Assessment Strategies for Identifying Clinical High Risk and First Episode Psychosis in Youth

Iruma Bello, PhD, Co-Associate Director, OnTrackNY, New York State Psychiatric Institute, Columbia University Medical Center

Tamara Sale, MA, Oregon Health & Science University- Portland State University School of Public Health

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Disclosures

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Learning Objectives

1. Become familiar with the diagnostic criteria for clinical high risk and early psychosis with a focus on differential diagnosis.
2. Review validated assessment instruments for assessing psychosis and discuss appropriateness for their use across varying contexts and clinical presentations.
3. Understand pros and cons of using structured and unstructured assessment strategies to promote engagement.
4. Practice using different assessment strategies to reach differential diagnoses.
1. What has been your experience assessing psychosis?
2. What are some effective strategies you have used in your work?
3. What are some persistent challenges?
What is Psychosis?

• Symptoms may include:
  • Unusual thoughts or beliefs that appear strange to the young person or others
  • Feeling fearful or suspicious of others
  • Seeing, hearing, smelling, tasting or feeling things that others do not
  • Disorganized, “odd” thinking or behavior
  • Strange bodily movements or positions
The Basics: Psychotic Symptoms

- Delusions: False personal beliefs not subject to reason or contradictory evidence and not explained by culture and religion.
- Hallucination: Perception of visual, auditory, tactile, olfactory, or gustatory experiences without an external stimulus and with a compelling sense of their reality.
- Disordered speech and behavior
Causes of Psychotic Symptoms

• Different diagnoses (e.g., Schizophrenia, Affective Disorders, Anxiety Disorders, Borderline Personality),
• Medical conditions
• Medication reactions
• Substance use
• Acute Stress
• Sensory distortions due accidents, stress, lack of sleep, etc.
Schizophrenia (DSM-5)

- Symptoms: Delusions; Hallucinations; Disorganized speech; Grossly disorganized or catatonic behavior; Negative symptoms (two or more for a month)
- Level of functioning declines
- Lasts at least six months
Schizophrenia: Big Picture

- Occurs worldwide (~0.5-1.5%): annual incidence 15.2 per 100,000; Male/female: 1.4-1.6
- Usually develops age 16 to 25; men younger than women
- Accounts for 25% of all hospital bed days
- Accounts for 40% of all long-term care days
- Accounts for 20% of all Social Security benefit days
- Costs the nation up to $156 Billion per year
Clinical High Risk

• Syndromes that may predict the onset of psychosis
• Structured Interview of Psychosis- risk Syndromes (SIPS)
  • Severity Scale (the scale of Psychosis-risk Symptoms- SOPS)
  • Anchored Global Assessment of Functioning
  • DSM-IV Schizotypal Personality Disorder Checklist
  • Brief assessment of the family history of psychosis
  • Criteria of Psychosis Risk Syndromes (COPS)
  • Presence of Psychosis Scale (POPS)
  • DSM-5 Attenuated Psychosis Syndrome criterion
Psychotic Risk Syndromes

- Brief Intermittent Psychotic Syndrome
  - frankly psychotic symptoms that are recent and very brief

- Attenuated Positive Symptom Syndrome
  - Requires one or more sub-threshold positive symptoms that have been present in the last month and have begun or worsened in the past year

- Genetic Risk and Deterioration Syndrome
  - Requires a family history of psychosis or personal history of schizotypal personality disorder and 30% decline in GAF score
Sample SIPS Assessment Questions

• Have you had the feeling that something odd is going on or that something is wrong that you can't explain?

• Have you ever been confused at times whether something you have experienced is real or imaginary?

• Does your experience of time seem to have changed? Unnaturally faster, unnaturally slower?
Delusional Ideas: Severity Scale

0- Absent

1- "Mind tricks" that are puzzling. Sense that something is different.

2- Overly interested in fantasy life. Unusually valued ideas/beliefs. Some superstitions beyond what might be expected by the average person but within cultural norms.

