



with Professor Gordon Parker

mind over matter

Analysing psychosis

The psychosis was obvious and profound, but what was the underlying diagnosis?

PRESENTING SYMPTOMS

Dr W, a 34-year-old GP, rang unexpectedly and reassured me that she had just worked out the “hidden police cameras in her bedroom” were actually present to ensure her “safety and protection”.

HISTORY

Dr W had been a popular and vivacious medical student.

In her final year, however, she had rung the professor of surgery to whisper that the police had staked out her house. The professor felt the hair on the back of his neck rise – a common phenomenon when someone you know moves into a state of psychosis – and he arranged an urgent psychiatric assessment.

When interviewed, she paced up and down in extreme agitation and spoke rapidly about having AIDS, her mother’s affair, and the police camera in her bedroom.

DIAGNOSTIC QUESTION

Though psychosis was obvious, the three principal options were schizophrenia, mania or a drug-induced psychosis, the last readily excluded.

While the psychotic features were schizophrenia-like, there was no such family history. But a grandfather had had depression, and two cousins had suicided. The immediate task was, however, to manage the psychosis.

IMMEDIATE MANAGEMENT

Initially, hospital admission was avoided, as she agreed to take antipsychotic medication and stay at home with a family member there at all times. Her

psychotic symptoms settled over a fortnight.

A week later she required involuntary hospitalisation.

After claiming she had designed a rotisserie-like device for sunbakers (to slowly rotate them to achieve an even tan), she had demanded export funding from the Premier’s Office and, when prevented from entering, had attacked the security staff.

On admission to hospital, her speech was pressured and grandiose, she was bright-eyed and energetic, and she was unable to stop talking.

An antipsychotic and lithium were prescribed, and she remitted after three weeks.

My follow-up 15 years later established she had married, was the mother of two children, and was a successful GP. She had remained on lithium, having few mood swings, with most relatively minor, apart from four depressive episodes – three manic and one psychotic.

During such times, she would get a locum, commence an antipsychotic and take time away from her family.

During the last manic episode, its speedy onset had taken her unawares, side-stepping

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her usual safeguards, perhaps because of her reinterpretation of the cameras – now interpreted as there to protect her rather than being a menace.

She wanted to bring it to my attention, as “medical students need to be taught such things”.

MANIA CLUES

Previously in this column, we detailed that ‘highs’ involve states where the individual feels ‘energised and wired’, noting features common to bipolar I

and II disorders.

In mania (part of bipolar I disorder), that core state is more severe, anger more common, but with delusions and/or hallucinations providing the category-defining feature.

While commonly consistent with the mood state (for example, grandiose delusions when

‘high’, and derogatory features when depressed), many experience schizophrenia-like features, such as feeling persecuted, and consequently often receive an incorrect diagnosis.

Bipolar I disorder should be considered if there is evidence of a significant mood component – whether preceding, during or following onset of psychosis. A family history of mood disorder (not necessarily bipolar disorder) may support this, as does seasonal worsening (spring and,

to a lesser extent, autumn).

During – and following – an initial undifferentiated psychotic episode, the clinician should look for mood perturbations, as the more characteristic pattern often crystallises over a few years.

While some sufferers experience pristine episodes – with euthymic inter-episode periods of months or years, most have ongoing mood symptoms, while a small percentage may have ongoing psychotic symptoms.

MANAGEMENT

During a ‘high’, patients need to be closely protected to ensure their increased libido, disinhibition and recklessness do not compromise safety, reputation or finances.

Though keen for discharge and relaxing of the therapeutic protective system, clinicians should work to the principle that a manic patient is always worse than they appear or report.

While most require one or more ongoing mood stabilisers, the high rate of suicide argues for treating episodic depressive and manic episodes assertively.

Our previous rule, “once better, you’ll only need a mood stabiliser”, only works for a minority.

Current management commonly involves selection of one or more mood stabilisers, an antidepressant and/or an antipsychotic drug.

Patients should be encouraged to expect a good outcome but be aware that arriving at the correct prophylactic mix may take years. Considerable ‘tweaking’ of medication, along with development of an assertive and relevant ‘stay well’ plan, is required.

MO
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For further information on bipolar disorder, visit blackdoginstitute.org.au