# Key psychosocial interventions in assertive early intervention services

*Philippe Conus*

*Département de psychiatrie - CHUV*

# DISCLOSURE

I have no potential conflict of interest to report

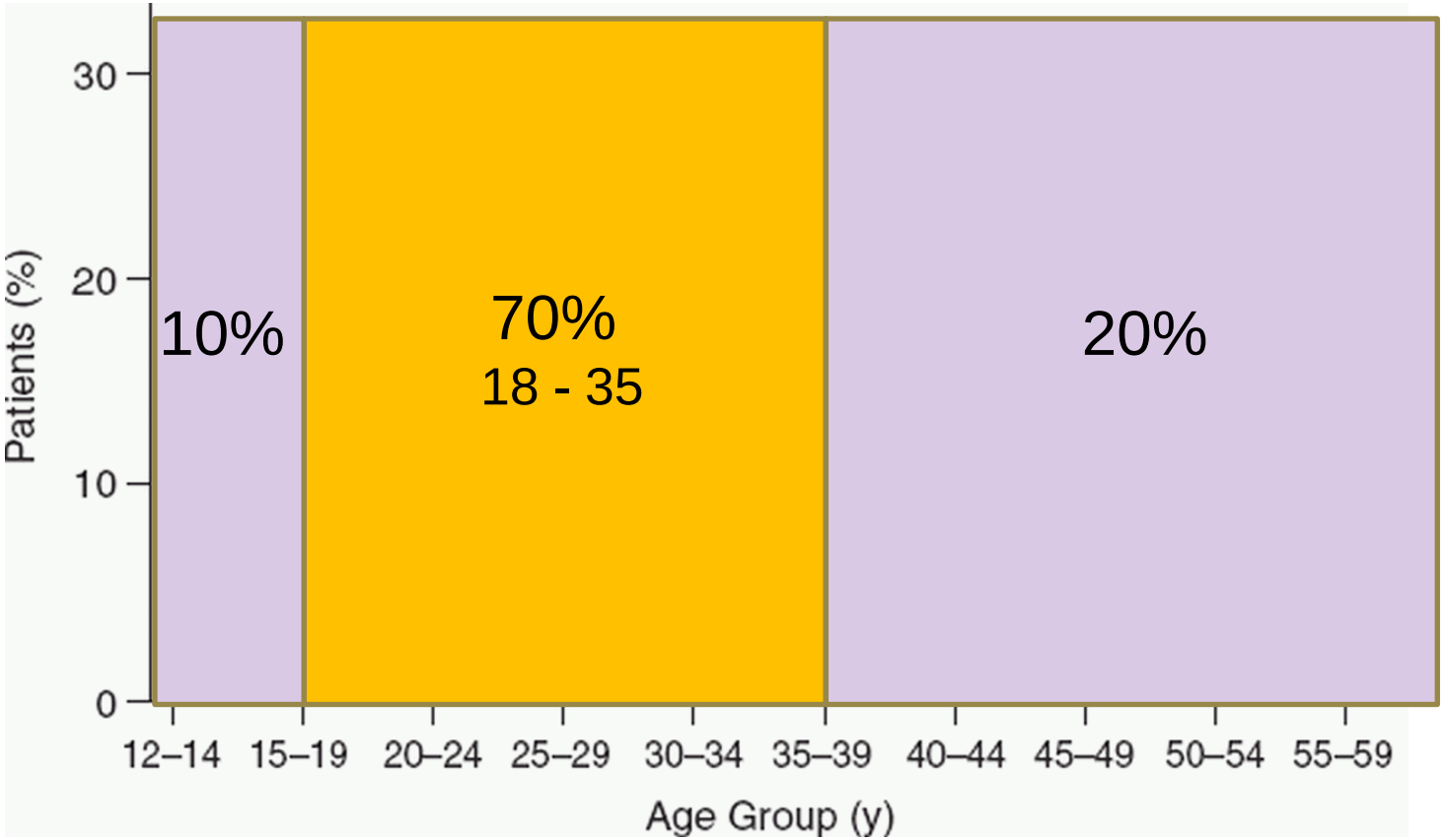
# Key psychosocial interventions in assertive early intervention services for young people

