International Journal of Healthcare Sciences ISSN 2348-5728 (Online)
Vol. 6, Issue 1, pp: (176-181), Month: April - September 2018, Available at: www.researchpublish.com

REVIEW OF DIAGNOSIS AND THERAPEUTIC OPTIONS OF FIRST EPISODE PSYCHOSIS

[1]Nasser Awadh Saeed Alshehri, [2]Tariq Hameed R Alotaibi, [3]Sami M Althobaiti, [4]Huda D Alsaadi, [5]Ahmed Awadh Saeed Alshehri, [6]Haseah Fahad Albasam

Abstract: **This paper reviews the diagnosis of first-episode psychosis and treatment options. A search of electronic databases conducted in May 2018 identified relevant studies concerning, and discussion of psychotic, diagnosis and treatment. First-episode psychosis typically causes confusion, depression, and fear in sufferers who are usually likewise trying to manage the uncertainties of adolescence. Patients can endure isolation through the disruption of social networks and the difficulties of disturbing behaviour. They are at higher risk of harm, both physical and psychological. The families and carers of these young people can deal with confusion, fear, and unpredictability as they handle the loss of relationships as they recognized them, in addition to the physical, psychological, and financial concern of care. Early treatment can possibly make a distinction to the course and severity of a person's disease. It could definitely make a distinction to the distress that patients and those close to them experience. With hold-ups in treatment of approximately 2 years after psychotic symptoms present, medical care specialists should be extra vigilant in properly assessing symptoms, and either starting therapy, or referring patients to specialist services.**

1. INTRODUCTION

First-episode psychosis (FEP), the first discussion of psychotic symptoms, normally happens in adolescence, a time of great modification and upheaval [1].The effect on the patient ('the patient') and their family members and carers could be enormous, with patients frequently confused, afraid, clinically depressed, socially separated, and ruined by the disruption to their lives and objectives [2].Patients commonly experience injury from their troubling symptoms, from therapy itself, and have enhanced physical and psychological risks, including that of suicide [3].Family and carers usually endure distress, fear, and confusion to the patient's irregular and typically aggressive behaviour, while holding the physical and emotional worry of care, and taking care of the stigma and guilt connected with mental disease [4].

Very early treatment in FEP is essential in minimizing the distress and anxiousness associated with psychotic signs, along with reducing the danger of suicide [5].The delays in getting therapy could be either the failing of individuals to look for help, or the failure of health professionals to recognize psychotic symptoms [6].Both health-care experts and the community should be educated in early detection of signs, suitable avenues of reference, and to support individuals in accessing this aid [7].

The nurse's duty is to reduce suffering, aid recuperation, and reduce the threat of relapse. They do this via the restorative relationship, and make use of the abilities of assessment and threat recognition in order to maximize patient end results [8]. Nurses take care of the symptoms and concerns of psychotic ailment in teens, including family members' treatments, education, and drug management [8] prepare patients to then re-enter their own atmosphere with skills and understanding, and objective to minimize the threat of relapse [9].

This paper review the diagnosis of first-episode psychosis and treatment options.

2. METHODOLOGY

A search of electronic databases conducted in May 2018 identified relevant studies concerning, and discussion of psychotic, diagnosis and treatment. We then searched the references lists of identified studies for more relevant articles. We limited our search to only English published articles with human subjects.

3. DISCUSSION

- **Validity of the psychiatric diagnosis**

The validity of an assessment instrument could be defined as its capacity to measure exactly what it is meant to measure. Anticipating validity could be statistically analyzed via procedures such as sensitivity (percentage of properly determined favorable situations), specificity (proportion of correctly recognized negative cases), positive anticipating value (chance that instances determined as positive are certainly positive), and negative predictive worth (probability that situations identified as negative are indeed negative). The medical diagnosis thought about as true or extra reliable is established as the "gold criterion". Figure 1 defines the evaluation of predictive validity.

