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From Portland to Paris: Clinical Perspectives on Supporting Young People Suffering from Early Psychosis

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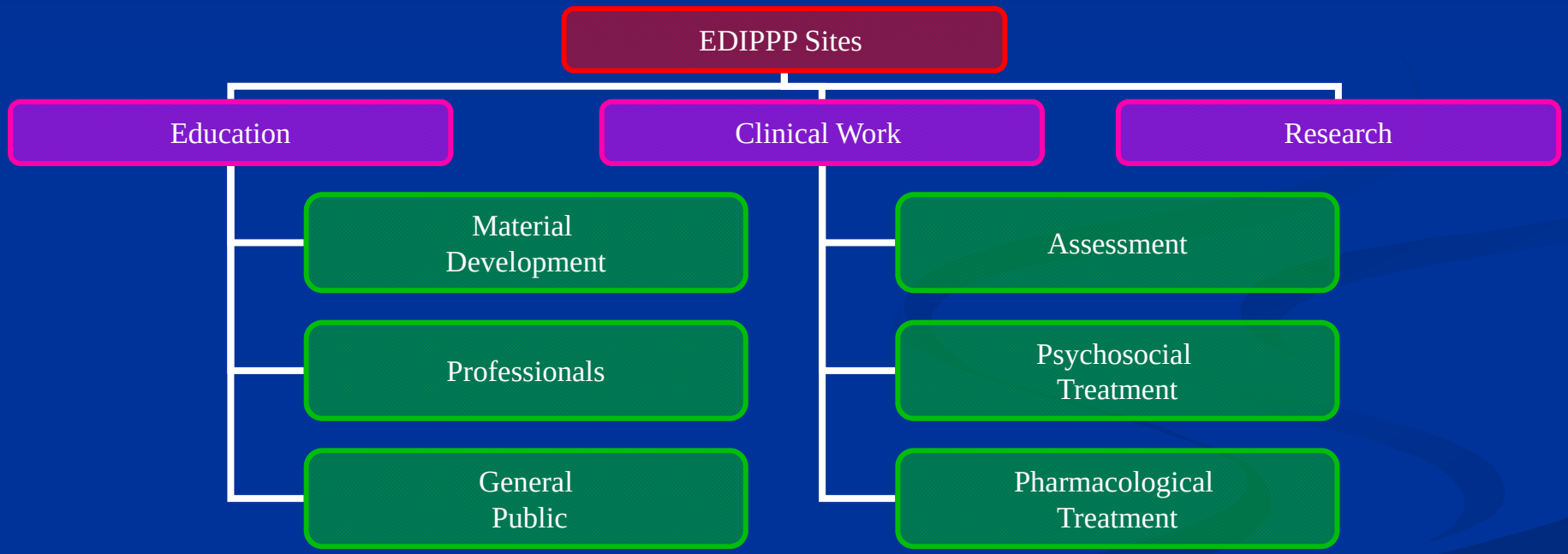
Early Detection and Prevention of Psychosis Program (EDIPPP)
Robert Wood Johnson Foundation

Multi-site study of the effectiveness of Family-Aided Assertive Community Treatment (FACT) in preventing the onset of psychosis in a nationally representative sample of at-risk young people

Early Detection and Prevention of Psychosis Program (EDIPPP) Sites

- Maine Medical Center, Portland, ME
- University of California Davis, Sacramento, CA
- University of New Mexico, Albuquerque, NM
- Washtenaw Community Health Organization,Ypsilanti, MI
- Zucker Hillside Hospital, Glen Oaks, NY
- Mid-Valley Behavioral Care Network, Salem, OR

EDIPPP


EDIPPP Sites
Education
Clinical Work
Research
Material Development
Professionals
General Public
Assessment
Psychosocial Treatment
Pharmacological Treatment

Outreach Defined

- Activities designed to educate key audiences about the importance of early detection and intervention of psychosis for the purposes of developing a network of early identifiers while developing and maintaining relationships with community members

- Outreach Objectives
  - Knowledge
  - Early Identification
  - Referrals
  - Network