*Philippe Conus*

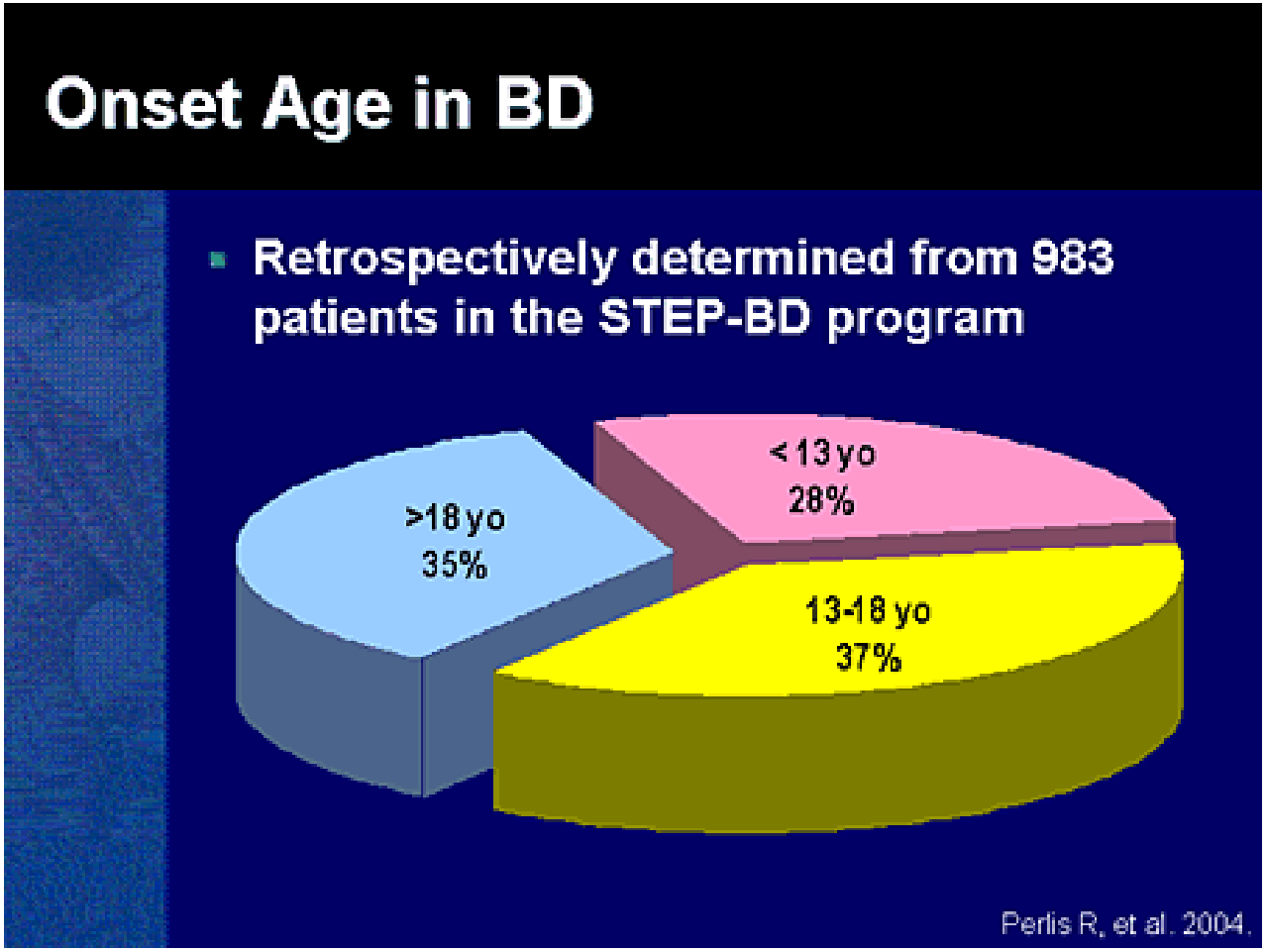
*Département de psychiatrie - CHUV*

# FIRST PSYCHOTIC EPISODE: WHAT IS THE IMPACT?

# WHEN DOES PSYCHOSIS EMERGE?



# WHEN DOES PSYCHOSIS EMERGE?



# WHEN DOES PSYCHOSIS EMERGE?

# POTENTIAL IMPACT OF FEP

*« Psychosis is often (while not always) experienced as a personal disaster with a potentially damaging mix of secondary trauma and losses.*

*The individual's self-esteem may be battered by the self stigma associated with becoming a « psychiatric patient ».*

*Furthermore, most psychotic disorders emerge during adolescence and young adulthood, threatening disruption of the person's developmental trajectory ».*

*Jackson et al, 1999*

# *ADOLESCENCE: NUMEROUS SOCIAL CHALLENGES*

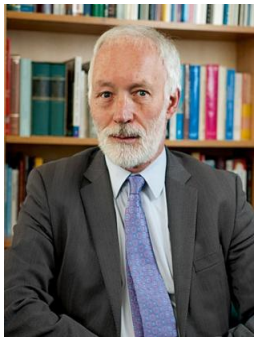
- To define one's identity
- To become independant from family while preserving links
- To establish a social network
- To develop first intimate relationships
- To complete one's education
- To choose a profession




# Additional challenges for FEP treatment

- Need for emancipation and reluctance towards authority
- Sense of invulnerability and reluctance to seek help
- Frequent use of denial as a strategy to face difficulties
- Negative stereotypes in society towards mental illness
- Limited experience with health systems
- Fear from hospitalisation
- High prevalence of substance abuse

# IMPACT OF FEP



0022-3018/91/1795-0253$03.00/0
THE JOURNAL OF NERVOUS AND MENTAL DISEASE


## Posttraumatic Stress Disorder Following Recent-Onset Psychosis

### An Unrecognized Postpsychotic Syndrome

PATRICK D. McGORRY, M.B.B.S., M.R.C.P. (U.K.), F.R.A.N.Z.C.P., ANDREW CHANEN, B.MED.SCI., ELIZABETH McCARTHY, B.MED.SCI., RAPHAEL VAN RIEL, B.A.(HONS.), DEAN McKENZIE, B.A.(HONS.), AND BRUCE S. SINGH, M.B.B.S., F.R.A.C.P., F.R.A.N.Z.C.P., PH.D.[1]

Clinical experience with psychotic patients early in the course of their illness suggested that symptoms of posttraumatic stress disorder (PTSD) may not be uncommon after recovery from an acute psychotic episode. Thirty-six patients recovering from an acute psychotic episode within 2 to 3 years of onset of their illness were assessed as inpatients and followed up on two occasions during the year after discharge. The prevalence of PTSD was found to be 46% at 4 months and 35% at 11 months, measured by a questionnaire linked to DSM-III criteria. The relationships between negative symptomatology and PTSD symptoms and between depressive symptomatology and PTSD symptoms were also examined; a significant correlation was found only for the latter. The psychopathological, preventive, and therapeutic implications of these findings are discussed, and future research strategies are proposed.

—*J Nerv Ment Dis* 179:253–258, 1991

# IMPACT OF FEP

most
patients found the experience highly stressful
and do experience
PTSD.

