EARLY PSYCHOSIS TRAINING SERIES

step Learning Collaborative

CTC Connecting to Care

Early Psychosis Basics: Early Identification in Psychosis

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Outline

- **Early Identification**
  - What is psychosis
  - Common causes, differential diagnoses
  - Signs and symptoms
  - Risk factors
  - Assessment tools and strategies

- **STEP Learning Collaborative**
  - Mission
  - Offerings

- **Q&A / Discussion**

What is psychosis?

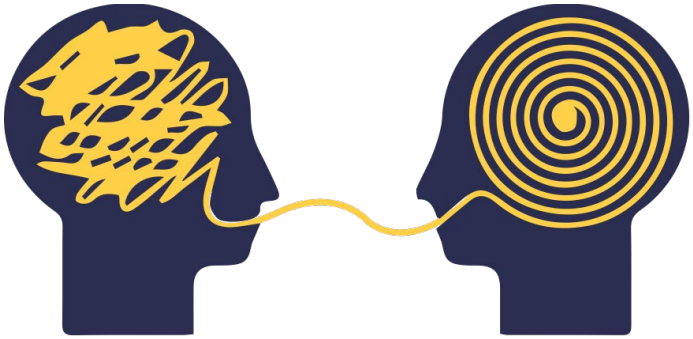
- Difficulty with perceiving reality accurately and with coherent thinking *"What's real? What's not real?"*
  - Disturbances in perception (hallucinations)
  - Belief and interpretation of the environment (delusions)
  - Disorganized speech patterns (thought disorder)

- ~ 3 in 100 people will experience psychosis
  (>2.2 million people)

- Usually develops ages 16-35 (earlier in men than women)
  - Peak at **21 yrs** old (M:F, 3:1)
  - "Chronic diseases of the young" *(Insel, 2005)*

Common causes of psychosis

- Mental Illnesses (more common)
  - Schizophrenia spectrum
  - Affective psychosis
  - Others
- Secondary Causes (rare)
  - Parkinson's, epilepsy
- Substances (such as alcohol or drugs)



Differential Psychiatric Diagnoses in Early Psychosis

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- **(Non-Affective) Primary Psychotic Disorders**:
  - Brief Psychotic Disorder/Schizophreniform
  - Schizophrenia
  - Delusional Disorder
  - Schizoaffective Disorder
- **Affective/Mood Psychosis**:
  - Bipolar DO w/psychotic features
  - MDD w/psychotic features
- **Personality Disorders:**
  - Schizoid/Schizotypal
  - Borderline PD* ('micro-psychoses')
- **Other**:
  - Attenuated Psychotic Symptom Syndrome
  - Substance-Induced psychosis
  - Psychosis secondary to a medical condition
  - Psychosis related to complex trauma/PTSD

Questions to Guide Dx:

- Explained by medical illness or substance use?
- Prominent mood sx? (Schizoaffective, MDD, Bipolar DO)
- Mainly non-bizarre delusions? (Delusional disorder)
- Illness duration:
  <1 mo = Brief psychotic d/o
  1-6 mo schizophreniform
  > 6 mo schizophrenia
- Can't decide? (prodrome, unspecified, alternative)
- May need to "rule out" alternative diagnoses
- Consider timing of sx

Common Signs and Symptoms

Positive - *add to* or *distort* an individual's normal functioning, perception or behavior

- Hallucinations, delusions, paranoia, bizarre behavior, disorganized communication…with ***limited insight***

Hallucinations

Hearing, seeing, tasting, or smelling things that are not there

Delusions

Believing in things that are not true, and may be impossible

Negative - a *reduction* or *loss* in an individual's normal functioning, perception or behavior

- Decreased motivation, energy and speech, social withdrawal, flat affect, no enjoyment, poor hygiene, decline in functioning

Withdrawal

Distancing oneself from people or previously enjoyable activities

Cognitive

- Executive functioning decline, attention, working memory, learning, preoccupation, thought blocking, reduced abstraction ability

