Primary psychosis: more to know, much more to do

In this issue of the journal, Maj et al[1] make clear the implications for a field that has turned slowly from concepts of various psychotic disorders as disease entities to recognition of the heterogeneity within each diagnostic group and the shared psychopathology across traditional diagnostic groups.

The concept of "primary psychosis" brings clinical attention to a range of disorders where disorganization of thought and behavior and/or delusional thinking and/or hallucinatory phenomena are prominent, and cases are not easily distinguished by specific causation or mechanism of pathophysiology. With a focus on clinical intervention, the authors make clear the numerous therapeutic targets potentially present and the necessary evaluation of each case with the goal of comprehensive and personalized treatment.

Eighteen leaders of psychosis research, in their words, describe "systematically the salient domains that should be considered in the characterization of the individual patient with primary psychosis aimed at personalization of management". They succeed beautifully, with much to offer everyone. It is a comprehensive guide. I will here provide a view on why this is a remarkable contribution by stating what can be done with the content. Please find yourself below:

- As an experienced and well informed clinician, you will be surprised at a few areas not quite on your radar screen. A gift for you is the information on assessment interviews that you may wish to use, or better understand their value in research, or enable a team member to utilize in order to acquire information otherwise neglected. You will assume integrated care as a mandate.
- As a person in training for a career in mental illness services, you will find in one place a clear and succinct description of what you need to evaluate with each patient and a guide to where you may wish to develop special expertise. The assessment approaches, carefully developed for research, will help clarify each concept and provide a method you may wish to use when evaluating patients.
- As a person responsible for a clinical care program, you will find a clear view of the range of management and treatment expertise that you will need to provide. This will support clinical care staff in understanding potential patient needs and clarify where and what expertise is needed in each case.

The above comments assume available staff, expertise and time. Not likely in most settings. But the material presented can support the effort to develop resources for comprehensive care. Examples are:

- What it would cost to provide the expertise, time and knowledge to support clinical care based on this information. I hope economists will develop models based on this material informing on finance of the necessary services.
- A new view on essential staffing for clinical care will emerge. Training programs will have guidance on essential knowledge and skills to be acquired by trainees.
- Services experts may develop a view as to how to institute personalized care in low and middle income countries.
- In locations already supporting integrative care for the mentally ill, a broader mission may evolve from a heightened awareness of the range of issues in the context of primary psychosis.
- For wealthy countries failing to support accessible and informed clinical care, the content of this report, backed with organizational and financial information, may enable advocates to lobby for full implementation of required structure for comprehensive and personalized clinical care. This is critically important in a country such as the US where clinical care is not accepted as a moral obligation and most persons with psychotic disorders do not have access to care that approaches expectations of this model. The neglect of fundamental clinical care results in large numbers of homeless or imprisoned persons struggling with psychosis. This presentation from experts provides a critical understanding of what is required for personalized medicine related to primary psychosis. This is a powerful information document in the effort to influence leaders responsible for developing and funding clinical care for persons with psychotic illness.
- Services investigators can address comparative clinical and functional outcomes with comprehensive integrative personalized care contrasted with treatment as usual in various settings. Here costs related to housing, employment, hospitalization, prison as well as clinical, functional and quality of life assessments are essential.
- Those involved in the creative acquisition of knowledge aimed at identifying prevention and therapeutic targets on which to base novel treatment advances will find many areas of current scientific neglect. The roadmap for personalized treatment of primary psychosis makes clear that diagnostic categories are not an adequate basis for comprehensive treatment. Antipsychotic drugs, for example, are approved for schizophrenia but have efficacy for only one aspect of the multiple psychopathologies that may be present. But the same drug will be efficacious for that same psychopathology associated with some or many other diagnostic categories. Many of the issues detailed as essential to personalized care in Maj et al's paper may help identify targets for development of novel therapeutics.

There is anticipated "payoff" in science as new concepts guide the effort to understand mechanisms for discreet aspects of psychopathology. The needs addressed by the authors provide many targets. I believe regulatory bodies concerned with drugs and devices are early in a shift from DSM/ICD diagnoses as guiding entities. This shift requires recognition of clinical syndromes with movement to more precise elements of psychopathology as a target for medication or device approval. Syndrome status

was made explicit in the DSM-5 for schizophrenia spectrum disorders. The influence on clinical trials methodology will be profound. Many therapeutic and management approaches must be developed without commercial finance and it will be challenging for funders of public science to adequately address the need for knowledge acquisition in the range of psychopathology essential for broadly integrative care.

