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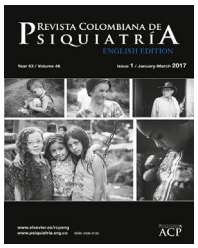

Letter to the Editor

We have to talk about prevention and psychosis☆

Tenemos que hablar sobre prevención, psicosis

Dear Editor,

There are few psychiatric conditions more destabilising for the person who suffers from it and their family than psychosis. Therefore, having analysed the review article "Review of early intervention programmes for psychosis: implementation proposal in Peru" published in *Revista Colombiana de Psiquiatría*,[1] we can see that it is essential to establish an early intervention programme, but not only based on the early identification of psychotic symptoms themselves or the observation of first episodes of psychosis (FEP). We also need to be attentive to prodromal symptoms that serve as warning signs to identify patients with high-risk mental states (HRMS).

The Domínguez et al. study found significant differences between the HRMS and FEP groups (Table 1), including that the age at onset of nonspecific symptoms, the first specialised treatment, and prodromal symptoms were later in patients with FEP than in patients with HRMS; these patients also had higher scores in symptoms in general, mania and premorbid adjustment from early adolescence.[2] This period of prepsychotic disturbance can be prolonged, with a mean duration of 1–5 years, and is often associated with substantial levels of psychosocial impairment and disability.[2]

In an analysis of the different factors in the affected person's own environment, Ortega et al., for example, found that one risk factor for psychosis accompanied by more severe positive psychotic symptoms is child abuse.[3] An association was also found between sexual abuse and greater severity of hallucinatory symptoms and delusions, while an increase in the intensity of negative symptoms is associated with neglect.[3]

There is evidence that, in families with high degrees of expressed emotion, there is a higher rate of relapses.[4] Betsen et al. found that single-parent families, such as single mothers who spent a lot of time with their schizophrenic son, fostered more anxiety and depression.[5] Meanwhile, Anderson et al. report that there is a correlation between a very limited social network and the patient having had a much longer illness.[6]

This is just a small example of the fact that social environment and previous experiences have a fundamental influence on the development of psychosis and the severity of presentation. I completely agree that we live in a country with a high degree of stigmatisation around and discrimination against schizophrenia,[1] and in fact against psychiatric disorder, so it is important to promote a culture of mental health free from any sense of shame or stigma. It is evident that we urgently need an early intervention programme. Whatever type of programme is established, it is essential that it also assesses family members and possible emotional precipitants. Such interventions must particularly be accompanied by awareness campaigns to remove prejudices about the different disorders and symptoms. This is important, as early detection can alert us and help prevent the chronic and disabling illness, the all-too-usual poor prognosis leading to increased mortality rates and high economic costs that stem from psychosis, and, from that, the quintessential psychosis which is schizophrenia.[7]

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Table 1 – Differences found in the Domínguez et al. study.[2]

	HRMS (n = 43)[a]		FEP (n = 40)[b]	
Main reason for consulting a mental health service	State of mood/depression/sadness/low self-esteem		Paranoid thoughts/suspiciousness or delusions	
Current psychiatric treatment	Antidepressant medication predominant		Antipsychotic medication predominant	
[0,1–3]*History of current disorder*				
Age (years) at onset of nonspecific symptoms	14.5 ± 4.1		21.6 ± 7.0	
Age (years) at onset of prodromal symptoms	17.4 ± 3.4		23.1 ± 6.0	
Age (years) at onset of psychotic symptoms	N/A		24.1 ± 6.2	
Age (years) at the first specialist psychiatry psychology visit	18.4 ± 4.5		24.1 ± 6.4	
Duration of untreated illness (DUI) (weeks)	94.1 ± 185.4		72.1 ± 144.9	
Duration of untreated psychosis (DUP) (weeks)	N/A		55.1 ± 100.2	
[0,1–3]				
[0,1–3]*Symptom severity*				
General CGI	2.9 ± 0.8		3.4 ± 1.0	
General PANSS	36.8 ± 9.0		31.5 ± 8.2	
Prodromal symptoms (CAARMS)	Severity	Frequency	Severity	Frequency
Positive symptoms	9.5 ± 3.6	10.4 ± 4.0	N/A	N/A
Cognitive change	4.3 ± 1.8	3.4 ± 1.4	N/A	N/A
Emotional disorder	5.1 ± 2.9	6.7 ± 4.3	N/A	N/A
Negative symptoms	7.8 ± 3.0	9.1 ± 3.0	N/A	N/A
Behavioural change	8.6 ± 3.4	8.5 ± 3.8	N/A	N/A
Motor/physical changes	4.7 ± 3.23	4.2 ± 3.4	N/A	N/A
General psychopathology	13.7 ± 5.8	12.9 ± 6.3	N/A	N/A
[0,1–5]*Affective symptoms*				
Mania (YMRS)	[0,2–3]4.8 ± 4.8		[0,4–5]2.6 ± 3.8	
Depression (CDS)	[0,2–3]6.7 ± 4.9		[0,4–5]5.2 ± 4.8	
Premorbid adjustment (PAS)[c]*, n*	[0,2–3]43		[0,4–5]40	
Childhood	[0,2–3]0.31 ± 0.14		[0,4–5]0.25 ± 0.15	
n	[0,2–3]43		[0,4–5]40	
Early adolescence	[0,2–3]0.41 ± 0.16		[0,4–5]0.30 ± 0.18	
n	[0,2–3]38[d]		[0,4–5]36[d]	
Late adolescence	[0,2–3]0.44 ± 0.17		[0,4–5]0.33 ± 0.17	
n	[0,2–3]30[e]		[0,4–5]32[e]	
Adulthood	[0,2–3]0.49 ± 0.15		[0,4–5]0.41 ± 0.19	
Quality of life (WHOQOL-BREF)[f]*, n*	[0,2–3]41		[0,4–5]25[g]	
Total quality of life score	[0,2–3]5.9 ± 1.9		[0,4–5]6.6 ± 1.4	

CAARMS: Comprehensive Assessment of At-Risk Mental States interview; CDS: Calgary Depression Scale; CGI: clinical global impression scale; DUI: duration of untreated illness; DUP: duration of untreated psychosis; HRMS: high-risk mental states; N/A: not applicable; PANSS: Positive and Negative Syndrome Scale; PAS: premorbid adjustment scale; FEP: first-episode psychosis; WHOQOL-BREF: short version of the World Health Organisation quality of life questionnaire; YMRS: Young Mania Rating Scale.
Unless otherwise indicated, values are express mean ± standard deviation.

[a] Age 14–30 years.
[b] Age 16–40 years.
[c] A lower score indicates a "healthier" level of functioning.
[d] The PAS late adolescence subscale was not applicable to patients under 15 years of age.
[e] The PAS adult subscale was not applicable to patients under 18 years of age.
[f] A higher score indicates a better quality of life.
[g] The WHOQOL-BREF data were only collected from 25 patients with FEP because this questionnaire was not initially included in the assessment protocol for patients with FEP, but was included later.

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