

9 Psychoses: a primary care perspective

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General practitioners are well placed for early intervention and continuing care of people with psychoses.

Continuing changes to Australia's psychiatric services, with an ongoing shift from the provision of treatment in hospital to community settings, have resulted in an enlarging role for general practitioners in the care of patients with psychotic illnesses. Although psychoses are considerably rarer than other psychiatric problems in general practice, especially anxiety disorders and depression, a considerable proportion of psychotic patients are initially diagnosed and referred for psychiatric assessment by general practitioners. Much treatment for such patients for both psychological and physical problems takes place within primary care settings.¹

General practitioners are also likely to play an important role in the detection of prodromal symptoms, in treating and supporting relatives of patients with psychotic illness, and in working in collaboration with psychiatric and other mental health care workers in both the public and private psychiatric sectors.

The spectrum of psychotic disorders

The psychoses are characterised by severe disturbances in cognition, perception and reality testing. Although no firmly validated boundary criteria have been established between the various psychoses, the categorisations used in arbitrary but epidemiologically influenced diagnostic systems such as DSM-IV² and ICD-10³ are of some assistance in determining prognosis and in selecting optimal treatment strategies. For example, schizoaffective disorder has a better prognosis than schizophrenia⁴ and, in contrast to schizophrenia, more frequently warrants a trial of mood stabilising drugs, in conjunction with antipsychotic medication.⁵

In DSM-IV (see Box 1), the most common psychotic disorder, schizophrenia, is differentiated from other psychotic disorders by the absence of identifiable causative factors (cf, substance-induced or medically caused psychotic disorders), the longer duration of disturbance (cf, brief psychotic and schizophreniform disorders), minimal mood disorder (cf, schizoaffective disorder, and psychotic disorders associated with major depression or bipolar disorder), and the presence of psychotic symptoms in addition to delusions (cf, delusional disorder).

There are limited and often difficult to interpret epidemiological



Ferocious faces — stylised representations of hallucinations. A painting from the Cunningham Dax Collection of Psychiatric Art in the Mental Health Research Institute of Victoria, reproduced with permission.

Synopsis

- ▶ General practitioners (GPs) play an increasingly important role in the assessment and management of patients with psychotic disorders. Their position enables them to provide continuity of care in a low-stigma setting with a family orientation.
- ▶ In caring for people with psychoses, GPs can benefit from close collaboration with specialist mental health services.
- ▶ A knowledge of the prodromal and early phase of illness, hallmarks of psychotic illnesses, and of the availability of specialist assessment services may minimise delays in patients' receiving appropriate treatment.
- ▶ Patients presenting with psychotic illnesses should have a thorough psychiatric and physical examination and undergo appropriate investigations to ensure that related medical and substance-abuse disorders are diagnosed and treated.
- ▶ Patients with treatment-sensitive schizophrenia should be managed with the lowest effective dose of either conventional antipsychotic drugs or the newer extrapyramidal side effect sparing drugs risperidone or olanzapine
- ▶ Only clozapine has so far demonstrated superior efficacy in the management of treatment-resistant schizophrenia.
- ▶ Antipsychotic drugs may be useful in the acute treatment phase of affective psychoses, but the maintenance phase of treatment for these disorders should mainly involve the use of mood stabilising or antidepressant drugs.
- ▶ Electroconvulsive therapy has a valuable role in the treatment of psychotic depression.