# TWO COMMON REACTIONS…

DENIAL

DISENGAGEMENT

# TWO COMMON REACTIONS…

DISENGAGEMENT

# THE FIRST CHALLENGE:
# TO ENGAGE PATIENTS

# Situation in Lausanne in 2000

MÉMOIRE ORIGINAL

## Insertion dans les soins après une première hospitalisation dans un secteur pour psychose

C. BONSACK [1], T. PFISTER, P. CONUS

L'Encéphale, 2006 ; *32 :* 679-85

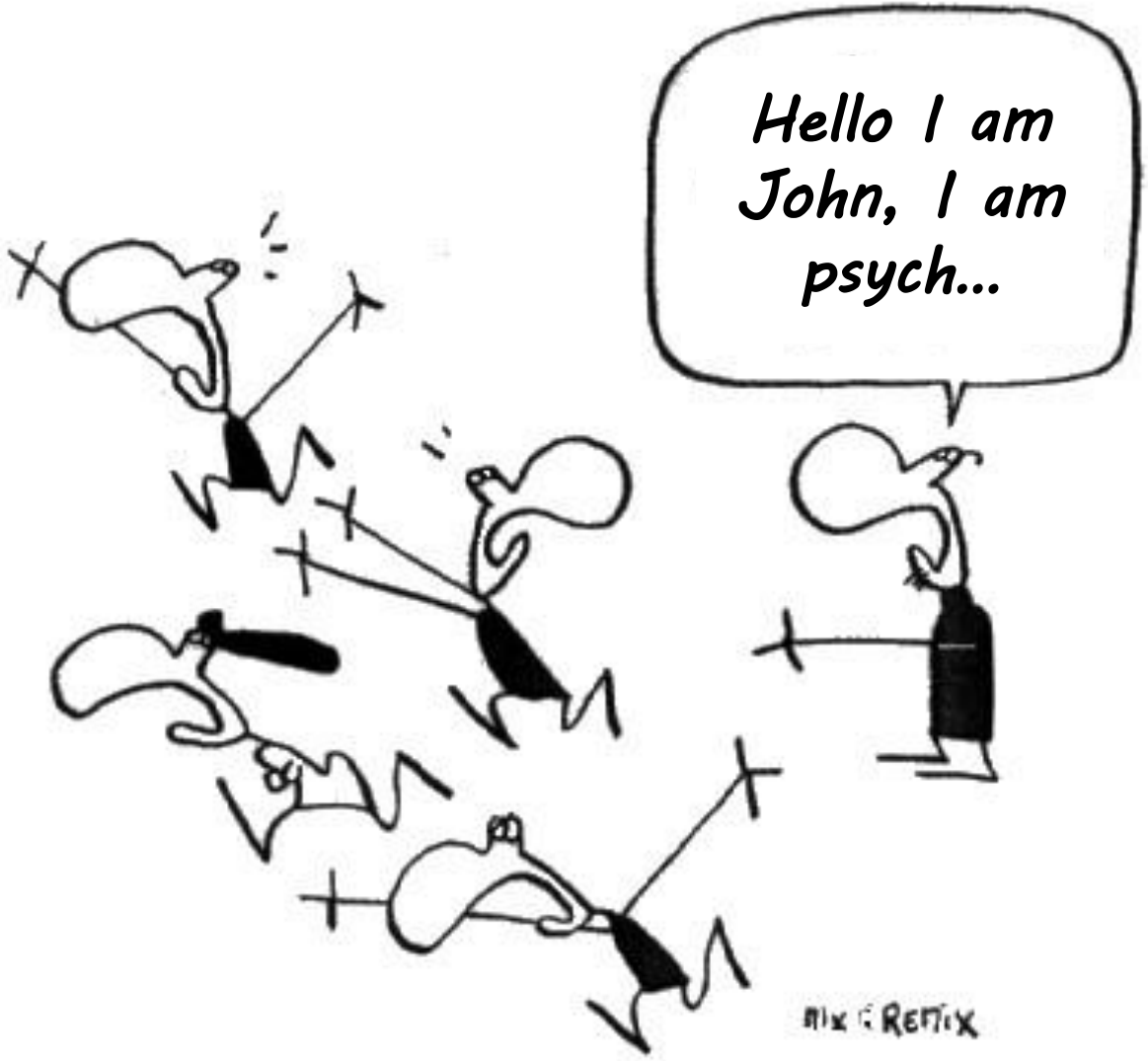
**Linkage to care after first hospitalisation for psychosis**

**Summary. Background.** *First hospitalisation for a psychotic episode causes intense distress to patients and families, but offers an opportunity to make a diagnosis and start treatment. However, linkage to outpatient psychiatric care remains a notoriously difficult step for young psychotic patients, who frequently interrupt treatment after hospitalisation. Persistence of symptoms, and untreated psychosis may therefore remain a problem despite hospitalisation and proper diagnosis. With persisting psychotic symptoms, numerous complications may arise : breakdown in relationships, loss of family and social support, loss of employment or study interruption, denial of disease, depression, suicide, substance abuse and violence. Understanding mechanisms that might promote linkage to outpatient psychiatric care is therefore a critical issue, especially in early intervention in psychotic disorders.* **Objective.** *To study which factors hinder or promote linkage of young psychotic patients to outpatient psychiatric care after a first hospitalisation, in the absence of a vertically integrated program for early psychosis.* **Method.** *File audit study of all patients aged 18 to 30 who were admitted for the first time to the psychiatric University Hospital of Lausanne in the year 2000. For statistical analysis, $\chi^2$ tests were used for categorical variables and t-test for dimensional variables ; $p < 0.05$ was considered as statistically significant.* **Results.** *230 patients aged 18 to 30 were admitted to the Lausanne University psychiatric hospital for the first time during the year 2000, 52 of them with a diagnosis of psychosis (23 %). Patients with psychosis were mostly male (83 %) when compared with non-psychosis patients (49 %). Furthermore, they had (1) 10 days longer mean duration of stay (24 vs 14 days), (2) a higher rate of compulsory admissions (53 % vs 22 %) and (3) were more often hospitalised by a psychiatrist rather than by a general practitioner (83 % vs 53 %). Other socio-demographic and clinical features at admission were similar in the two groups. Among the 52 psychotic patients, 10 did not stay in the catchment area for subsequent treatment. Among the 42 psychotic patients who remained in the catchment area after discharge, 20 (48 %) did not attend the scheduled or rescheduled outpatient appointment. None of the socio demographic characteristics were associated with attendance to outpatient appointments. On the other hand, voluntary admission and suicidal ideation before admission were significantly related to attending the initial appointment. Moreover, some elements of treatment seemed to be associated with higher likelihood to attend outpatient treatment : (1) provision of information to the patient regarding diagnosis, (2) discussion about the treatment plan between in- and outpatient staff, (3) involvement of outpatient team during hospitalisation, and (4) elaboration of concrete strategies to face basic needs, organise daily activities or education and reach for help in case of need.* **Conclusion.** *As in other studies, half of the patients admitted for a first psychotic episode failed to link to outpatient psychiatric care. Our study suggests that treatment rather than patient's characteristics play a critical role in this phenomenon. Development of a partnership and involvement of patients in the decision process, provision of good information regarding the illness, clear definition of the treatment plan, development of concrete strategies to cope with the illness and its potential complications, and involvement of the outpatient treating team already during hospitalisation, all came out as critical strategies to facilitate adherence to outpatient care. While the current rate of disengagement after admission is highly concerning, our finding are encouraging since they constitute strategies that can easily be implemented. An open approach to psychosis, the development of partnership with patients and a better coordination between inpatient*

# 52 first admission for psychosis in 2000

- Long delay between onset and first treatment (DUP)
- Development of comorbidities before access to care
  - *13% suicide attempts*
  - *50% SUD*
- Major social impact of the illness at entry *(44% unemployement at admission)*
- Traumatizing initial treatment (compulsory admission, seclusion…)
- Trauma for families before access to care
- **POOR INSERTION IN TREATMENT AFTER DISCHARGE: 50% of patients did not attend the first out-patient appointment**
- ***CONCLUSIONS***
- ***Without specific organisation and strategies, poor engagement in treatment***