3- Unanticipated mental events that are puzzling, unwilled, but not easily ignored. Experiences seem meaningful because they recur and will not go away. Functions mostly as usual.
Delusional Ideas: Severity Scale

4- Sense that ideas/experiences/beliefs may be coming from outside oneself or that they may be real, but doubt remains intact. Distracting, bothersome. May affect functioning.

5- Experiences familiar, anticipated. Doubt can be induced by contrary evidence and others' opinions. Distressingly real. Affects daily functioning.

6- Delusional conviction (with no doubt) at least intermittently. Interferes persistently with thinking, feeling, social relations, and/or behavior.
First Episode Psychosis

- **Age:** 16-30

- **Diagnosis:** Primary psychotic disorder. Diagnoses include: Schizophrenia, Schizoaffective disorder, Schizophreniform disorder, Other specified schizophrenia spectrum and other psychotic disorder, Unspecified schizophrenia spectrum and other psychotic disorder, or Delusional disorder

- **Duration of illness:** Onset of psychosis must be $\geq 1$ week and $\leq 2$ years
Structured Clinical Interview for DSM-5 Disorders (SCID-5)

• Semi-structured interview for making DSM-5 diagnoses
• Administered by a clinician or trained mental health professional
• Can take 45 to 120 min to administer
• Assessment is proprietary
SCID- Sample Delusion Questions

• Has it ever seemed like people were talking about you or taking special notice of you? (What do you think they were saying about you?)

• Did you ever have the feeling that something on the radio, TV, or in a movie was meant especially for you? (Not just that it was particularly relevant to you, but that it was specifically meant for you.)

• What about anyone going out of their way to give you a hard time, or trying to hurt you? (Tell me about that.)

• Have you ever had the feeling that you were being followed, spied on, manipulated, or plotted against?
Positive and Negative Syndrome Scale (PANSS)

- Semi-structured scale for assessing symptom severity in schizophrenia
- Individuals are rated on a scale of 1-7 on 30 different symptoms
  - Positive scale, Negative Scale and General Psychopathology Scale
- Takes 45 min to administer
PANSS: Sample Delusion Questions

- Can you tell me something about life and its purpose?
- Do you follow a particular philosophy?
- Can you read other people’s minds? How does that work? Can others read your mind? How do they do that?
- Who controls your thoughts?
- Are there people in particular you don’t trust?
- Does anyone ever spy or plot against you?
PANSS: Delusions Scoring

1-Definition does not apply.

2-Questionable pathology; may be at the upper extreme of normal limits.

3-Presence of one or two delusions, which are vague, uncrystallized, and not tenaciously held. Delusions do not interfere with thinking, social relations, or behavior.

4-Presence of either a kaleidoscopic array of poorly formed, unstable delusions or a few well-formed delusions that occasionally interfere with thinking, social relations, or behavior.

5-Presence of numerous well-formed delusions that are tenaciously held and occasionally interfere with thinking, social relations, or behavior.

6-Presence of a stable set of delusions which are crystallized, possibly systematized, tenaciously held, and clearly interfere with thinking, social relations, and behavior.

7-Presence of a stable set of delusions which are either highly systematized or very numerous, and which dominate major facets of the patient’s life. This frequently results in inappropriate and irresponsible action, which may even jeopardize the safety of the patient or others.
Discussion

• Under what circumstances are semi-structured assessments useful?
  • What are the positive attributes to these assessments?
  • What are the difficulties associated with these?
Evaluation: Key Concepts

• What are you trying to learn?
  ▪ Qualifying symptoms
  ▪ Date of onset
  ▪ Substance use history
  ▪ Presence and/or history of affective components
  ▪ General Medical Conditions
Sub-threshold vs. Threshold

Alex

• Last summer I started feeling like people on the subway were watching me. First it was just on certain trains that I take to go to school, and then it was all the time. I think they were thinking bad things about me— it was whenever I wore blue, that meant something bad to them, and I knew it because they would blink at me in a certain pattern. It became harder to do the things I was doing because I couldn’t take trains to get anywhere.