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1 The spectrum of psychotic disorders (DSM-IV)²

	Duration of disturbance	Identified aetiological factors	Prominence of mood disorder	Non-bizarre delusions only
Schizophrenia	≥ 6 months	–	Not prominent	No
Psychotic disorder due to a medical condition	Not specified	+	Not specified	Possible
Substance-induced psychotic disorder	Not specified	+	Not specified	Possible
Brief psychotic disorder	≥ 1 day-< 1 month	–	Not prominent	Possible
Schizophreniform disorder	≥ 1 month -< 6 months	–	Not prominent	No
Major depressive disorder with psychotic features	≥ 2 weeks	–	Very prominent (must overlap exclusively with psychosis)	Possible; usually (but not necessarily) mood-congruent
Bipolar disorder with psychotic features	≥ 1 week	–		
Schizoaffective disorder	≥ 1 month	–	Prominent, but there must also be > 2 weeks' psychosis in the absence of major mood disturbance	No
Delusional disorder	≥ 1 month	–	Not prominent	Yes

A further disorder, "Psychotic disorder not otherwise specified", is a psychosis in which the criteria for other psychotic disorders are unmet.

data on the comparative incidence and prevalence of psychotic disorders. The most definitive incidence study is the World Health Organization's 10-country, 12-catchment-area investigation,⁶ which showed that broadly defined schizophrenia comprised more than 60% of all incident cases of psychotic disorders, and that, apart from schizophreniform psychoses, other psychoses are comparatively rare (Box 2). US-centred studies tend to confirm the relatively high frequency of schizophrenia (with an estimated 1.3% lifetime prevalence in the Epidemiological Catchment Area (ECA) Study)⁷ in comparison with other psychoses; for example, delusional disorder (with a proposed lifetime prevalence of 0.05%–0.1%).² They also suggest that schizophreniform disorder may be comparatively infrequent, with a one-month prevalence rate one-sixth that of schizophrenia,⁷ and that schizoaffective and mood disorder related psychoses may be relatively more common than suggested by the WHO study. For example, the ECA study reported that the one-year incidence of affective psychoses was almost the same as schizophrenia (1.7 vs 2.0/1000, respectively).⁸ Although only 15% of major depressive episodes are associated with psychotic

symptoms,⁹ the lifetime prevalence of major depressive episode has been estimated to be approximately 4.5 times greater than that of schizophrenia.⁷ Approximately 60% of patients with bipolar disorder have experienced at least one psychotic symptom during their lifetimes, usually during a manic phase.¹⁰

Assessment

In order to reach a diagnosis in a psychotic patient, it is important to consider the possibility of medically related or substance-induced psychotic disorders. Although the former probably represent no more than 3% of newly presenting patients with "apparent" schizophrenia,¹¹ failure to detect the underlying conditions may lead to their progression and to symptom-oriented therapies in lieu of more appropriate and definitive treatments.

Medical conditions which may be associated with psychotic symptoms include those listed in Box 3.

A detailed psychiatric and physical (especially neurological) examination should be conducted on all patients suspected of suffering from a first episode of psychotic illness. Medical investigations should also be ordered, not only to exclude relevant differential diagnoses, but also to assess the extent to which comorbidities such as poor nutrition and alcohol and drug abuse might be affecting the patient's general health. A suggested set of screening investigations is provided in Box 4. Although cranial computed tomography (CT) is often carried out in the assessment of first episode patients to exclude focal brain lesions before commencing what might be long-term or even life-long treatment, the rate of detection of treatment-altering abnormalities is low.¹²

In addition to these tests, it may be appropriate to order other investigations, depending on the nature of the clinical presentation. Other investigations might include magnetic resonance imaging, autoantibodies, HIV serology, serum copper levels, cerebrospinal fluid microscopy, culture and

2 Number of incident cases of ICD-9 psychotic disorder in the WHO 10-country study^{6*}

Schizophrenia (broadly defined)	766	(61%)
Acute schizophreniform psychoses	274	(22%)
Other psychoses incl. affective psychoses	113	(9%)
Schizoaffective psychosis	68	(5%)
Paranoid psychosis	32	(3%)
All psychoses	1253	(100%)

* Additional information from Professor A Jablensky, University of Western Australia.

serology, and chromosome studies. Second line investigations such as these should be considered in patients who display neurological signs, who present with catatonia or significant disorientation and perplexity, or who manifest atypical psychotic features (e.g., predominant tactile or olfactory hallucinations).^{13,14}

Drug abuse and psychosis

Drug abuse can give rise to psychotic symptoms, often in association with signs of intoxication such as confusion and disorientation, impaired motor coordination or psychomotor agitation or retardation. Such symptoms generally last hours, days or, at most, a few weeks. In the Australian setting, such drug-induced psychoses are most commonly the result of the use of amphetamines or cannabis.