This report would be valid if addressing schizophrenia rather than primary psychosis. The authors have given emphasis to transdiagnostic conceptualization of psychopathology related to psychosis. This advance has been unnecessarily slow. A personal milestone is our 1974 paper[2] summarizing data that made clear, to us, that schizophrenia was a clinical syndrome rather than a disease entity. Six aspects of psychopathology were viewed as separate targets for discovery not unique to schizophrenia. However, in 1983, the DSM-III viewed schizophrenia as a disease based on the belief that heterogeneity would be addressed when clinicians used specified symptoms for the diagnosis and gave prominence to Schneiderian first-rank symptoms. It was three decades later that the DSM-5 made explicit the syndrome status and identified dimensions of psychopathology relevant for psychotic illnesses.

A turn to transdiagnostic psychiatry is being supported by the US National Institute of Mental Health's Research Domain Criteria[3]. Very controversial at the outset, the view that dimensions of psychopathology can be investigated across diagnostic boundaries has taken hold. The comparison of schizophrenia patients versus non-ill controls is gradually giving ground to paradigms involving specific aspects of psychopathology with potential relevance across diagnostic boundaries. A nosology with specific diagnoses is necessary for many reasons, and schizophrenia is not an exception. The key is understanding the implications of the diagnosis and the need for a further clinical characterization in order to personalize management.

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2. Strauss JS, Carpenter WT Jr, Bartko JJ. Schizophr Bull 1974;11:61-9.
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DOI:10.1002/wps.20807

From exception to the norm: how mental health interventions have become part and parcel of the humanitarian response

Humanitarian psychiatry is the provision of services for mental health and psychosocial support in a humanitarian context – that is, to populations exposed to collective violence, forced displacement or natural disasters. Unfortunately, humanitarian needs have grown: nearly 80 million are forcibly displaced in the world today, that is one in a hundred people, with diminishing numbers returning home. These figures do not include those with humanitarian needs who are not displaced, but who are also in danger, as for example in Yemen at this time.

When the first author of this paper began her career in humanitarian psychiatry 30 years ago, during the Balkan wars, psychiatry in humanitarian settings focused largely on one diagnosis (post-traumatic stress disorder, PTSD) and individualized medical interventions to prevent and/or address it. She encountered the same approaches in Iraq in 2003, and after the 2004 South-East Asian tsunami[1].

The publication in 2007 of the Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings heralded a new understanding and a new approach. Namely, that tightly defined psychiatric problems are only part of a spectrum of mental health and psychosocial needs. These may be prevented or mitigated if people's basic needs for food, shelter and security, and their social needs for connection and justice, are addressed in a dignified and equitable manner that respects human rights (see Silove[2] in this issue of the journal).

This requires multi-sectoral action, with different levels of intensity and specialization. Clinical services constitute a modest part of the pyramid of multi-layered mental health and psychosocial services and supports, the others being: a) focused non-specialized psychosocial support, b) strengthening the capacity of individuals, families and communities to support themselves, and c) embedding social and psychological considerations into the way basic needs and security are delivered.

That is not to say that clinical needs are insignificant. The latest World Health Organization (WHO) figures show that more than one in five people in post-conflict settings have depression, anxiety disorder, PTSD, bipolar disorder or schizophrenia[3]. Fortunately, certain barriers to addressing psychiatric disorders in emergency settings have been removed. Prior to 2009, mental health problems were not included in the health information system of the United Nations High Commissioner for Refugees (UNHCR), which meant they were invisible. Since then, the inclusion of seven, and currently nine, mental and neurological categories has highlighted the significance of these conditions[4]. Another problem was that only three psychiatric medications were included in WHO essential drug kits for emergencies. The increase to five in 2011, continued in 2017, has meant that pharmacological treatments are now available in emergencies[5].

The first most significant development of the last decade is the recognition that the provision of essential mental health services is not the exclusive realm of mental health specialists. It can be done by non-specialized health workers, particularly in primary care, if they are well trained and supervised. The development