Audience-Specific Outreach: Professional and Public Education

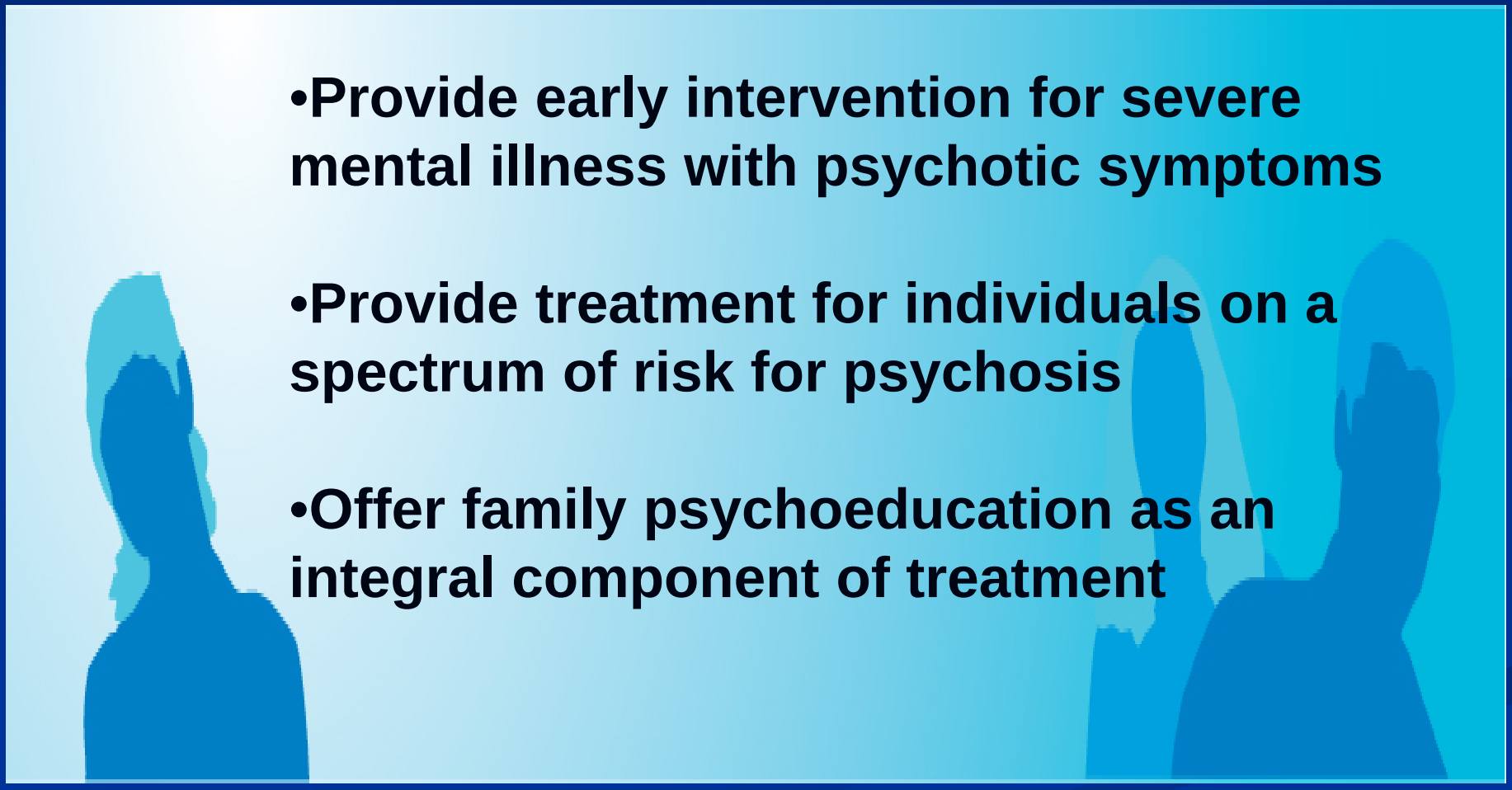
- Reducing stigma
- Information about modern concepts of psychotic disorders– *specific to audience*
- Increasing understanding of early stages of mental illness and prodromal symptoms
- How to get consultation, specialized assessments and treatment quickly
- Ongoing inter-professional collaboration

Early Psychosis Program

Reducing the incidence of major psychotic disorders in a defined population, by early detection and treatment:

Indicated prevention

Early Psychosis Program Mission



- **Provide early intervention for severe mental illness with psychotic symptoms**
- **Provide treatment for individuals on a spectrum of risk for psychosis**
- **Offer family psychoeducation as an integral component of treatment**

Psychosis Can Develop in the Following Mental Health Disorders:

- Schizophrenia spectrum disorders
- Bipolar disorder
- Major depression
- OCD
- PDD spectrum disorders
- Substance use or abuse
- Medical illnesses
- Trauma and PTSD

(Mueser & Gingerich, 2006)

What are the Early Warning Signs Before Psychosis Starts?