Attempting to distinguish between these drug-induced psychoses and primary psychotic disorders, although often difficult, is important in order to avoid inappropriately assigning patients to months of antipsychotic medication. Even if the primacy of the role of illicit drugs cannot be clearly delineated, awareness by the clinician that the patient is using such drugs helps to identify an important and potentially controllable factor which might be contributing to the initiation or exacerbation of a primary psychotic disorder.¹⁵

In view of the fact that urinary drug screens, especially for cannabinoids, may be positive in a significant minority of patients with schizophrenia,¹⁶ this investigation has limited value in the differential diagnosis of primary versus secondary psychosis. Of greater value in this regard is a history (either from the patient or an informant) of a high level of consumption or of rapidly escalating drug use in a person who has no past history of psychotic disorders occurring in a drug-free state.

Often the role of drug abuse, especially cannabis abuse, in the genesis of the psychosis is unclear. However, because there is reasonable evidence that drug abuse adversely affects the course¹⁷ and aggravates the symptoms of the disorder,¹⁸ it is advisable for patients with schizophrenia to stop using illicit drugs, or at least reduce their use. Medical practitioners often counsel their patients to follow this advice, but there are, to my knowledge, no systematic studies of the effectiveness of giving such advice. The notable dearth of specialised drug abuse treatment programs in Australia for patients with serious cannabis dependence and for psychiatric patients who abuse drugs needs correction.

Prodromal symptoms

Delays in the detection and treatment of first episode psychoses are associated with slower and less complete recoveries.¹⁹ Box 5 lists some prodromal symptoms. Until recently, it was held that a much narrower range of symptoms should be designated prodromal, but research has indicated that many apparently non-specific symptoms — for example, depression, anxiety, withdrawal and restlessness — fairly commonly precede the onset of schizophrenia.^{20,21}

In many young people these symptoms will be of minimal consequence or will precede the onset of some other disorder. The likelihood that they are harbingers of psychosis is

3 Some medical conditions associated with psychotic symptoms

Neurological disorders

- Infections; especially viral, including HIV
- Cerebrovascular disease; linked to late-onset psychosis
- Cerebral trauma; usually with long latency
- Multiple sclerosis; especially when many periventricular lesions are present
- Huntington's disease; psychotic symptoms in 5%–10% of cases
- Epilepsy; especially complex partial seizures
- Neoplasms; most commonly of the temporal lobe and cingulate gyrus
- Other space occupying lesions; e.g., abscesses

Endocrine, metabolic and autoimmune disorders

- Cushing's syndrome; psychosis occurs in up to 20% of patients
- Hyperthyroidism and hypothyroidism
- Hyperparathyroidism; psychosis may occur with a clear sensorium
- Porphyria; acute intermittent porphyria and porphyria variegata
- Vitamin B₁₂ deficiency; depression more common
- Systemic lupus erythematosus, and associated steroid-induced psychosis
- Wilson's disease

strengthened by marked, unexplained and consistent changes in behaviour, a pattern of increasing severity, a clustering of additional symptoms, and the presence of a family history of psychotic disorder.

If there is a high index of suspicion that a person might be on the verge of developing a psychotic illness, referral should be made to a psychiatrist or to the growing number of services specialising in the assessment and diagnosis of first-episode psychoses, such as the Early Psychosis Prevention and Intervention Centre associated with the Royal Melbourne Hospital.²²

The role of the general practitioner

The general practitioner is well placed to provide rapidly responsive, low-stigma, cost-effective treatment to patients with schizophrenia and other psychoses, and which incorporates consideration of concomitant physical conditions and is sympathetic to social and family circumstances. The management of 75%–90% of all treated psychiatric illnesses occurs within a primary care setting.¹ According to an Australian study,²³ 28% of general practitioners regularly prescribed antipsychotic medication and 96% indicated a willingness to follow up patients with psychotic disorders.