Kevin

• Last winter my best friend said I should start watching this TV show that he really likes. At first I liked it, but then I started wondering if the people on the show were talking about me or maybe trying to say something to me. For example, I was breaking up with my girlfriend, and all of a sudden the TV couple would also break up. It was weird, but after watching it more I just realized that it was part of the story and didn’t have anything to do with me.
Qualifying Symptoms

- Delusions*
  - Referential; Persecutory; Grandiose; Somatic; Control (thought insertion/withdrawal); Though broadcasting (mind being read)
- Hallucinations
  - Auditory; Visual; Tactile; Gustatory; Olfactory
- Disorganized Thinking (formal thought disorder)
- For each positive symptom, determine
  - Impact,
  - Intensity,
  - *Degree of conviction (lack of insight must be present to meet threshold symptoms for delusions)
Evaluation: Timeline Assessment

- Identify which psychotic symptoms met threshold criteria
- Create timeline for each qualifying symptom
  - Helpful to understand prodromal phase (assess functioning and impairment)
- Confirm the absence of symptoms before the earliest date:
  - Correlate psychotic symptoms with any applicable substance use, affective components, trauma history, and/or major life events (occurring prior to onset)
08/2013: Moved out of state for college

Fall 2013: Continued smoking marijuana (about once per week)

Spring 2014: Coursework became more difficult; dropped all extracurricular activities

Spring 2014: Went to ER for anxiety; Saw a therapist on campus twice for anxiety; no meds, stopped going for therapy

May 2014: Began feeling like others were talking about me, felt like TV was talking to me

June 2014: Increased cannabis (daily use) used to "slow down the thoughts"; taken to ER by parents, 1st hospitalization

June 2014: Moved back home for Summer
Key Points

• Successes and struggles are important on timeline
• Assess for presence and absence of symptoms
• Focus on time indicators
• Balance time to complete assessment—keep your objective in mind
Engagement Strategies

• What’s *their* story?
• Working backwards from recent incidents (e.g. hospitalization).
• Working forward from high school/college/employment benchmarks.
• Integrating information from multiple sources (e.g. family members, medical records), without losing sight of hearing from the individual.
• Using non-clinical language
Clinical High Risk

• Have familiarity with existing diagnosis (if present)
• Must administer the SIPS
Group Discussion

• You are about to meet with Katie, a 20 yo potential client, for an eligibility evaluation. From previous interactions, her mom seems to answer most questions for her and wants to be involved in everything. Katie’s dad has very specific views about her illness—his brother had Schizophrenia, and he does not believe that her symptoms are the same. You were able to talk to Katie once before, but she is very quiet around her parents.

• How would you proceed with the evaluation?
Important Points

• Provide enough information about services
• What are the next steps
• Provide some psychoeducation as needed and answer any questions parents may have
• Prioritize the individual and ultimately doing the evaluation with the her alone
• Get information and each of the parent’s points of view
Common Traps

- Making the process seem like an interview
- Not allowing enough time and space for young person to share their perspective
- Making assumptions or jumping to conclusions too quickly
- Depending only on medical records
- Using language that is too clinical
Differential Diagnoses

- Substance Induced Psychosis
- Major Depression with psychotic features
- Affective Disorders
- Comorbid Diagnoses (psychiatric and medical conditions like diabetes, heart conditions)

**Could inform initial treatment planning**
Substance Use- assess for all substances

- Sedatives-hypnotics/anxiolytics (e.g. Xanax, Ambien)
- Cannabis
- Stimulants
- Opioids (e.g. Heroin, OxyContin)
- Cocaine
- Hallucinogens (e.g. LSD, MDMA/ecstasy)
- Dissociative anesthetics (e.g. PCP, Ketamine)
- Alcohol
- Other: diet pills, steroids, glue, paint thinners, inhalants
Types of Substances

Some substances are more likely to be associated with/cause psychotic symptoms. Some examples include:

• Cocaine (closely connected with delusions), PCP, amphetamines, benztropines or anti-cholinergic medication (closely connected with hallucinations), LSD/Acid, K2, Molly