- Feeling “something’s not quite right”
- Jumbled thoughts and confusion
- Trouble speaking clearly
- Being fearful for no good reason
- Hearing sounds/voices that are not there
- Declining interest in people, activities and self-care
- Deterioration in functioning (work/school/hygiene)

Psychosis Occurs on a Spectrum

Grandiosity

Youth enjoys basketball and expects to attend college on a full scholarship.

Youth is heading to New York City because he believes he is talented enough to join the Knicks.

Suspiciousness

Young woman goes to the mall and feels like people are looking at her.

She refuses to go to the mall because she is certain that a specific person is out to harm her

Auditory Hallucinations

Hearing indistinct buzzing or whispering

Hearing a voice clearly outside your head saying, “You’re a loser” or “You’re a failure.”

Assessing Risk for Psychosis

Structured Interview of Psychosis Risk Syndromes (SIPS)

- Developed at Yale University
- Diagnoses presence of psychosis
- Diagnoses “prodromal” syndromes
- Measures severity and change
- Interrater reliability and predictive validity
- Translated into 14 languages

Case Example:
Symptomatic Prodromal Client - Alex

- 19 Year-old Male
- Social Withdrawal
- Exaggerated Suspiciousness
- Perceptual Abnormalities

SIPS Sample Questions

Unusual Thought Content

- **Have you ever been confused at times whether something you have experienced is real or imaginary?**
- **Do familiar people or surroundings ever seem strange?** Confusing? Unreal?
- **Do you ever feel as if somehow thoughts are put into your head or taken away from you?**

Suspiciousness

- **Do you ever feel that you have to pay close attention to what's going on around you in order to feel safe?**
- **Do you ever feel like people might be intending to harm you?**

Grandiosity

- **Have you ever behaved without regard to painful consequences? For example, do you ever go on excessive spending sprees that you can't afford?**
- **Do you ever think of yourself as a famous or particularly important person?**

SIPS Sample Questions (cont)

Perceptual Abnormalities/ Hallucinations

- **Do you ever hear unusual sounds like banging, clicking, hissing, clapping, ringing in your ears?**
- **Do you seem to feel more sensitive to light or do things that you see ever appear different in color, brightness or dullness; or have they changed in some other way?**

Disorganized Communication

- **Do people ever tell you that they can't understand you? Do people ever seem to have difficulty understanding you?**
- **Are you aware of any ongoing difficulties getting your point across, such as finding yourself rambling or going off track when you talk?**

Alex's signs of prodromal psychosis

Changes in behavior, thoughts and emotions, with preservation of insight:

Unusual Thought Content:

- Confusion between what really happened and what he had dreamed
- Had a strong feeling that something bad was going to happen
- Sensed a presence in his room

Suspiciousness:

- Notion that people are hostile and going to hurt him – began carrying a knife
- Thoughts of being watched

Perceptual Abnormalities/ Hallucinations:

- Changes in the way things look and sound
- Hearing a louder male voice at night and heard his name called
- Fleeting apparitions

Disorganized Communication:

- Says his thoughts are jumbled in his head and can't say what he means to say

Other signs of psychosis risk syndromes

- Significant deterioration in functioning
  - Unexplained decrease in work or school performance
  - Decreased concentration and motivation
  - Decrease in personal hygiene
  - Decrease in the ability to cope with life events and stressors
- Social withdrawal
  - Loss of interest in friends, extracurricular sports/hobbies
  - Increasing sense of disconnection, alienation
  - Family alienation, resentment, increasing hostility, paranoia

Structured Interview for Prodromal Symptoms (SIPS)
Summary of data from the
Scale of Prodromal Symptoms (SOPS)

Positive Symptom Scale

0 Never, Absent	1 Questionably Present	2 Mild	3 Moderate	4 Moderately Severe	5 Severe but Not Psychotic	6 Severe and Psychotic