A study conducted in 13 general practices in London²⁴ showed that patients with schizophrenia consulted their general practitioners 11 times more often than average patients,

4 Screening tests to be considered in the assessment of patients presenting with an apparent first episode of psychosis

- Electrolytes
- Erythrocyte sedimentation rate
- Thyroid function tests
- Liver function tests
- Full blood examination
- Iron studies
- Vitamin B₁₂ and folate levels
- Syphilis serology
- Electroencephalogram
- Urinary drug screen
- Cranial computed tomography

and at a rate similar to patients with chronic physical illnesses such as epilepsy, rheumatoid arthritis and multiple sclerosis. Interestingly, because the consultations with patients with schizophrenia were more likely to involve physical complaints than average patients, they were half as likely to receive consultations targeting their primary disorder than patients with chronic physical diseases.

Such data suggest that general practitioners may sometimes need to make a special effort to ensure that their patients' mental health needs are not dealt with in a cursory manner while they attend to physical complaints. However, it is important not to de-emphasise this latter role because the coordination of care of patients with schizophrenia in the public sector is increasingly in the hands of non-medical case managers. Furthermore, the twofold relative mortality of patients with schizophrenia in comparison with the general population is contributed to not only by a high rate of suicide, but also by an increased rate of disorders such as cardiovascular disease and infections.²⁵ Cigarette smoking, which is twice as common in patients with schizophrenia than in the general community,²⁶ contributes to these and other comorbidities. Many of these comorbidities remain unrecognised, with one study²⁷ showing that 53% of a sample of patients with chronic mental illness had undiagnosed medical problems, the majority of which required changes in management.

The comprehensive management of patients with complex and disabling psychotic disorders increasingly involves a collaboration between general practitioners and psychiatric service providers. The rationale, logistics and types of such collaborations were reviewed comprehensively in chapter 2.²⁸

A particular example of a shared care program is the Consultation Liaison in Primary Care Psychiatry Program (CLIPP),²⁹ which operates in north-west metropolitan Melbourne. It focuses on several features, such as providing general practitioners with contingency plans in case of changes in clinical circumstances, characterising "relapse signatures" (recognised patterns of behaviour indicating imminent psychotic relapse) to enable the early detection of relapse, and establishing ready and regular communication between area

mental health service providers and general practitioners. While much of the medical and psychiatric care of patients suffering from schizophrenia can be carried out by general practitioners, area mental health services have greater expertise in monitoring the continuity of care. They have responsibility for case registration and tracking, thereby ensuring that patients are not lost to follow-up. If psychotic patients become non-attenders or irregular attenders at appointments with their general practitioners, the linked mental health service in such programs will intervene assertively and attempt to ensure their return to regular medical care.

Pharmacological management of psychotic disorders

Antipsychotic drugs, usually as sole agents, are the preferred form of pharmacological treatment for schizophrenia, schizophreniform disorder and delusional disorder. Mood-stabilising drugs, such as lithium, carbamazepine and sodium valproate, antidepressant drugs and electroconvulsive therapy are used in the treatment of mood disorder related psychoses, sometimes in conjunction with antipsychotic drugs in the acute phase of the illness. The treatment of schizoaffective disorder often involves the concomitant use of antipsychotic drugs with mood-stabilising or antidepressant drugs, although the empirical basis for such combination therapy is far from convincing.