Other substances are not known to induce psychotic symptoms

• Example: Opioids (pain relievers) do not generally cause psychotic symptoms
## Substance Use Assessment (sample)

<table>
<thead>
<tr>
<th>Type of Substance</th>
<th>Pattern of use (dates and age): Start/stop dates, periods of sobriety, periods of intoxication</th>
<th>Pattern of use: Amount, administration</th>
<th>Additional notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>Began drinking age 16; 3 blackouts from intoxication (heaviest ages 19-22, most weekends); stopped drinking 2 months before date of onset—no Tx</td>
<td>4-6 drinks in one setting, mostly mixed drinks and liquor</td>
<td></td>
</tr>
<tr>
<td>LSD</td>
<td>Used twice, 1&lt;sup&gt;st&lt;/sup&gt;: age 19, 2&lt;sup&gt;nd&lt;/sup&gt;: age 21</td>
<td>Between 200-400ug taken orally</td>
<td>Experienced “trips” for up to 12 hours</td>
</tr>
<tr>
<td>Cannabis</td>
<td>Tried once age 16; 19-21 increased use (every other day); stopped 1 month before date of onset</td>
<td>Smoked 1-2 joints 3-4 times p/week</td>
<td>Possibility that cannabis was sometimes laced with PCP (in college)</td>
</tr>
</tbody>
</table>
Affective Components

- Major Depressive Episodes
- Manic Episodes
- Periods of overlap
Major Depressive Episode

Assess for symptoms lasting for $\geq 2$ weeks (this would indicate an MDE)

- Nine characteristic symptoms: at least 5 must be present every day or nearly every day for at least 2 weeks
- Refrain from using loss of interest as a key characteristic (can also be a negative symptom)—when assessing for psychotic symptoms within episode, MDE must definitely include depressed mood
Manic Episode

Assess for symptoms lasting for $\geq 1$ week (this would indicate a Manic Episode)

- Seven characteristic symptoms: 3 must be present for at least one week
- DSM-V changes: Abnormally elevated/irritable mood AND increased energy/activity (for at least a week)
Schizophrenia/Schizoaffective vs. Mood Disorder with Psychotic Features

• Schizophrenia/Schizoaffective: Psychotic symptoms during times when person is not suffering from Major Depressive or Manic Episode

• Mood Disorder With Psychotic Features: Psychotic symptoms are confined to Major Depressive or Manic Episodes
Vignette: Sarah Part I

Sarah was going to be a junior in college in Massachusetts in the fall of 2013. She was majoring in finance and accounting and worked part-time while attending school full-time. In August 2013, a few weeks before school was going to begin, Sarah went out with some friends and smoked a lot of marijuana. While driving in the car she became fearful that her male friends were trying to kidnap her and she was brought to the hospital immediately.
Questions:

• What are some of the differential diagnoses you might be considering if you assessed Sarah at this point?
• What assessment tools might you use?
• What questions might you ask and who would you want to speak to?
She was prescribed Geodon and was discharged after a two week stay. At the time, Sarah did not believe she had had anything but a bad reaction to marijuana and chose not to fill her prescription.

Sarah returned to school in September 2013 and her symptoms returned fairly quickly. She began having auditory hallucinations, delusions of references and evidenced thought disorder. She began to have "racing" thoughts and what she describes as a "false reality." Sarah thought people were trying to kill her and she started hearing voices telling her that she was "at fault." She believed that her teachers were reading her mind and that they were inside of her brain. She was suspicious of her roommates trying to hurt her and wanted to "get back at them." Sarah began to believe that music was sending messages to her and cameras were watching her all of the time. In October 2013, Sarah was picked up by the police, when she was found wandering the streets, listening to the messages from the “yellow lines” on the street. She was brought to the hospital once again.
Questions:

• What are some of the differential diagnoses you might be considering if you assessed Sarah at this point?
• What assessment tools might you use?
• What questions might you ask and who would you want to speak to?
Discussion/ Questions?
Thank You