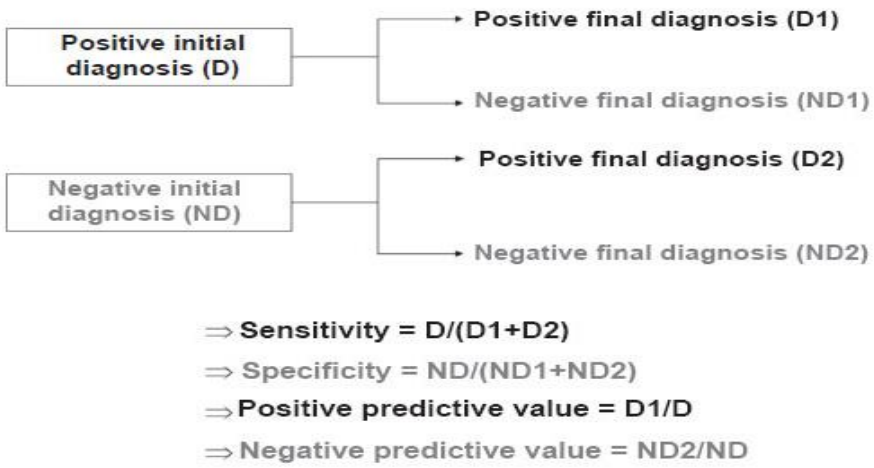

Figure 1. Methods used to assess the predictive validity of psychiatric diagnosis

The stability of the medical diagnosis has been recommended as a criterion contributing to its validity, given that the much more secure a medical diagnosis is, the more it will continually show an underlying psychopathological or physiopathological procedure [11], [13].

Security describes the percentage of diagnoses that continue to be the same in time according to several, succeeding evaluations. For a diagnosis to be stable, it has to be reliable in the first place. Nevertheless, security is not merely a function of diagnosis integrity, yet it is additionally reliant on numerous various other variables. The very first of these aspects refers to those qualities that are inherent to the mental illness itself, which might have signs and symptom variants along its program. Furthermore, unique info could show up over the longitudinal follow-up causing a reformulation of the initial diagnosis [11],[12].Conversely, technical artefacts in the analysis procedure, such as variability in info resources, poor or lacking use reliable diagnostic classification systems and standardized diagnostic tools, and lack of expert experience all might lead to blunders in the first medical diagnosis [13]

Current diagnostic classification systems in psychiatry, containing the DSM, published by the American Psychiatric Association [10], and of Section 5 of the International Classification of Diseases (ICD-10), published by the World Health Organization [14], have considerably contributed to boost the security of the psychiatric medical diagnosis executed throughout a first psychotic episode or in the initial psychiatric hospitalization. As a whole, the medical diagnoses of schizophrenia and mood disorders -especially bipolar affective disorder - done according to both classification systems for patients in an initial psychotic episode confirmed to have ample favorable anticipating values [11],[12],[15]-[18].Conversely, the medical diagnoses of short psychotic problem, schizophreniform problem (included only in the DSM), and schizoaffective problem seem to have reduced anticipating values [12], [16], [18].

A lately published research study [19] examined the stability of diagnoses carried out over 2 years with use of the SCID by skilled specialists in an example of 500 patients in their initial psychotic episode. The medical diagnosis of bipolar disorder was one of the most durable, maintained in 96.5% of the situations, adhered to by the diagnosis of schizophrenia (75%), delusional condition (72.7%), major depression with psychotic symptoms (70.1%), and short psychotic condition (61.1%). Diagnoses of schizophreniform disorder had a reduced positive anticipating value, preserved in just 10.5% of the patients.

Schizophreniform problem is a diagnostic category suggested only in the DSM-IV and characterized by the existence of misconceptions, hallucinations, unfavorable symptoms, essential thought lack of organization, and disorganized or comatose actions, just like the criteria proposed for the medical diagnosis of schizophrenia besides the duration, which need to lie in between one and 6 months [10].Earlier outcomes have questioned the clinical efficiency of the diagnosis of schizophreniform disorder due to its high migration to a diagnosis of schizophrenia [20].Only quarter of instances detected with schizophreniform disorder in the initial assessment had their medical diagnosis maintained after six months [21], and around one-third had their medical diagnosis transformed to state of mind problems after 6 years of subsequent [22].Other research studies suggest that the regression rate in patients with a diagnosis of schizophreniform disorder is high, leading to the relocation of patients to the schizophrenia analysis group [23], [24].

Brief psychotic problem is specified by the presence of the signs formerly defined for the diagnosis of schizophrenia or schizophreniform problem, but lasting for no more compared to one month and with complete remission and return to pre-morbid functioning levels [10].The validity of this diagnostic category is additionally limited. After one year of follow-up, the preliminary diagnosis was transformed in half of the situations, most often to mood problems (28%) and schizophrenia (15%) [25].The medical diagnosis of acute polymorphic psychotic problem, recommended in the ICD-10, is likewise identified by the abrupt onset of psychotic signs lasting in between 2 and 30 days and presented somewhat better security levels, with around 75% of patients maintaining the same medical diagnosis after a three-year follow-up period. A lot of instances moved to a new category obtained a medical diagnosis of state of mind condition [26].