5 Prodromal symptoms of psychosis

- Suspiciousness
- Depression
- Anxiety
- Irritability
- Restlessness
- Change in appetite
- Sense of alteration of self, others or the outside world
- Social isolation or withdrawal
- Marked impairment in role functioning
- Markedly peculiar behaviour
- Marked impairment in personal hygiene
- Blunted, flat or inappropriate affect
- Digressive, vague or metaphoric speech
- Odd or bizarre ideation
- Unusual perceptual experiences
- Marked lack of initiative, interests or energy

Many of these symptoms are non-specific, but incipient psychosis is suggested by:

- Marked, unexplained and consistent changes in behaviour
- A pattern of increasing severity
- Clustering of symptoms
- Family history of psychosis

Case history 1: Chronic schizophrenia, with the GP as primary caregiver

A 39-year-old man had been under treatment for schizophrenia for 10 years at his local mental health clinic. His illness developed over eight months and was characterised by increasing hostility, irritability and a withdrawal from friends and family. He became implacably convinced that certain political figures and union leaders were attempting to “freeze” his thoughts and paralyse his arms and legs by directing miniature laser pointers towards him as he went about his daily business.

These delusions were soon accompanied by auditory hallucinations — mainly of aggressive men who constantly harangued him about his “inadequacies” — especially his physical appearance. Early in his illness, he resigned from his job as a printer, moved out of his flat, and saw his wife only infrequently. During the first four years of his illness he had several severe exacerbations which involved three suicide attempts and five hospitalisations. He had been treated with a variety of conventional antipsychotic medications — including high-dose haloperidol and trifluoperazine.

By the tenth year of his illness, his delusions and hallucinations, although still present, were well controlled. At this stage, his main disabilities related to his poor motivation, limited coping skills and the fact that his insight, though reasonably good, could deteriorate at times. Because of the stability of his symptoms, he was transferred from the mental health clinic to a “shared care” program in which his primary management was undertaken by a general practitioner who saw him every three to four weeks. She monitored his use of low dose haloperidol, diagnosed and managed his type II diabetes (with diet and glipizide), helped him deal with insomnia and encouraged him to retain contact with friends and community support groups.

Six-monthly psychiatric consultations provided by the local mental health clinic assisted in the early diagnosis of mild tardive dyskinesia, in the transfer of therapy from haloperidol to olanzapine and in the assessment and treatment of a secondary depressive episode for which the differential diagnosis was an exacerbation of his negative symptoms.

Schizophrenia

Three trends have characterised the use of antipsychotic drugs in schizophrenia over recent years. The first has been a decline in the doses of conventional antipsychotic medication. This is associated not only with a lower prevalence of extrapyramidal side effects, such as parkinsonism, dystonia and akathisia, but may be associated with increased efficacy.^{30,31} The use of adjunctive benzodiazepines (oral and intravenous) to treat psychoses associated with severe agitation, restlessness or aggression³² helps to ensure that the dose of high potency antipsychotic drugs (such as haloperidol or trifluoperazine) is not simply titrated upwards in an effort to gain behavioural control by this means alone. Because the high potency antipsychotic drugs, in contrast to lower potency drugs (such as chlorpromazine and thioridazine), have limited sedative properties, inappropriately high and sometimes massive doses have been used in the past. The practice of administering lower doses of antipsychotic medication has meant that there is less need to consider the concomitant use of prophylactic antiparkinsonian agents such as benztropine or benzhexol. Antiparkinsonian agents may still be needed — for example, for the first few weeks of treatment in patients who are recommencing high potency antipsychotic drugs and who suffered extrapyramidal side effects (particularly dystonia) when previously exposed to them.³³

A second trend has been to use the newer antipsychotic drugs risperidone and olanzapine in the treatment of newly diagnosed patients with schizophrenia. These drugs have a highly favourable extrapyramidal side-effect profile when used in the recommended dosage range, and demonstrate significant antagonism at both the serotonin (5-HT₂) and dopamine (D₂) receptors.³⁴ Risperidone is associated with dose-related extrapyramidal side effects when used at doses higher than the most commonly prescribed 4–6-mg range. Olanzapine (usual dose, 10–20 mg) appears to have a low liability to cause extrapyramidal side effects but may be associated with weight gain and somnolence.³⁵ Clinicians who transfer patients from conventional antipsychotic drugs to risperidone or olanzapine, on the assumption that this will eventually result in a lower incidence of tardive dyskinesia, should be aware that this extrapolation has yet to be validated.

