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Psychosis – A Need for Preemptive Intervention?

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ABSTRACT

With the advent of newer antipsychotic medications with fewer side-effects both clinicians and patients may be more willing to take early preemptive measures in treating psychotic disorders. We present a case report of use of pharmacotherapeutic intervention in an individual with either possible prodromal symptoms of schizophrenia or a subthreshold disorder.

This case presented to us with the ethical dilemma inherent in treating a patient with subthreshold disorder. The options were either watchful waiting or preemptive treatment. In this case the patient was very distressed by his symptoms and had requested treatment with medications. Indeed, treatment has resulted in the remission of his symptoms and restored him to his previous level of functioning.

Keywords: intervention, prodrome, psychosis

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INTRODUCTION

Recently, administration of antipsychotic medications to non-psychotic subjects with the schizophrenia spectrum has been reported[1,2]. With the advent of newer antipsychotic medications with fewer side-effects both clinicians and patients may be more willing to take early preemptive measures in treating schizophrenia and related disorders, including targeting treatment to those who are symptomatic and requesting treatment, but do not yet have a fully developed psychotic disorder.

CASE REPORT

Mr P is a 19-year-old Chinese man who is serving his compulsory military service. He presented to our services on his own accord because he was feeling dysphoric and extremely anxious. He was struggling with various sexual and religious conflicts because he was attracted to both men and women. Three months prior to presentation, he began to feel that his colleagues in the army could read his mind and knew all about his "sexual thoughts". Gradually he had this uneasy feeling that some of his colleagues' actions and conversations were directed solely at him. In addition, he felt that he could in some ways influence the actions of the people around him. He had difficulty in concentration and his work performance suffered. These symptoms intensified over a period of time; he began to find the environment in his military camp and almost any situation outside his home intolerable. His parents noticed that in the past few months, Mr P had become more withdrawn and seemed preoccupied. He is the third of five children and there is no family history of mental illness. Academically he had always done well and had secured a place in the university. He played in the school band, was a school prefect and had a number of good friends. There was no history of any drug abuse.

On clinical assessment other than ideas of reference, magical thinking and few mild negative symptoms patient did not show evidence of a psychotic disorder. His thoughts were well organised and he did not report any perceptual abnormality. In neuropsychological evaluation patient was found to have deficits in memory functioning. Impairments were also found in his attention and concentration. Investigations, which included a full blood count, serum electrolytes, liver function tests, thyroid function tests and CT scan of the brain were all within normal limits. Urine toxicology was negative.

A definite diagnosis of psychosis could not be made but Mr P was very keen for some treatment (preferably "some medication") to alleviate his distress. We discussed at length with Mr P and his parents that these behaviour changes could constitute the prodrome of a psychotic disorder, but we were unable to predict if he would subsequently develop the disorder. The option of watchful waiting versus active treatment was also discussed. Mr P felt that his symptoms were significantly impairing him and hence in collaboration with the patient, we decided to start him on a trial of risperidone. It was agreed in advance that medication would be terminated if there were any intolerable side effects, or lack of response after six weeks. Assessment using the Positive and Negative Symptoms Scale (PANSS), Simpson-Angus Rating Scale, Abnormal Involuntary

Movements Scale, Barnes Akathisia Rating Scale was done at baseline and at regular intervals. After two months of treatment a reassessment on PANSS showed absence of positive symptoms and minimal negative symptoms. (The PANSS score decreased from 60 at baseline to 39 at the end of two months.) On being retested on neuropsychological functioning he showed significant improvement in his ability to acquire and recall verbal information. His executive functioning showed that he was able to shift between concepts considerably better. Apart from mild hand tremor he tolerated risperidone at a dose of 1.5 mg/day well.

DISCUSSIONS

Pharmacotherapy of putative prepsychotic state and prediagnostic stages of psychotic illness is controversial[3,4]. This case presented to us with the ethical dilemma inherent in treating an individual with either possible prodromal symptoms of schizophrenia or a subthreshold disorder. The options are either careful watching or preemptive treatment. Prodromal symptoms which are varied and include magical thinking, ideas of reference, difficulty in concentration, social withdrawal are also found in individuals who are at risk for schizophrenia but do not subsequently develop the disorder[5]. Therefore, there is a risk of labelling "false positive" with possible negative consequences, including stigmatisation, unnecessary worry and anxiety for the individual and his family, and receiving medications with their potential adverse effects. On the other hand, there may negative consequences from withholding treatment. Left untreated, subthreshold disorder may deteriorate into a more severe and disabling form with reduction in quality of life, self-devaluation and social isolation[6].

In this case, the patient was both informed and competent. He had sought help on his own accord and had requested active treatment with medication. Intervention could also be justified on the basis of the extent and intensity of his distress and impairment. Indeed, treatment has resulted in the remission of his complaints and restored him to his previous level of functioning and relieved his distress. Further, by intervening in the pre-psychotic phase we may have successfully prevented or delayed the onset of psychosis, thus allowing this young man to develop educational, vocational and coping resources. However, further clinical research is clearly necessary to construct a sound evidence base concerning the effectiveness of a range of biological and psychosocial treatment strategies. In the meantime, the minimum standard of care for patients with subthreshold psychotic features who seek help is therapeutic engagement, regular mental state monitoring and psychosocial support.

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