# It still scares people to see a psychiatrist…



# 3 KEY ENGAGEMENT STRATEGIES

1. Changing organisation of services
2. Promoting engagement
3. Preventing disengagement

# 1. A MATTER OF ORGANISATION

TIPP : Treatment and early Intervention in Psychosis Program

Stéph

aumann

Intensive ACT

Prolonged care

Families
GP
Psychiat
Emerger
Schools

HARGE
ment
ution
psy

Disengagement: <10%

Hospital unit

# 1. A MATTER OF ORGANISATION

Psychiatry Research 239 (2016) 212–219

Contents lists available at ScienceDirect

Psychiatry Research

journal homepage: www.elsevier.com/locate/psychres

## Assertive outreach for "difficult to engage" patients: A useful tool for a subgroup of patients in specialized early psychosis intervention programs

Luis Alameda [a,b,*], Philippe Golay [b,c], Philipp Baumann [a,b], Stéphane Morandi [c], Carina Ferrari [a,b], Philippe Conus [b], Charles Bonsack [c]




# 2. PROMOTING ENGAGEMENT

INTERVENTION INSIGHTS

**The therapeutic alliance: is it necessary or sufficient to engender positive outcomes?**

**Craig A. Macneil[1], Melissa K. Hasty[1], Melanie Evans[1], Cassie Redlich[1], Michael Berk[1,2,3,4]**

Acta Neuropsychiatrica 2009: 2:95–98

# 2. PROMOTING ENGAGEMENT

- *Take time to understand the whole person rather than focus solely on psychopathology*
- *Understand the person's explanatory model*
- *Enquire about patient's previous experience of treatment*
- *Explore strengths and hopes and not only difficulties*
- *Tailor intervention to patient's stage of recovery*
- *Plan treatment on the basis of patients' priorities*
- *Encourage realistic hopes and optimism*
- *Be prepared for ruptures which can be a fertile ground*
- *Engagement is an ongoing process: it takes time and perseverance*
- *Let patients matter to you*

# 2. PROMOTING ENGAGEMENT

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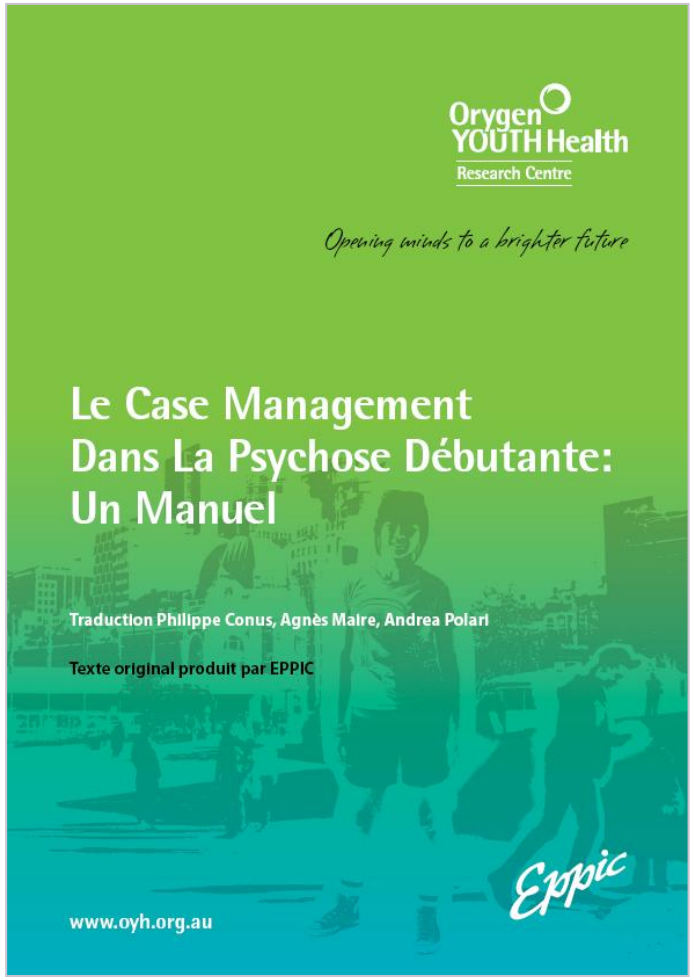


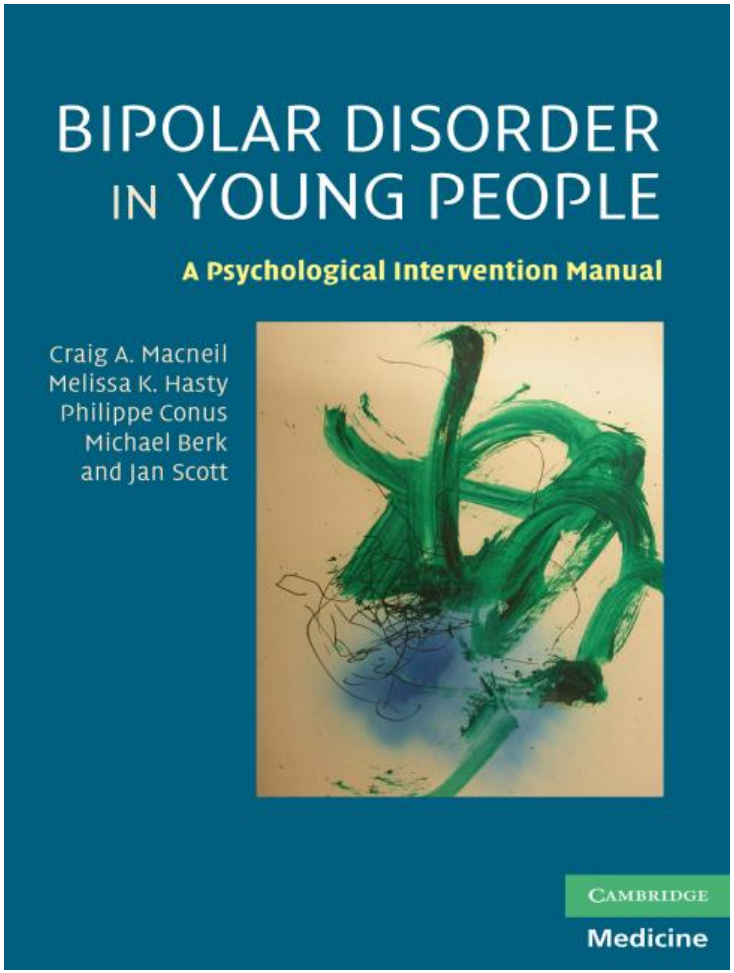

# 3. PREVENTING DISENGAGEMENT

Schizophrenia Research 118 (2010) 256–263

Contents lists available at ScienceDirect

Schizophrenia Research

journal homepage: www.elsevier.com/locate/schres

## Rate and predictors of service disengagement in an epidemiological first-episode psychosis cohort

Philippe Conus [a,b,*], Martin Lambert [c], Sue Cotton [b], Charles Bonsack [a], Patrick D. McGorry [b], Benno G. Schimmelmann [d]