- **Treatment**

Early intervention

Early intervention in FEP consists of the very early discovery of psychotic symptoms, lowering the time prior to very first treatment, and ongoing treatments in the 3-- 5 years after onset. As shown previously, very early treatment potentially could lead to better clinical end results and can additionally decrease the impacts of anxiety, complication, and distress of both family and patient [2].The nurse's duty, for that reason, as with other wellness experts, is to assist in early intervention through acknowledgment of symptoms and recurring analysis [27].Nurses could often be the very first factor of contact for a patient displaying prodromal or psychotic signs and symptoms, and they should identify them any place they take place [27].

Assessment and risk reduction

Nurses additionally should be entailed with physical, psychological health and danger assessment, as these variables all influence clinical results. Physical assessment consists of comorbid elements, such as various other diseases and material usage, and the sideeffects of antipsychotic drug [28] Side-effects could include extrapyramidal, anticholinergic, and various other autonomic signs. It is vital for nurses to analyze patients for these signs and symptoms, and to help patients in their drug management [29].Psychological health evaluation consists of symptoms, characteristics, and mental state, as well as the psychosocial factors appropriate to the patient [8].Registered nurses help to develop baseline data for a patient, as well as being included in the recurring analysis of patients. This will include talking with both patients and their family members [28].As discussed earlier, a patient suffering from FEP is at higher risk of injury to themselves and others. The nurse is liable, with other participants of the therapy group, to recognize the nature and level of a patient's self-destruction risk, danger to others, and threat to themselves, and to plan interventions that reduce that danger, as an example, assisting to swiftly reduce psychotic signs and symptoms [30]

A nurse has to also assess for substance use/abuse, as SUD could lead to poorer therapy feedback, can be connected to bad drug compliance, has physical health risks such as cancer, and could boost the risk of suicide [31].Research study has additionally revealed that compound misuse has been connected with aggressiveness and violence to others [33].Nurses have to be associated with evaluation important abuse, as well as education and learning and treatments that could lower the problem, or the threats related to it [31].In order to combat the increased danger of pregnancy, sexually transferred

infections, and HIV, the nurse requires to be associated with examining patient's threat and giving education [32].Shield et al. [32] stress and anxiety the value of behavioral education amongst patients suffering from psychosis, in addition to providing access to additional assistance groups.

Therapeutic relationship

The healing relationship, the basis of care in psychological health nursing, need to be constructed on good rapport, trust, genuineness, and patient-centred goals if it is to be reliable [8].Trust is the crucial element in the healing relationship, however could be particularly hard to establish with adolescents. Nurses need to understand the one-of-a-kind qualities of the adolescent phase, and the process of youths's social support and advancement. Effective therapeutic relationships help to alleviate anxiety and complication, and enable the patient to feel a lot more in control [30].Nurses also should recognize the injury connected with hospitalization and treatment, that this trauma could lead to patients preventing treatment, and longer therapy times. Nurses need to guarantee they are treating patients in the least stressful and restrictive way [28].

Integrated therapy

As gone over formerly, FEP affects and is influenced by the family members and carers of the patient. It is not shocking that study has revealed that incorporated therapy that includes family/carers causes far better patient outcomes, including reduction in symptoms and minimized treatment time. Nurses are associated with inte grated strategies to treatment including psychoeducation, which give patients and their families/carers with clear and understandable info and education to boost understanding of mental disorder and the problems which connect to it [2].Nursing care could likewise be intended at sustaining households and patients to utilize their own resources and abilities in living with mental disease, as well as 'showing them crisis management, interaction and analytical skills' [2].

Integrated treatment has likewise been shown to reduce degrees of EE by families and carers, bring about not just a decrease in subjective degrees of household worry, but also much better patient results [35].It is the registered nurse's function then, to support and be involved in integrated treatment, and probably in order to help target those families which would most benefit from it [35].

Medication

Nurses are likewise in charge of the management of medication treatment. Nurses not just carry out medication, however need to know the signs, contraindications, and side-effects of medicine prescribed. Medication side-effects have to be managed collaboratively with the patient, and registered nurses require to comprehend the reasons patients do not take medication, and have abilities to decrease the effects of these barriers [8].