Positive Symptoms

P1. Unusual Thought Content / Delusional Ideas	0	1	2	3	4	5	6
P2. Suspiciousness / Persecutory Ideas	0	1	2	3	4	5	6
P3. Grandiosity	0	1	2	3	4	5	6
P4. Perceptual Abnormalities / Hallucinations	0	1	2	3	4	5	6
P5. Disorganized Communication	0	1	2	3	4	5	6

What the Scores 'Mean'

P.2 DESCRIPTION: SUSPICIOUSNESS/PERSECUTORY IDEAS

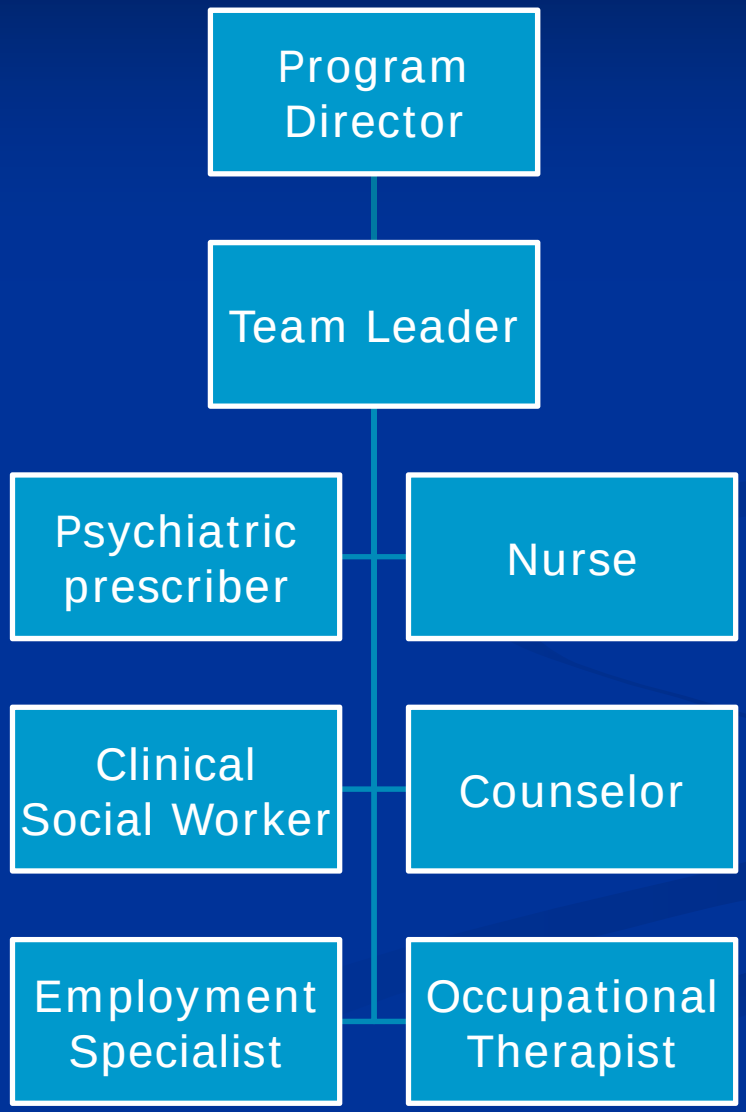
1-2 MILD **3-5 PRODROMAL SYMPTOM RANGE** **6- PSYCHOTIC**

0 Absent	1 Questionably Present	2 Mild	3 Moderate	4 Moderately Severe	5 Severe but Not Psychotic	6 Severe and Psychotic
	Wariness.	Doubts about safety. Hypervigi-lance without clear source of danger.	Notions that people are hostile, untrustworthy, and/or harbor ill will easily. Sense that hypervigilance may be necessary. Mistrustful. Recurrent (yet unfounded or exaggerated at times) sense that people are thinking or saying negative things about person. May appear mistrustful with interviewer.	Clear or compelling thoughts of being watched or singled out. Sense that people intend to harm. Beliefs easily dismissed. Presentation may appear guarded. Reluctant or irritable in response to questioning.	Loosely organized beliefs about danger or hostile intention. Skepticism and perspective can be elicited with non-confirming evidence or opinion. Behavior is affected to some degree. Guarded presentation may interfere with ability to gather information in the interview.	Delusional paranoid conviction (with no doubt) at least intermittently. Likely to affect functioning.