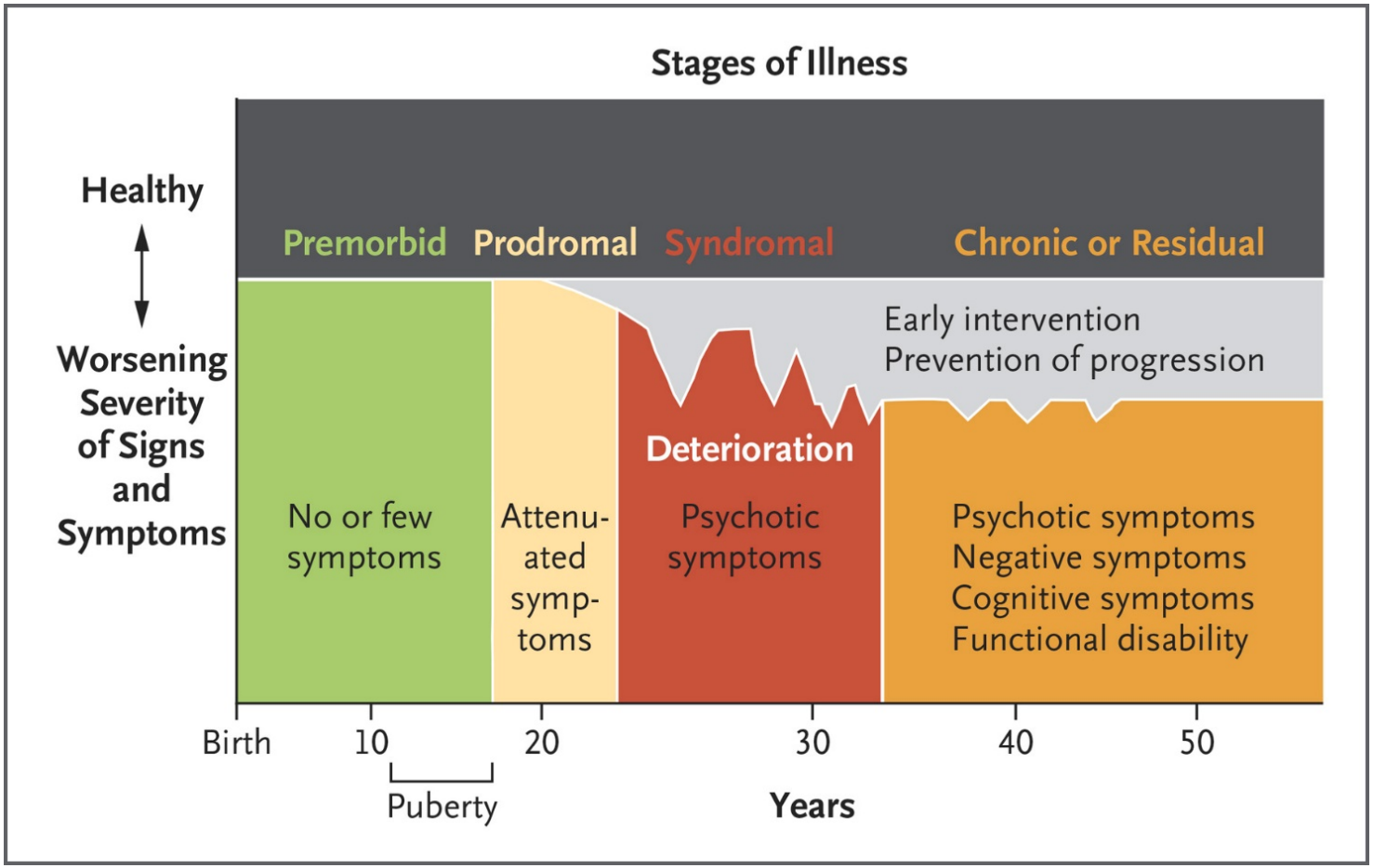
Increased Distractibility

Decline in cognitive abilities including memory and attention

Mood

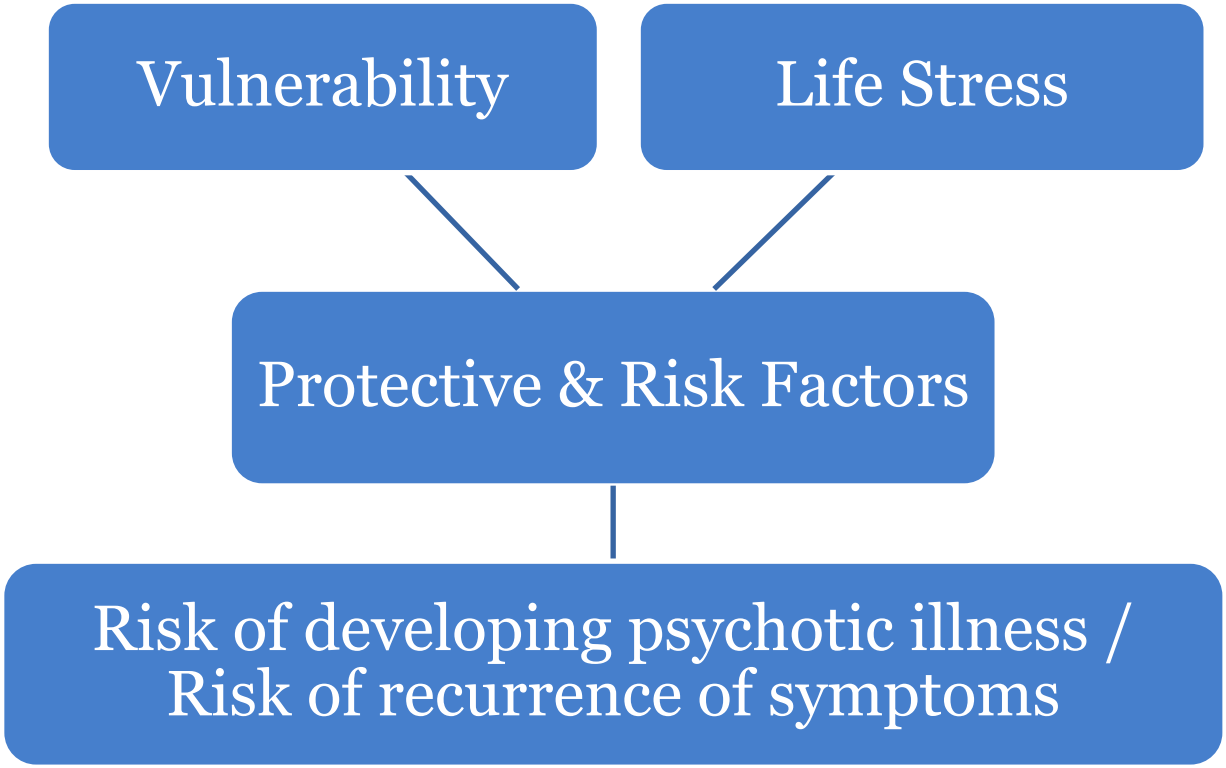
- Fluctuations, anxiety, depression, suicidal ideation

Course of Schizophrenia



Jeffrey A. Lieberman, and Michael B. First. Psychotic Disorders. *N Engl J Med* 2018; 379:270-280

What contributes to the development of psychosis?



What are the risk factors for psychosis onset?

