reduction, problem solving, and psychological education. He continues to see a psychiatrist monthly for ongoing monitoring of his mental status and medication.

Summary points

- Diagnostic criteria for psychosis are based on Western standards and may not account for ways in which people of other cultures express distress
- Intimate involvement of family members in the care of Asian patients with psychoses may be at odds with concepts of patient confidentiality and privacy
- Primary care of Asian patients with psychotic disorders requires an understanding of the cultural differences in how psychotic disorders are expressed and treated

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PSYCHOTIC DISORDERS IN THE PRIMARY CARE SETTING

Psychosis is a syndrome of psychiatric signs, symptoms, and behaviors that usually include hallucinations, delusions, disorganized speech and functioning, and impaired judgment. People with psychosis usually have an impaired ability to function in everyday life.

A patient with psychotic symptoms usually perceives aspects of everyday life in a way that is not based in reality. The syndrome of psychosis is most closely associated with the diagnosis of schizophrenia, although it can also be seen in association with bipolar disorder, major depression, substance-induced psychotic disorders, delusional disorders, and brief psychotic disorders.

Presentation and assessment

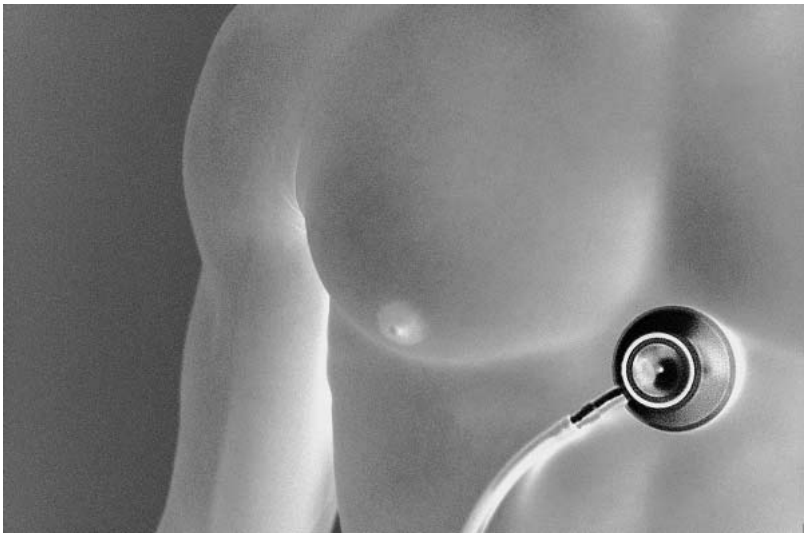
A patient with a first episode of psychosis often presents with anxiety, depression, poor concentration, irritability, suspiciousness, and social withdrawal. When psychosis is suspected, the physician should explore possible changes

in social functioning, family relationships, cognition, and thought content. Changes in the person's personal hygiene, speech pattern or content, and outbursts of anger may also be part of a developing psychosis. Information from the family can be useful to gain a complete picture of the patient's behavior.

Acute symptoms and aggressive or self-injurious behavior may call for emergency measures such as immediate medication, calling on personnel trained in emergency care, enactment of security measures, or hospitalization. The priority for the primary care physician seeing patients with a psychotic disorder is to ascertain if they are a danger to themselves (including lack of self-care that may result in harm) or to others. Even if the plan is to refer the patient immediately for assessment by a mental health professional, a determination must be made that the patient is stable enough to leave the premises.

Prompt referral to a psychiatrist is recommended, because early psychiatric intervention is associated with better response to treatment. Evidence indicates that lengthy delays in initiating drug treatment (delays of 6 months or more from onset) are associated with a greater need for inpatient care and a worse social and vocational outcome.[1-3] If an immediate referral is not required, then patients must be actively monitored for changes in their mental status.

Patients presenting for the first time should always receive a full review of symptoms and a thorough physical examination. This is because psychotic symptoms may be due to organic causes—such as brain trauma or metabolic abnormalities. Inappropriate dosages of medications, drug interactions, drug abuse or misuse, over-the-counter remedies, and herbal preparations can all cause psychotic symptoms.