Structured Interview for the Prodromal Syndrome (SIPS), McGlashan, T., *et al, 2003*

Intervening to Prevent Onset

Trans-Disciplinary Treatment Team



Family-aided Assertive Community Treatment (FACT): Clinical and functional intervention

- Proactive Outreach – meet the client in their environment/ with supports
- Trans-disciplinary team planning, treatment and case accountability
- Small caseload – 1:15
- Fixed point of responsibility
- Flexible service delivery
- 24/7 availability

Family-aided Assertive Community Treatment (FACT):
Clinical and functional interventions

- Community-Based Treatment
- Crisis Prevention and Intervention
- Creative and strengths based engagement
- Family Psychoeducation: Multiple Family Groups
- Careful medication administration and side-effect monitoring
- Case Management using key Assertive Community Treatment methods: outreach PRN; rapid response; continuous case review
- Individual Therapy
- Cognitive and Functional Assessments administered by OT
- Supported employment and education

Typical Mental Health Assumptions

- You must be 100% compliant and 100% abstinent from illicit drugs.
- You must accept your illness and make the effort to attend your appointments.
- You must never work harder then your client.
- Close clients that do not show for appointments.
- A clear exit from the system is never a goal.
- Stability is the goal.
- Therapists should not do service coordination.
- Maintain strict boundaries with your client.
- Some people just can't be helped.
- Adults and Children should be in different systems.
- Families are a barrier to treatment.

I'M Sorry but you need to go back through intake!

Engagement Strategies: (Xavier Amador: LEAP)

- Listen
- Empathize
- Agree
- Partner

I'm not sick, I don't need help!

Instead Engage!

- Put person at ease.
- Meet in a location that is comfortable for the client.
- Try side-by-side.
- Take individuals seriously despite what is said
- Acknowledge viewpoint/collaborative empiricism
- Be flexible, active and helpful
- Spend time socializing, focus on interests, especially those you have in common. Identify common ground or create it.
- Explain procedures & write things down with clear instructions.
- Worry about assessment at later time, it is recommended to gather information gradually and in the form of story telling (aids in memory and identifying negative cognitions and stigma.)
- Find a common ground.

Why Focus on Engagement?

- Anosognosia
- Stigma
- Side effects

Cognitive therapy for psychotic symptoms:

- Is well researched (at least 23 randomized studies)
- Shows substantial positive effects
- Has a few published therapy manuals
- Is on Oregon's list of evidence based practices
- Developed and practiced mostly outside of the United States so far (probably due to the strong biological bias in this country.)

Cognitive Therapy and Medications

- The evidence base is with clients who also took medications
  - Cognitive therapy worked to reduce the symptoms the medication did not control
- As a result of cognitive therapy, clients are often able to use less medication
- Case study reports show cognitive therapy is often helpful with clients who refuse medications.

Dialogue and the Edge between Balance and Imbalance

- Rationality emerges out of dialogue
  - Not by suppressing "irrational" views
- Health is not the absence of disruptive emotions and thoughts
  - But rather a meta-balance between what is disruptive and what is stabilizing

My feelings and emotions tell me what is real: if I'm feeling down then I'm doing terrible, if I feel scared, then I'm in danger, etc.

My feelings and emotions give me suggestions about what may be real.

I decide whether they are accurate or not. If they are accurate, I act on them, if not, I just accept them and let them go.

My feelings and emotions are my enemy: I need to block them out (or drug them away)

Elements of the Cognitive Approach

- Goals structured around what client wants
- Collaborative Empiricism
- Middle ground between confrontation and collusion
- Socratic Dialogue
- Avoiding the role of "expert"
- Curiosity about client's efforts to make sense
- Empathy
- Self disclosure

One example of a cognitive approach

- Engage in discussion about the same belief
- Use "collaborative empiricism"
  - Avoid confrontation or collusion
  - First, briefly explore why "client" believes it
  - Then, gently draw out from the "client" any possible reasons to doubt that the belief is completely true
- Remember, Relationship First!

Shame and Blame Model: "you must have chosen to become like this and you could chose to get over this if you want to – pull yourself up by your bootstraps"

Cognitive model: "You aren't to blame for falling into this problematic pattern, you didn't know enough to anticipate it, but with effort and with help you may learn to get out of it"

Medical model: "You have a brain disease and/or a biochemical imbalance: you aren't responsible, your thoughts & decisions played no role in this"

Delusions: Hypervigilant for Threat Vs. Overly Rigid in Defense

I define myself completely independently of the perceptions of others:

I am as grand as I want to be, I am invulnerable.