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1st degree relative = **6-13x** more likely

factors for psychosis onset

Distal (premorbid) risk factors	Proximal risk factors
Foetal life: • Maternal pregnancy complications/perinatal trauma, (especially foetal hypoxia)[51] • Family history of psychotic disorder (for a review, see Olin & Mednick, 1996 [52]) • Candidate genes (DTNBP1, NRG1, DAOA, RGS4, COMT, DISC1, DISC2, BDNF; for a review, see Weinberger & Berger, 2009 [53]) • Developmental delay (for a review, see Rustin et al., 1997 [54]) • Season of birth (late winter/early spring[55, 56]) • Ethnic minority group membership [57] **Early life:** • Quality of early rearing environment buse or neglect) [58] e personality (e.g., schizoid personality	**Late childhood/adolescence:** • Age [61] • Urbanicity [62] • Substance (especially cannabis) use • Traumatic head injury (for a review, see Kim et al., 2007 [64]) • Stressful life events (for a review, see Phillips et al., 2007 [65]) • Subtle impairments in cognition (for a review, see Pantelis et al., 2009 [66]) • Poor functioning [67, 68] • Cognitive, affective, and social disturbances subjectively experienced by the individual ('basic symptoms')[69] • Migration [70]

Adolescent cannabis exposure = **2-4x more likely** to develop schizophrenia spectrum disorder

Greater freq, duration, earlier first use, and higher potency THC = greater risk

34% of people with FEP experienced childhood sexual / physical abuse

PTSD 10x higher than general population

2-4x risk with childhood migration in minority folks

(Orygen: Australian Clinical Guidelines for Early Psychosis, 2016)

Why is treating psychosis important?

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- **Individual and Family Impact:**
  - often leads to frequent hospitalization, and can derail functioning in school, career, and family
    - Risk of suicide (~1/100 w/FEP complete suicide, as many as 10% attempt suicide within the first 5 years)
    - Long-term cardiovascular and other physical health risks (shorter life expectancy)
  - Family / caregiving burden

- **Societal/Economic Impact:**
  - A top 10 leading cause of disability *(WHO)*
  - Criminal justice involvement
  - Homelessness (20% of have SMI) *(NAMI, Mental Health Ripple Effect)*
  - $193.2 billion in lost earnings in US / year *(Kessler, et al., 2008)*

- ***Early identification and intervention can greatly minimize the disability and improve lives!***

What about risk?

- **Risk of suicide:**
  - ~ 1/100 individuals with FEP die by suicide
  - In schizophrenia, nearly 50% of all suicides occur in the first 5 years of illness.

- **Risk of Violence:**
  - Majority of people with schizophrenia are NOT violent
  - The risk of violence in schizophrenia is highest for those with no, delayed, or inadequate treatment and comorbid substance use disorders during the initial episode

- **Risk of Neglect and Victimization:**
  - Rates of sexual / physical abuse 2x as high for women with psychosis
  - Men with schizophrenia more likely to die by homicide

"I can actually control other people's emotions with my thoughts, it's a special gift"

"Lately, I've been having a hard time telling what was in my dream and what was real"

"Every time I hear my classmates laughing in the hall, I'm pretty certain it's about me… "

Grandiosity

Confusion about what is real

Mind Reading

"I keep seeing blue cars, I wonder if that's a sign I should pay attention to, I think about it a lot"

"I feel like my family is tracking my every move and thought… they must've put a chip in my head while I was sleeping"

Suspiciousness

Positive Symptoms

Ideas of Reference

"Eminem is sending me coded messages through his songs, it's because I'm famous, too"

Disorganized Communication

"Everything has started to sound too loud and too close– I can hear everything at once"

Perceptual Disturbances

Odd Beliefs

"Sometimes I feel like my thoughts are being broadcast out loud for everyone to hear… so that's why I don't leave my house"

"They tell me I'm no good and that I should hurt myself"

(Images from FFT-CHR Manual; Miklowitz, O'Brien, et al., 2010)

Assessment tools and strategies

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Assessments:

- Structured Interview for Psychosis Risk Syndromes (SIPS)
- Mini SIPS (+Online Training Program)
- We don't have a perfect screening tool…
  - Prodromal Questionnaire – Brief (PQ-B)
  - PQ-16
  - Prodrome Questionnaire - Brief Child Version (PQ-BC) (ages <10)

Strategies:

- Ask soft questions, consider cultural explanation, be patient, normalize, be curious… try not to overreact
  - What's it like? How is it impacting them? Is it recurring/progressing?
- Thorough review of medical records
- Use collateral supports for info (if available!)