Physical examination and medical management of physical illnesses should not be overlooked in patients with psychosis

Barriers to diagnosis and treatment

Psychotic symptoms on initial presentation may be more severe in Asian patients than in other ethnic groups. The reason for this disparity is that the stigma and shame associated with mental illness in Asian cultures delays appropriate and timely care. In addition, patients' symptoms are often kept within the family until the symptoms become intolerable or unmanageable, or legal involvement occurs.

The diagnosis of psychosis relies to a great extent on the evaluation of a person's language, behavior, thoughts, and perceptions. Evidence-based algorithms, such as those from the Harvard Medical School Department of Psychiatry (available at www.mhc.com/Algorithms mhc.com/Algorithms), may be used to assist in accurate diagnosis. Issues such as cultural diversity and racism, however, can still impede both diagnosis and treatment.

The conflicting demands experienced by a person of one culture having to adapt to another may lead to personality and relationship difficulties, anxiety, and identity confusion. The economic and environmental changes that accompany moving between cultures may aggravate preexisting physical and psychological vulnerabilities.[4] Racism—in the form of not having control over one's fate and repeated negative encounters with other, more dominant, cultures—may produce a pattern of helplessness and a belief that the environment is hostile, more powerful, and ultimately interested in hurting the person affected. Practitioners who are uninformed about another culture and their experiences of racism, or who harbor negative stereotypes about that culture, may tend to diagnose psychosis when symptoms are better accounted for by a mood disorder. For example, the negativism experienced as a result of racism can be misinterpreted as paranoia. Primary care providers should consider these factors or consult with a specialist who is knowledgeable about the culture of Asian patients before making a definitive diagnosis.

The beliefs that patients have to explain their illness may influence them to first seek out non-medical or non-psychiatric assistance, for example, family members and traditional healers, thereby delaying necessary care and worsening the presentation.

A common finding in Asian patients is that complaints are solely physical, without any cognitive complaint. In fact, the culture may not include any terminology for psychiatric distress, further confusing the presentation to the primary care provider.

These possible situations must be handled with sensitivity and understanding. Most patients in distress need to feel that they are first safe, then understood.

TREATMENT

Overview of treatments

Patients with psychosis generally receive both pharmacologic and nonpharmacologic treatments. The goal of phar-

macologic treatment is to stabilize and control the acute symptoms and behaviors associated with psychosis (see p 271). Nonpharmacologic treatment provides the patient and the family with support, education, and the work and social skills necessary to live and function in the community.

Once it is determined that psychotic symptoms are present, management requires identification of target symptoms and behaviors. These are observed and monitored to determine the patient's response to treatment and the need for further intervention. Definitive diagnosis of the exact type of psychosis can wait until after further observation of the patient and the patient's response to treatment as well as elucidation of predisposing factors and family history.

After acute symptoms are stabilized, the physician monitors the patient for symptoms and behaviors that indicate a possible relapse. The physician should be aware that even grossly psychotic patients are able to control behaviors and act according to cultural expectations. Patients may lack insight about their illness, which affects how they respond to the physician's questions about symptoms and behaviors. The physician must work with the family as a corroborating source of information about the patient's status and condition. Even moderate changes in behaviors, mood, or thoughts may indicate a possible relapse.

Patients with chronic illness who are stable may only require infrequent, but regularly scheduled checkups for evaluation of medication side effects, compliance, and blood tests. At the very least, a complete blood count and differential to monitor for agranulocytosis, and liver function tests for rare hepatotoxicity, are recommended for patients receiving antipsychotic therapy. When psychiatric consultation is unavailable or limited, primary care practitioners who understand the target symptoms and the medications used to control them can manage treatment. This decision depends on the severity, chronicity, and frequency of the disorder, the nature of the pharmacologic and biopsychosocial treatment given, and the availability of social support systems for the patient.

Psychiatric symptoms can prevent patients from following medical recommendations for their physical diseases. This is one of the reasons why psychiatric patients have higher morbidity and mortality associated with a range of physical conditions compared to the general population.[5]

Monitoring psychotic illness

The signs and symptoms that are important to consider when monitoring a patient's level of psychosis and response to treatment are shown in box 1.

Referral to a mental health specialist

Indications for requesting consultation with a psychiatrist include the following:

Box 1 Symptoms and signs of psychosis

Hallucinations

Auditory hallucinations are the most common type of hallucination seen with psychosis. Visual, tactile, and olfactory hallucinations may occur, but these should increase the index of suspicion of a biological cause such as head trauma or withdrawal syndromes, especially if symptoms are new or of sudden onset.