4. CONCLUSION

First-episode psychosis typically causes confusion, depression, and fear in sufferers who are usually likewise trying to manage the uncertainties of adolescence. Patients can endure isolation through the disruption of social networks and the difficulties of disturbing behaviour. They are at higher risk of harm, both physical and psychological. The families and carers of these young people can deal with confusion, fear, and unpredictability as they handle the loss of relationships as they recognized them, in addition to the physical, psychological, and financial concern of care. Early treatment can possibly make a distinction to the course and severity of a person's disease. It could definitely make a distinction to the distress that patients and those close to them experience. With hold-ups in treatment of approximately 2 years after psychotic symptoms present, medical care specialists should be extra vigilant in properly assessing symptoms, and either starting therapy, or referring patients to specialist services. Community stakeholders that spend time with those at greatest danger, such as teachers, counsellors, and those in the justice system, need information and education regarding how symptoms might present, and ways to get help for those in their care. Nurses are in a setting to make a real difference in the care of patients with FEP and their families. Reliable therapeutic relationships, combined with very refined assessment and education skills, could decrease the impacts of distress, confusion, and the dangers associated with psychological ailment. Nurses who can promote or assist early treatment and integrated treatment gain for their patient's better clinical outcomes, reduction in distressing symptoms, and assist to lower the risk of regression. Lastly, nurse's discharge planning assists assistance patients to go back to their environments and relationships.

REFERENCES

[1] Harris, A., Brennan, J., Anderson, J. et al. (2005). Clinical profiles, scope and general findings of the Western Sydney First Episode Psychosis Project. Australian and New Zealand Journal of Psychiatry, 39 (1–2), 36–43.

[2] Kilkku, N., Munnukka, T. & Lehtinen, K. (2003). From information to knowledge: The meaning of information-giving to patients who had experienced first-episode psychosis. Journal of Psychiatric and Mental Health Nursing, 10 (1), 57–64.

[3] Jackson, C., Knott, C., Skeate, A. & Birchwood, M. (2004). The trauma of first episode psychosis: The role of cognitive mediation. Australian and New Zealand Journal of Psychiatry, 38 (5), 327–333.

[4] Addington, J., Coldham, E. L., Jones, B., Ko, T. & Addington, D. (2003). The first episode of psychosis: The experience of relatives. Acta Psychiatrica Scandinavica, 108 (4), 285–289.

[5] Johannessen, J. O., Friis, S., Joa, I. et al. (2007). First-episode psychosis patients recruited into treatment via early detection teams versus ordinary pathways: Course, outcome and health service use during first 2 years. Early Intervention in Psychiatry, 1 (1), 40–48.

[6] Norman, R. M., Malla, A. K., Verdi, M. B., Hassall, L. D. & Fazekas, C. (2004). Understanding delay in treatment for first-episode psychosis. Psychological Medicine, 34 (2), 255– 266.

[7] Welch, M. & Garland, G. (2000). The safe way to early intervention: An account of the SAFE (Southern Area First Episode) project. Australian Psychiatry, 8 (3), 243–248.

[8] Keks, N. & Blashki, G. (2006). The acutely psychotic patient: Assessment and initial management. Australian Family Physician, 35 (3), 90–94.

[9] Gleeson, J. (2005). Preventing episode II: Relapse prevention in first-episode psychosis. Australasian Psychiatry, 13 (4), 384– 386.

[10] APA - American Psychiatric Association. *Diagnostic criteria from DSM-IV-TR*. Washington, D.C.: American Psychiatric Association; 2000.

[11] Fennig S, Kovasznay B, Rich C, Ram R, Pato C, Miller A, Rubinstein J, Carlson G, Schwartz JE, Phelan J. Six-month stability of psychiatric diagnoses in first-admission patients with psychosis. *Am J Psychiatry*. 1994;151(8):1200-8.

[12] Schwartz JE, Fennig S, Tanenberg-Karant M, Carlson G, Craig T, Galambos N, Lavelle J, Bromet EJ. Congruence of diagnoses 2 years after a first-admission diagnosis of psychosis. *Arch Gen Psychiatry*. 2000;57(6):593-600.

[13] Stanton MW, Joyce PR. Stability of psychiatric diagnoses in New Zealand psychiatric hospitals. *Aust N Z J Psychiatry*. 1993;27(1):2-8.