A third trend has been the increasing use of the atypical antipsychotic drug clozapine in the management of patients with treatment-resistant schizophrenia. Clozapine has been convincingly shown to be effective in up to 50% of patients who have responded poorly or not at all to several classes of conventional antipsychotic drugs.^{34,36} It is associated with several significant side effects, including sedation, hypotension, dizziness, seizures and weight gain, as well as the very serious and unpredictable complication of agranulocytosis. In Australia the incidence of neutropenia and agranulocytosis associated with clozapine use is 2.6% and 0.9%, respectively.³⁷ Frequent mandatory white blood cell counts, together with a centralised monitoring system (the Clozaril Patient Monitoring System, based at the Mental Health Research Institute of Victoria), have contributed to the fact that, although more than 6,300 Australian patients have taken clozapine since January 1994, none has died as a result of haematological complications.

The range of injectable depot antipsychotic drugs available in Australia now includes haloperidol decanoate, flupenthixol decanoate and zuclopenthixol acetate, as well as the previous mainstay of depot treatment, fluphenazine decanoate. All are high potency. Although the administration of these drugs, usually every 2–4 weeks, reduces non-compliance rates by 15%–20%,³⁸ the decision to use them should be carefully weighed in each patient because their very long half-lives substantially constrain treatment flexibility. It is not uncommon for psychiatrists to work in

Case history 2: The evolution of bipolar disorder in a patient presenting with depression

A 29 year old female architect was referred for psychiatric assessment by her general practitioner because of a four-month history of increasing and eventually deep despair, agitation, frequent spontaneous crying spells and an inability to cope with work demands.

She was diagnosed to be suffering from a major depressive episode, for which she was treated with the selective serotonin reuptake inhibitor paroxetine, as well as supportive psychotherapy.

After four months of successful treatment, management was transferred back to her general practitioner. Within three months of this transfer, her increasing self-confidence developed into grandiose and delusional preoccupations. For example, she believed that God had recognised her unusual architectural flair to the extent that he had chosen her to design a series of multid denominational religious temples in Australian capital cities. She believed that this project would dramatically reduce inter-racial disharmony throughout the country. She resigned from her job in order to work on the project, but did not commence it because of marked distractibility, manifested in part by her superficial involvement with a large and growing list of environmental and animal welfare causes. She had many other manic symptoms, including severe pressure of speech, sleeplessness and a reckless series of purchases of artworks and period furniture.

Diagnosed to be suffering from severe bipolar disorder with psychotic features, she was admitted to a private psychiatric hospital by her psychiatrist and was commenced on lithium carbonate. Initial behavioural control was obtained with coadministered chlorpromazine. Although her delusions faded and she was less frenetic after several weeks' treatment, she remained quite disinhibited and overactive. Her treatment was subsequently changed to sodium valproate, which gave better symptom control.

Her management is mainly undertaken by her general practitioner, but she has six-monthly appointments with her psychiatrist, as well as seeing him as soon as a relapse is suspected by her GP (the patient tends to have poor insight at times of relapse). She has had two mild depressions and one hypomanic episode in the three years since her initial manic episode. These have been treated without further hospitalisation.

collaboration with GPs in relation to depot drug treatment because GPs have practices which are more procedure oriented.