- Does the patient hear voices? Do the voices give the patient commands or tell the patient what to do? Do they tell the patient to harm him/herself or others? Are they more intense than in the recent past?
- Does the patient often appear more internally preoccupied or as if he/she is responding to something that is not present?

Delusions

- Does the patient have persecutory or grandiose thoughts or ideas?
- Does the patient have thoughts that he/she has a severe illness that has no medical basis (somatic delusions) yet remains convinced of this illness despite evidence to the contrary?
- Does the patient have ideas of being controlled, thoughts about mind reading, or of some force controlling his or her thoughts?

Thought process

- Do the patient's thoughts and speech seem logical?
- Are the thoughts jumbled and not organized in a clear flow?
- Is there an increased delay in response to simple queries?

Behaviors

- Does the patient have an unusual appearance or form of dress compared to previous assessments?
- Does the patient exhibit any aggressive, sexualized, or repetitive behaviors?

Affect

- Does he or she show a decrease of the full range of facial expression, have an inappropriate expression that is not consistent with his or her thoughts, or show poor eye contact?
- Does he or she show little interest in self-care?
- Does the patient avoid social interactions?

Impulse control

- What is the patient's potential to act on thoughts, ideas, or psychotic symptoms?
- Does he or she show high levels of inappropriate irritability?

Insight

- What is the patient's understanding of the illness? Is it consistent with the medical situation?
- Has the patient used traditional healing practices such as herbal remedies, spiritual healing, or acupuncture? Does it seem appropriate given the symptoms of distress?

Danger to self or others

- Does the patient have any thoughts about suicide, self-harm, homicide, or any other acts of aggression? Has the patient been giving possessions away, which may be a sign of suicidal thoughts?
- Does the patient have any history of self-destructive behavior, violence, or aggression?

- Acute stages of psychosis
- Initial presentation of psychotic symptoms or behaviors
- A possibility of danger to the patient or others
- Prescribing medications

Because the use of bilingual and culture-specific treatment programs can improve the treatment of psychosis in Asians and Asian Americans, referral to such services should be made whenever possible.[6]

Arranging hospital admission

Hospitalization is primarily indicated for:

- Diagnosis
- Stabilization of medication delivery
- Suicidal or homicidal ideation or behavior
- Disorganized or inappropriate behavior, including patients' inability to care for themselves or to meet their basic needs

Hospitalization decreases patients' stress by providing a structured and supportive environment. The length of stay depends on the severity of the illness, availability of outpatient treatment, and the level of family or community support. Whenever possible, patients should be sent to facilities with culturally competent, bilingual staff.

Outpatient therapy

Traditional outpatient therapy consists of individual, group, and family therapy and is an important adjunct to pharmacologic treatment of psychotic disorders. Regularly scheduled meetings with a physician, therapist, or counselor provide ongoing structure and support. Therapy sessions include monitoring treatment progress and status of target symptoms, providing education about illness and treatment, and assisting with problem-solving and stress reduction.

Group therapy may be useful, especially in providing a way to improve socialization, problem solving, and coping skills with others. The group must be culturally similar and cohesive or group therapy may not help Asian patients.

When treating Asians with psychotic disorders, inclusion of the family in therapy is important. They are an important source of information and support for the patient. Families need to understand what to expect in the course of the patient's illness, how to recognize signs of relapse of psychosis, what treatment options are available, and the expectations of treatment.

Culturally specific treatment programs

In our experience, culturally relevant treatment services that address language issues, use ethnic clinical staff, and respond to specific ethnic needs of the clients are more successful than usual care services in treating psychotic patients. Often, however, culturally relevant treatment services are unavailable.

Some treatment programs provide cultural relevance by providing translators on site or translation services; others replicate traditional treatment services with Asian bilingual staff. Culturally specific treatment programs incorporate different Asian cultural values, customs, and attitudes into treatment. Issues of immigration status, acculturation and assimilation, and the role of family and social organization within an ethnic community are considered in relation to treatment. Referral of Asian patients to culturally specific treatment programs is recommended whenever possible. If this type of care is not available, involvement of linguistically and culturally competent individuals can facilitate communication.

Box 2 Additional reading

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