[14] OMS. *Classificação dos transtornos mentais e de comportamento da CID-10*. Descrições clínicas e diretrizes diagnósticas. Porto Alegre: Artes Médicas; 1993.

[15] Jarbin H, von Knorring AL. Diagnostic stability in adolescent onset psychotic disorders. *Eur Child Adolesc Psychiatry*. 2003;12(1):15-22.

[16] Hollis C. Adult outcomes of child-and adolescent-onset schizophrenia: diagnostic stability and predictive validity. *Am J Psychiatry*. 2000;157(10):1652-9.

[17] Singh SP, Croudace T, Amin S, Kwiecinski R, Medley I, Jones PB, Harrison G. Three-year outcome of first-episode psychoses in an established community psychiatric service. *Br J Psychiatry*. 2000;176:210-6.

[18] Amin S, Singh SP, Brewin J, Jones PB, Medley I, Harrison G. Diagnostic stability of first-episode psychosis. Comparison of ICD-10 and DSM-III-R systems. *Br J Psychiatry*. 1999;175:537-43.

[19] Salvatore P, Baldessarini RJ, Tohen M, Khalsa HM, Sanchez-Toledo JP, Zarate CA Jr, Vieta E, Maggini C. McLean-Harvard International First-Episode Project: two-year stability of DSM-IV diagnoses in 500 first-episode psychotic disorder patients. *J Clin Psychiatry*. 2009;70(4):458-66.

[20] Strakowski SM. Diagnostic validity of schizophreniform disorder. *Am J Psychiatry*. 1994;151(6):815-24.

[21] Zhang-Wong J, Beiser M, Bean G, Iacono WG. Five-year course of schizophreniform disorder. *Psychiatry Res.*1995;59(1-2):109-17.

[22] Benazzi F. DSM-III-R schizophreniform disorder with good prognostic features: a six-year follow-up. *Can J Psychiatry.* 1998;43(2):180-2.

[23] Iancu I, Dannon PN, Ziv R, Lepkifker E. A follow-up study of patients with DSM-IV schizophreniform disorder. *Can J Psychiatry.* 2002;47(1): 56-60.

[24] Zarate CA, Jr., Tohen M, Land ML. First-episode schizophreniform disorder: comparisons with first-episode schizophrenia. *Schizophr Res.* 2000;46(1):31-4.

[25] Jorgensen P, Bennedsen B, Christensen J, Hyllested A. Acute and transient psychotic disorder: a 1-year follow-up study. *Acta Psychiatr Scand.* 1997;96(2):150-4.

[26] Sajith SG, Chandrasekaran R, Sadanandan Unni KE, Sahai A. Acute polymorphic psychotic disorder: diagnostic stability over 3 years. *Acta Psychiatr Scand.* 2002;105(2):104-9.

[27] Etheridge, K., Yarrow, L. & Peet, M. (2004). Pathways to care in first episode psychosis. Journal of Psychiatric and Mental Health Nursing, 11 (2), 125–128.

[28] Gorrell, J., Cornish, A., Tennant, C. et al. (2004). Changes in early psychosis service provision: A file audit. Australian and New Zealand Journal of Psychiatry, 38 (9), 687–693.

[29] Walker, H. & MacAulay, K. (2005). Assessment of the side effects of antipsychotic medication. Nursing Standard, 19 (40), 41–46.

[30] O'Toole, M. S., Ohlsen, R. I., Taylor, T. M., Purvis, R., Walters, J. & Pilowsky, L. S. (2004). Treating first episode psychosis – The service users' perspective: A focus group evaluation. Journal of Psychiatric and Mental Health Nursing, 11 (3), 319–326.

[31] Lambert, M., Conus, P., Lubman, D. I. et al. (2005). The impact of substance use disorders on clinical outcome in 643 patients with first-episode psychosis. Acta Psychiatrica Scandinavica, 112 (2), 141–148.

[32] Shield, H., Fairbrother, G. & Obmann, H. (2005). Sexual health knowledge and risk behaviour in young people with first episode psychosis. International Journal of Mental Health Nursing, 14 (2), 149–154.

[33] Milton, J., Amin, S., Singh, S. P. et al. (2001). Aggressive incidents in first-episode psychosis. British Journal of Psychiatry, 178 (5), 433–440.

[34] Raune, D., Kuipers, E. & Bebbington, P. E. (2004). Expressed emotion at first-episode psychosis: Investigating a carer appraisal model. British Journal of Psychiatry, 184 (4), 321– 326