[a] Treatment and Early Intervention in Psychosis Program (TIPP), Département Universitaire de Psychiatrie Adulte, Université de Lausanne, Clinique de Cery, Switzerland
[b] Orygen Youth Health and Research Centre, Centre for Youth Mental Health, University of Melbourne, Melbourne, Australia
[c] Psychosis Early Detection and Intervention Centre (PEDIC), Centre for Psychosocial Medicine, Department for Psychiatry and Psychotherapy, University Medical Centre Hamburg-Eppendorf, Germany
[d] Child and Adolescent Psychiatry, University of Bern, Switzerland

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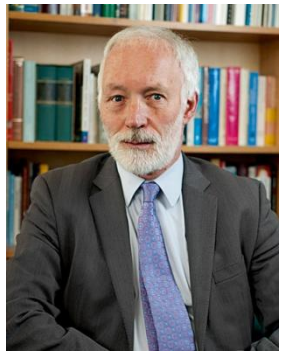
ABSTRACT

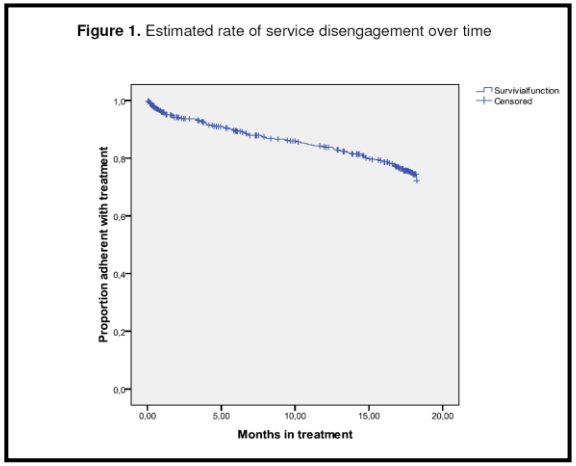
*Objectives:* To assess the prevalence and predictors of service disengagement in a treated epidemiological cohort of first-episode psychosis (FEP) patients.
*Methods:* The Early Psychosis Prevention and Intervention Centre (EPPIC) in Australia admitted 786 FEP patients from January 1998 to December 2000. Treatment at EPPIC is scheduled for 18 months. Data were collected from patients' files using a standardized questionnaire. Seven hundred four files were available; 44 were excluded, because of a non-psychotic diagnosis at endpoint ($n=43$) or missing data on service disengagement ($n=1$). Rate of service disengagement was the outcome of interest, as well as pre-treatment, baseline, and treatment predictors of service disengagement, which were examined via Cox proportional hazards models.
*Results:* 154 patients (23.3%) disengaged from service. A past forensic history (Hazard ratio [HR] = 1.69; 95%CI 1.17–2.45), lower severity of illness at baseline (HR = 0.59; 95%CI 0.48–0.72), living without family at discharge (HR = 1.75; 95%CI 1.22–2.50) and persistence of substance use disorder during treatment (HR = 2.30; 95%CI 1.45–3.66) were significant predictors of disengagement from service.
*Conclusions:* While engagement strategies are a core element in the treatment of first-episode psychosis, particular attention should be paid to these factors associated with disengagement. Involvement of the family in the treatment process, and focusing on reduction of substance use, need to be pursued in early intervention services.





# 3. PREVENTING DISENGAGEMENT

- **Context:** Disengagement rate in early psychosis:
  - *Standard care: 17 – 60%*
  - *Specialised first episode pychosis programs: 18 – 25%*
- **Aims:** Identification of predictive factors to diesengagement in an epidemiological cohort of 704 patients with first episode psychosis treated at EPPIC between 1998 and 2000




- *DISENGAGEMENT PREVALENCE over 18 months:* ***23%***
- *PREDICTIVE FACTORS (Cox regression)*
  - ➢ *Past forensic history (HR = 1.7)*
  - ➢ *Baseline CGI (HR = 0.6)*
  - ➢ *No contact with family (HR = 1.7)*
  - ➢ *Persistance of Substance abuse (HR= 2.3)*

# 3. PREVENTING DISENGAGEMENT

## WORKING WITH FAMILIES

- MULTIFAMILY GROUP SESSIONS ON EARLY PSYCHOSIS
  - 4 sessions
  - Families of patients recently invovled in the program
  - Focus on « early psychosis »
- INVOVLEMENT OF FAMILIES WITHIN THE TREATMENT
  - Assessment and interviews
  - Systemic approach
- THE TRIANGLE
  - Multi-disciplinary sessions: patients – relatives – mental health worker

# 3. PREVENTING DISENGAGEMENT

***SUBSTANCE ABUSE: SOME BASIC ELEMENTS OF TREATMENT***

- *A brief intervention is better than no intervention at all*
- *Treatment must be adapted to motivational stage*
- *Harm minimisation is often more realistic than abstinence*
- *A first psychotic episode is a strong motivational factor for change: do not miss this window of oportunity*
- *Favour motivational intervention*

# 3. PREVENTING DISENGAGEMENT

**Regular Article**

Psychotherapy and Psychosomatics

Psychother Psychosom 323466
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Published online: ■■■

## Motivational Intervention to Reduce Cannabis Use in Young People with Psychosis: A Randomized Controlled Trial

Charles Bonsack Silvia Gibellini Manetti Jerôme Favrod Yves Montagrin
Jacques Besson Pierre Bovet Philippe Conus

Department of Psychiatry, CHUV, Lausanne, Switzerland

Jérôme Favrod

# 3. PREVENTING DISENGAGEMENT





## Psychose, cannabis et groupes motivationnels

**En s'appuyant sur les acquis démontrés de l'entretien motivationnel individuel chez les patients psychotiques consommateurs de cannabis, une équipe suisse a complété leur prise en charge individuelle par des groupes motivationnels. Le format de ces groupes mobilise davantage ces patients et favorise notamment une mise en scène de la balance décisionnelle.**