Symptoms on a Continuum

Ex.) Have you ever found yourself feeling suspicious or mistrustful of other people?

Positive Symptom SOPS

0	1	2	3	4	5	6
Absent	Questionably Present	Mild	Moderate	Moderately Severe	Severe but Not Psychotic	Severe and Psychotic

"NORMAL" LIMITS

" I don't completely trust my new roommate, my mom told me not to trust people right away"

CLINICAL HIGH RISK

" I think my roommate might be poisoning my food in the fridge; sometimes I throw it out just in case… but I'm probably just being paranoid"

CONVERSION

" I'm certain that my roommate is out to get me and is poisoning my food. Sometimes, I don't eat for days."

QUALIFIERS
-Description, onset, freq., duration
-Distress & interference
-Conviction/"insight"

Interviewer "throws a rope"

How to ask about symptoms of psychosis

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- Do you ever feel that your mind is playing tricks on you? Or not working right?
- Have you felt confused whether an experience was real or imaginary? Have you thought that the world may not be real or that you may not be real?
- Have you felt that some person, force, or creature was around you, even though you couldn't see anyone?
- Have your thoughts been so strong that you felt you heard them or worried other people could hear them?
- Are you more sensitive to light? Have you seen objects, people, or animals that no one else could see?
- Do you find that you're more sensitive to sounds? Have you heard voices or sounds that no one else could hear?
- Have you thought that people were following or spying on you?
- Are you having more trouble understanding what people are saying? Getting your point across? Following multi-step directions?
- Have you ever felt that you are not in control of your own ideas or thoughts?

(SIPS; PsychosisScreening.org)

Why intervening *EARLY* is important?

Reducing the delay to treatment is associated with better outcomes

- Clinical, functional, and cognitive benefits
- Reducing the social consequences of psychosis onset
  - social isolation
  - unemployment
  - homelessness
  - deliberate self harm
  - violence toward others

Early identification and intervention can greatly minimize the disability and improve lives!

But we need to reach more people…

(Birchwood, Todd, & Jackson, 1998)

Current Offerings

- STEP Learning Collaborative – workforce development and community education initiative to bolster provider capacity to serve folks with early psychosis across Connecticut

- **Behavioral Health Providers:**
  - Early Psychosis ECHO - Case Discussions and brief didactics (2nd & 4th Thursdays at 12pm)
  - Webinars: e.g.) Early Psychosis Basics, Early Psychosis Treatment Approaches
  - Early Psychosis Course – upcoming!

- **Community Education:**
  - Family and community workshops
  - Virtual resources– http://www.ctearlypsychosisnetwork.org

Current Offerings

Early Psychosis ECHO - Case Discussions and brief didactics (2nd & 4th Thursdays at 12pm)

2022 Early Psychosis ECHO Schedule

Date	Brief Didactic Topic (Click Didactic Name for Zoom Registration Link)
Feb 10th	**Early Psychosis Overview**
Feb 24th	*Open Case Discussion*
March 10th	**Early Detection: Screening, assessment, and engagement**
March 24th	*Open Case Discussion*
April 14th	**Therapeutic approaches to positive symptoms**
April 28th	*Open Case Discussion*
May 12th	**Psychopharm Basics for Clinicians**
May 26th	*Open Case Discussion*
June 9th	**Understanding and approaching negative symptoms**
June 23rd	*Open Case Discussion*
July 14th	**The Role of Coordination**
July 28th	*Open Case Discussion*
Aug 11th	**Working with risky clients and crisis intervention**
Aug 25th	*Open Case Discussion*
Sept 8th	**Special Topic**
Sept 22nd	*Open Case Discussion*

Questions?

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www.CTEarlypsychosisnetwork.org

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Join us, Tues May 24th at 12pm for Early Psychosis Tx Approaches