Readers interested in a more detailed account of the general issues relating to antipsychotic drug strategies may wish to consult Schatzberg et al.,³⁴ the American Psychiatric Association guidelines,³⁵ or the *Psychotropic drug guidelines* of the Victorian Drug Usage Advisory Committee.³⁹

Affective and schizoaffective psychoses

Although conventional antipsychotic drugs are often used in the initial phase of psychotic mania in bipolar disorder because they rapidly control excitement, agitation, delusions and hallucinations,^{34,40} their role in the maintenance phase of the disorder is less well established. The mainstays for this phase are the mood-stabilising drugs: lithium, carbamazepine and sodium valproate.⁴¹ All appear to have similar antimanic effects, although the prophylactic value of lithium in reducing the frequency and severity of recurrent bipolar episodes has been the most convincingly demonstrated. Plasma monitoring of drug levels allows optimal dosing, although in neurological practice the value of routine monitoring of sodium valproate levels is considered unproven.⁴² All three drugs can cause nausea, rashes and weight gain. In addition, lithium may cause tremor, polyuria, polydipsia, and hypothyroidism; carbamazepine may cause agranulocytosis, aplastic anaemia, hyponatraemia and elevations in liver enzyme levels; and sodium valproate may be associated with severe hepatotoxicity, platelet dysfunction and tremor.^{34,42}

Patients with psychotic depression appear to respond better in the initial phases of illness to antidepressant drugs combined with either antipsychotic drugs or electroconvulsive therapy than to antidepressant drugs alone.⁴³ In the maintenance phases of both psychotic depression⁴³ and psychotic mania,⁴⁰ guidelines recommend that, if feasible, the dose of conventional antipsychotic drugs should be decreased and the drugs discontinued once symptomatic improvement has been achieved.⁴³ This is because these drugs may exacerbate depressive symptoms in patients with bipolar disorder,⁴⁴ and such patients may be at higher risk of tardive dyskinesia than those with schizophrenia.⁴⁵ Nevertheless, antipsychotic drugs may be useful in patients with persisting affective psychoses who are poorly responsive to standard treatment regimens, who are intolerant of mood stabilisers or antidepressants, or who are chronically non-compliant (in which case depot administration may be helpful).⁴⁰

The role of the newer antipsychotic drugs in the management of the affective psychoses has yet to be defined. Some retrospective studies have reported that patients with bipolar disorder with psychotic features or schizoaffective disorder respond better to clozapine than do patients with schizophrenia.⁴⁰ The clinical wisdom which holds that electroconvulsive therapy has a special place in the management of psychotic depression^{43,46} is supported by studies which have demonstrated that depressed patients with psychotic symptoms respond better to this form of treatment than do non-psychotic depressed patients.^{47,48}

It is difficult to provide clear guidelines for the management of schizoaffective psychosis, because so few well diagnosed patients with this condition have been studied in controlled trials.⁴⁹ Although many patients receive a combination of antipsychotic drugs and either mood stabilising or antidepressant drugs, there is limited evidence in support of the superior efficacy of lithium-antipsychotic drug combinations over antipsychotic drugs alone in schizoaffective psychosis of the manic type, and no evidence that combining antidepressants with antipsychotic drugs is superior to antipsychotic drugs alone in the treatment of depressed schizoaffective patients.⁴⁹

The patient: psychosocial and family considerations

To the maximum extent possible, all those involved in looking after patients with psychotic disorders should aim to engage them collaboratively in the treatment process. In addition to the necessary ingredients of all fruitful therapeutic relationships, such as empathy, encouragement, support, advice and counselling, psychotic patients, especially those suffering from schizophrenia, may often require sustained care, patience, tolerance of insightlessness and a realistic setting of expectations.

General practitioners are in a particularly good position to provide continuity of care and also to support, educate and counsel family members — many of whom otherwise have to cope unaided with significant stressors such as the unpredictable and socially awkward behaviour or relentless underactivity of their loved ones. Other stressors include the need for family members to sometimes arrange for involuntary hospital admissions under conditions of high tension, and concerns about the fate of adult children with schizophrenia as they, the parents, age and eventually die.

In addition to providing direct counselling, general practitioners may greatly assist patients and relatives by encouraging them to benefit from the services provided by support organisations such as the state Schizophrenia Fellowships.

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