Plusieurs études montrent que les personnes présentant un premier épisode de psychose consomment davantage de substances toxiques que la population générale, le cannabis étant la drogue la plus populaire (1, 2, 3). Les patients atteints de schizophrénie y recourent également plus fréquemment que ceux souffrant d'autres troubles psychiatriques, avec une prévalence moyenne de 40 %, les variations allant de 13 à 69 %, selon les études (4). Une méta-analyse récente indique par ailleurs que le taux médian d'usage de cette substance est plus élevé lors des premiers épisodes de schizophrénie qu'au long cours (5). En général, la consommation de cannabis est plus importante chez les hommes et chez les jeunes et elle est associée de façon constante à un risque de rechute et de non-adhérence aux traitements (6). Les interventions pour réduire cette consommation sont donc une piste prioritaire de recherche clinique. Deux études indiquent cependant que les patients qui ont diminué leur consommation lors d'un premier épisode psychotique peuvent avoir un meilleur pronostic d'évolution dans la maladie que ceux qui n'ont jamais abusé de substances (7, 8). L'explication tient probablement au fait qu'ils appartiennent à un sous-groupe de patients présentant un bon fonctionnement pré-morbide qui facilite l'accès au cannabis via leur réseau social. Reste que la consommation de cannabis aggrave la psychose (9). Dans ce contexte, on sait aujourd'hui que l'entretien motivationnel (EM) permet de réduire la consommation de substances chez les personnes souffrant de troubles psychiatriques, en comparaison du traitement usuel, et notamment pour l'alcool. Toutefois, il serait moins efficace pour le cannabis (10). Un inventaire récent des publications (41 études contrôlées avec des personnes atteintes de schizophrénie simultanément à un abus de substances) montre ainsi que les interventions psychosociales comme l'EM ou les thérapies cognitives et comportementales (TCC) sont opérantes sur l'ensemble des substances mais toutefois peu efficaces sur le cannabis (dans onze études ciblées uniquement) (11).

Plus récemment, deux nouvelles études ont été publiées. La première, multicentrique et britannique, qui examine les effets d'une intervention intégrant l'EM et la thérapie cognitive (12) ne note pas d'amélioration en termes d'hospitalisation, de fonctionnement ou de symptômes mais constate la réduction de la quantité de cannabis consommée, au moins un an après la fin de l'intervention. Une autre étude, conduite à Lausanne, évalue l'impact d'une proposition motivationnelle brève sur la consommation de cannabis de patients souffrant de psychose (13). L'intervention met en évidence une réduction de la consommation de cannabis à court terme lorsqu'elle s'ajoute aux soins habituels. Néanmoins, l'effet ne se maintient pas dans les six mois qui suivent la fin de l'intervention.

Selon nos connaissances, l'EM reste le meilleur outil pour réduire à court terme la consommation de cannabis mais il faut développer par ailleurs des interventions plus efficaces.

### L'ENTRETIEN MOTIVATIONNEL

Rappelons brièvement que l'EM est une intervention spécifique basée sur la collaboration et centrée sur la personne, avec pour objectif d'engendrer et de renforcer la motivation à changer (14). Développé à partir de l'approche centrée sur la personne de Carl Rogers (voir l'article de T. Le Mardy p. 42), il est volontairement orienté vers l'objectif de conduire au changement, d'explorer et de résoudre l'ambivalence. L'écoute réflective est un élément central de l'EM mais elle est utilisée pour guider la personne à résoudre l'ambivalence autour du changement de comportement. Le professionnel qui applique l'EM écoute la personne en utilisant des stratégies qui suscitent son propre désir de changer. Durant la séance, le soignant cherche à renforcer le patient dans l'expression de sa motivation pour la modification comportementale visée. L'effet thérapeutique de l'EM paraît lié à trois facteurs : l'expérience interne de contradiction vécue par le patient, son expression de l'intention de changer et le recours par le

Jérôme FAVROD* [a, b], Silvia GIBELLINI MANETTI** [b], Sara CRESPI* [b], Shyhrete REXHAJ* [a,b], Philippe CONUS*** [c], Charles BONSACK*** [a]

* Infirmier, ** Psychologue, *** Psychiatre
a) Service de psychiatrie communautaire, Département de psychiatrie, Centre hospitalier universitaire vaudois, Site de Cery, Prilly.
b) Ecole La Source, Haute école spécialisée de Suisse occidentale, Lausanne.
c) Service de psychiatrie générale, Département de psychiatrie, Centre hospitalier universitaire vaudois, Site de Cery, Prilly.

# TWO COMMON REACTIONS…

DISENGAGEMENT

DENIAL

# TWO COMMON REACTIONS…

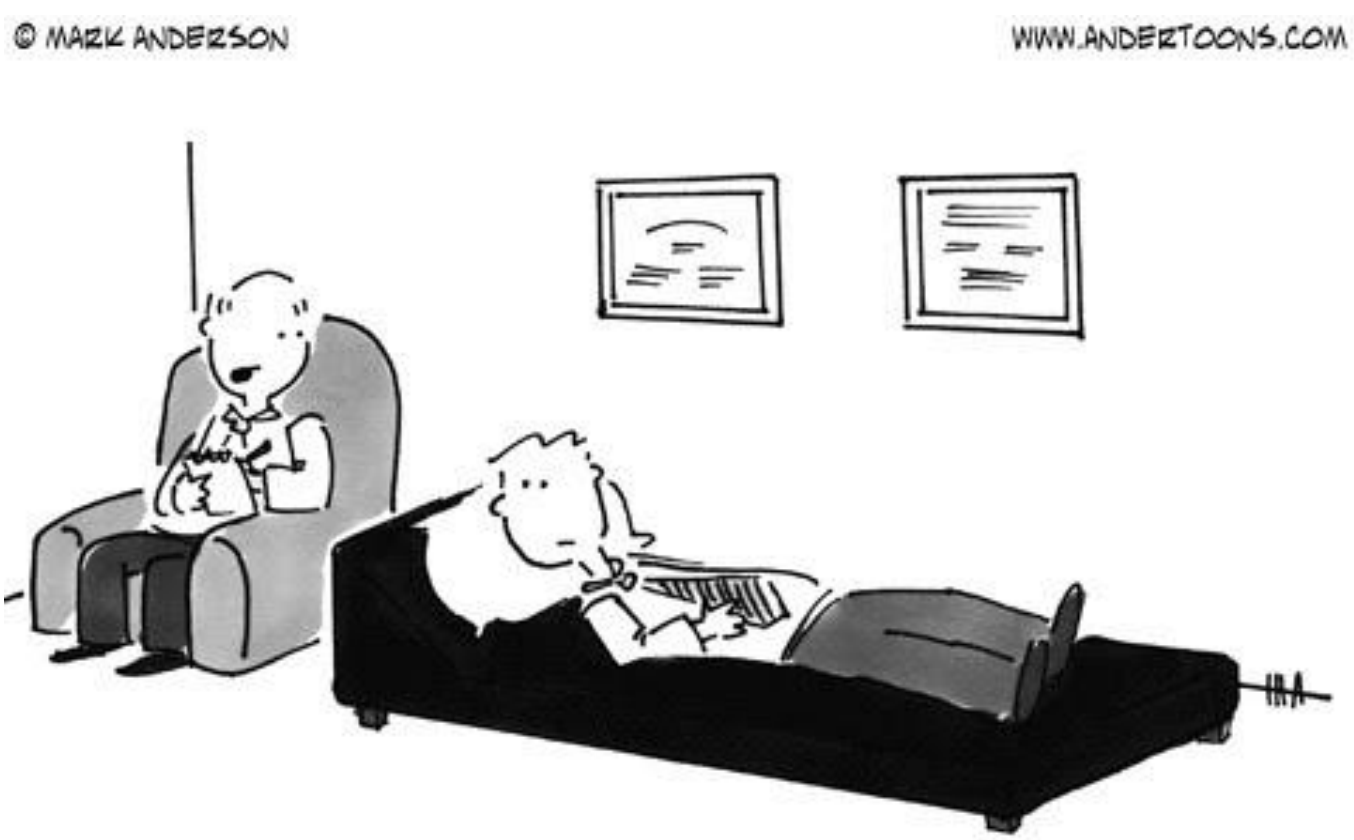
DENIAL

# THE SECOND CHALLENGE: TO PROMOTE INSIGHT (A THERAPEUTIC STRATEGY)

# INSIGHT

- One heritage from psychoanalysis
- «**Moment of clear, deep and sometimes sudden understanding of a complicated problem or situation** »
- In order for it to induce a beneficial impact, insight must go along with some degree of **elaboration**
- This suggests and **active role from the patient** rather than paternalistic explanation or « education »
- **There is no short cut…**

# INSIGHT




"What do you say we blame your parents and knock off early?"

# INSIGHT AND PSYCHOSIS

- In the field of psychosis, frequent reduction of the concept:
  - *Insight: accepting the status of an ill person who needs treatment because of symptoms*
  - *Insight is present if the patient aggrees with psychiatrist's explanatory model…*
- Frequently considered simply as « present » or « absent » (and sometimes « partially present »)
- Contemporary conceptualisation
  - Insight is multidimensional
  - Various degrees of insight regarding each of these dimensions

# POSITIVE IMPACT OF INSIGHT

- Facilitates therapeutic relationship
- Allows better relationship with family
- Reduces risk to act on delusional ideation
- Impact on adherence to medication  treatment
  - Moderate correlation
  - Adherence is also possible in the absence of insight
- Impact on outcome:
  - Patients with insight have a better symptomatic and functional outcome *(Thompson 2003, …)*

# POSSIBLE NEGATIVE IMPACT OF INSIGHT

- Insight can sometimes aggravate the situation: « adding insight to injury »
- Risk of self stigmatisation
- Risk of identification to the role of a chronic patient
- *« Patients with insight can suffer from the presence of this knowledge of their disorder and hence present a higher degree of distress »* *Roback 1979*
- Post psychotic depression *McGlashan 1979*
  - *Observed in 25% of patients after an acute phase of psychosis*
  - *Is significantly linked to the presence of insight*
  - *Is more frequent in patients who develop a processus of intergration of the episode than in patients who are in denial*

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ORIGINAL ARTICLE

# Insight as a social identity process in the evolution of psychosocial functioning in the early phase of psychosis

H. S. Klaas[1]*, A. Clémence[2], R. Marion-Veyron[3], J.-P. Antonietti[2], L. Alameda[3], P. Golay[3] and P. Conus[3]

[1] *Swiss National Centre of Competence in Research LIVES, Life Course and Inequality Research Centre (LINES), Faculty of Social and Political Sciences, University of Lausanne, Switzerland*
[2] *Psychology Institute, Faculty of Social and Political Sciences, University of Lausanne, Lausanne, Switzerland*
[3] *Treatment and Early Intervention in Psychosis Program (TIPP), Service of General Psychiatry, Département de Psychiatrie Centre Hospitalier Universitaire Vaudois (CHUV), Université de Lausanne, Clinique de Cery, 1008 Prilly, Switzerland*

**Background.** Awareness of illness (insight) has been found to have contradictory effects for different functional outcomes after the early course of psychosis. Whereas it is related to psychotic symptom reduction and medication adherence, it is also associated with increased depressive symptoms. In this line, the specific effects of insight on the evolution of functioning over time have not been identified, and social indicators, such as socio-occupational functioning have barely been considered. Drawing from social identity theory we investigated the impact of insight on the development of psychosocial outcomes and the interactions of these variables over time.

**Method.** The participants, 240 patients in early phase of psychosis from the Treatment and Early Intervention in Psychosis Program (TIPP) of the University Hospital of Lausanne, Switzerland, were assessed at eight time points over 3 years. Cross-lagged panel analyses and multilevel analyses were conducted on socio-occupational and general




- In the early phase of treatment, insight is linked to depressive symptoms
- These depressive symptoms decrease over time
- After 12 months in treatment, presence of insight is linked to better functioning , better quality of life and higher degree of self esteem

- **This positive impact seems to be linked to the development of a new and integrated social identity**

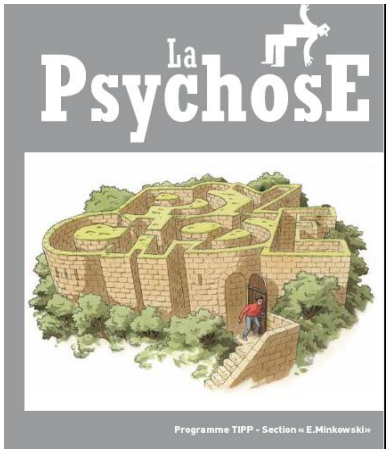
# Therapeutic approach to deficit of insight

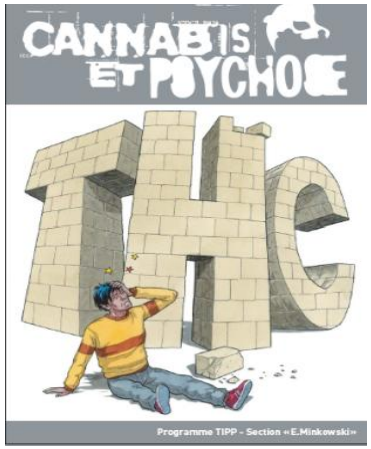
# BASIC PRINCIPLES

- Listen to the patient
- Define objectives that suit them
- Do not directly question denial
- Explore and try to understand the possible meaning of delusions
- Identify crisis factors
- Listen to their conception of what is happening
- Propose alternative  conceptions to explain crisis
- Be felxible
- Accept partial insight…
- Accept variations in degree of insight along time

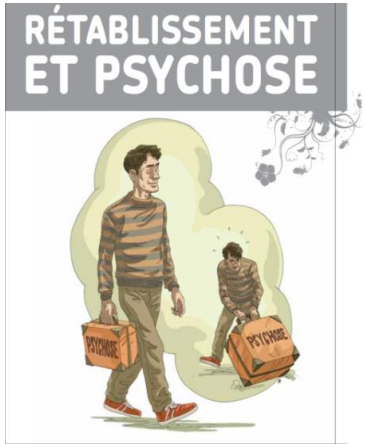
**Development of insight is an interactive process of construction of an understanding of oneself**

# INFORM ABOUT THE ILLNESS









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# PICTURES & PROSE

## A psychoeducation tool for patients with first-episode psychosis

PICTURES & PROSE

patients should also meet these different challenges.

**A psychoeducation tool for patients with FEP**

In this article, we present a four sessions' psychoeducational programme used in a hospital unit specialised in the acute treatment of FEP patients. The programme is currently composed of four modules: (a) psychotic symptoms, (b) cannabis and psychosis, (c) psychosis and medication and (d) psychosis and recovery. Each module includes a folder containing 9–11 cards. Each card contains a statement title illustrating a theme considered important for psychoeducation, a vignette related to this theme and is illustrated by a cartoon. Examples of cards are to be seen below:

Psychosis is not the end of the world



Suzanne just learned she has a psychotic disorder. She reminisces about 'One Flew over the Cuckoo's Nest' and thinks she will end up like a vegetable. She is terrified because not so long ago, just before she became sick, she had a lot of projects for her future.

The term 'psychotic' is a word that is often been misconstrued from its original meaning by the media. They use it in every way to designate fear, erratic behaviour, dangerousness or phenomena that are beyond belief. Terms stemming from psychiatry have often become part of everyday vocabulary while losing their medical meaning.

Its true that in the past, the treatment of psychotic disorders included medication that knocked the patients out or gave them a rigid demeanour, along with electroshock therapy or confinement. Nowadays, the medications have become much more specific and are prescribed in small dosage. From a neurological standpoint, they have very few to no side effects. Electroshock therapy is very seldom used and once the acute episode is under control, the treatment is ambulatory.

The reduction of risk factors, the monitoring of a preventive medication treatment and the acquisition of competences in disorder management allow to reduce the risk of a relapse and to actively work towards resuming life projects. About 85% of the patients will not experience psychotic symptoms after 6 months of treatment. One third of the patients fully recover. We also know that the chances of recovery increase if the patients and their therapeutic team manage to develop a cooperative relationship.

Its my soul that's hurting, not my molecules!!



Martin is not feeling well, he hears scary voices, he is sad and he has been suffering for several weeks. Yet, when the doctor suggests medication, he refuses and says:

'... I'm not feeling well, I'm sad, but it's not a chemical thing, it's feelings. It's my soul that's hurting, not my molecules!'

For quite a while, psychiatrists had a hard time agreeing:

1 Some were saying that psychosis was a psychological problem based on life's incidents, going through hardships and that the way to solve the problem was through psychotherapy.
2 Others were saying that psychosis is a brain disease, a matter of biology and that medication was the best way to deal with it.

We now know that its actually a little bit of both. The disease often manifests itself in the context of trying events in life, but biology also plays a part. The overwhelming majority of caregivers agree on the fact that the two kinds of treatments must be combined: medication and psychotherapy.

When dealing with psychosis, the recovery of a person's balance relies on several pillars: the patient's resources, the support of caregivers, friends and relatives, communication, psychotherapy and medication. Once that balance has been re-established, and the patients' resources are solid again, the other pillars can then be gradually removed; the person gets out of the hospital, they do not need as much help from caregivers and medication can be gradually decreased, if not terminated.

A good spliff is relaxing




The effects of cannabis vary not only from one person to the next, depending on the quantity used, but also on the context of this use. Consumers look for the relaxing or stimulating effects of Tetrahydrocannabinol (THC). But they do not always obtain these effects. Dependence to the product decreases these effects and increases the negative consequences. Think of the effects of your very first joints. How many do you need now to have the same reaction?

Cannabis makes psychosis worse by increasing strange voices and ideas. It seriously decreases the ability to focus on people suffering from this disorder and it reduces their motivation. These adverse effects increase social exclusion, which causes significant stress to the user.

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**Jérôme Favrod[1,2,3], Sara Crespi[1,3], Jean-Marc Faust[1,3], Andrea Polari[4], Charles Bonsack[3], Philippe Conus[1,3]**

[1]Treatment and Early Intervention in Psychosis Program (TIPP), Département de Psychiatrie CHUV, Université de Lausanne, Clinique de Cery, Prilly, Switzerland;

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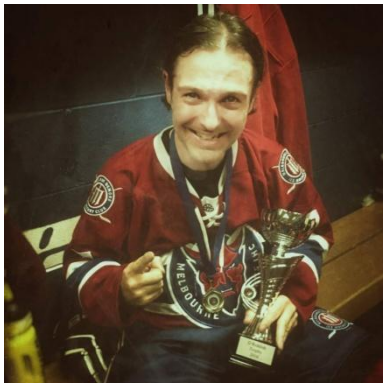

# MANY OTHER ELEMENTS OF TREATMENT

- Medication
- Psychotherapy
- Supported employment
- Promotion of physical health
- …

# CONCLUSION

- A first episode of psychosis may have a major impact on patients' lives
- Disengagement and denial are common reactions
  - **Engagement** can be promoted through
    - *Service organisation (assertive case management)*
    - *Specific engagement approach*
    - *Prevention of disengagement (treating SUD and involving families)*
  - **Development of insight** is a therapeutic process
- Once patients are engaged, many other strategies are available to promote recovery
- **Reorganisation of standard mental health services, specialized treatment programs and specific training should be provided considering their impact on these issues**

Thank you for your attention!