I negotiate my identity with others:

In general I care how others see me but I am not a total captive of the perspective of others. I decide what to make of how they see me.

I am completely vulnerable to how others see and define me:

Often I can't stand to be looked at because of what might happen to my self-definition.

Family Psychoeducation – Multiple Family Groups

The approach is designed to:

Help families and consumers better understand mental illness while working together toward recovery.

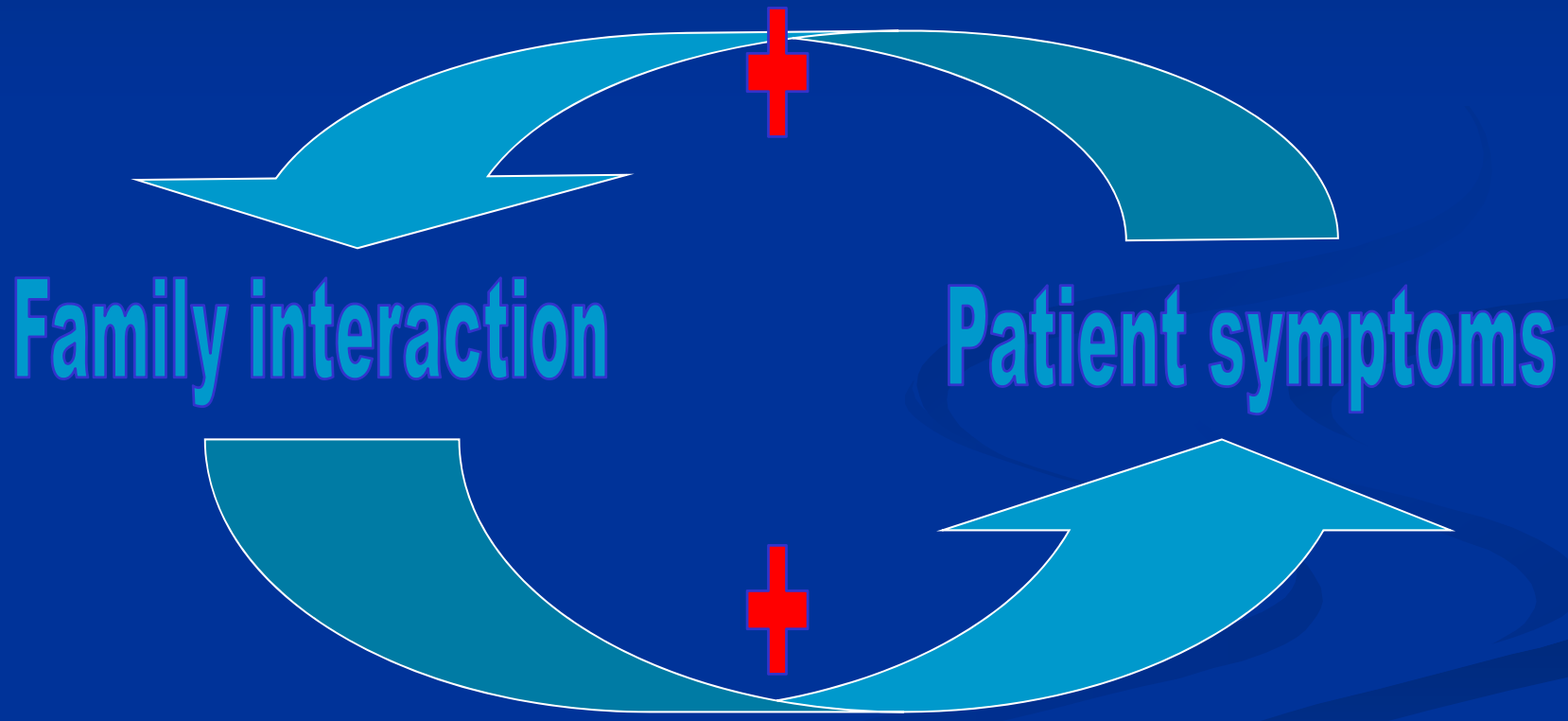
Recognize the family's important role in recovery: with or without client present, program provides support and skills for client's support network: family, school staff, supports

Help clinicians see markedly better outcomes for consumers and families.

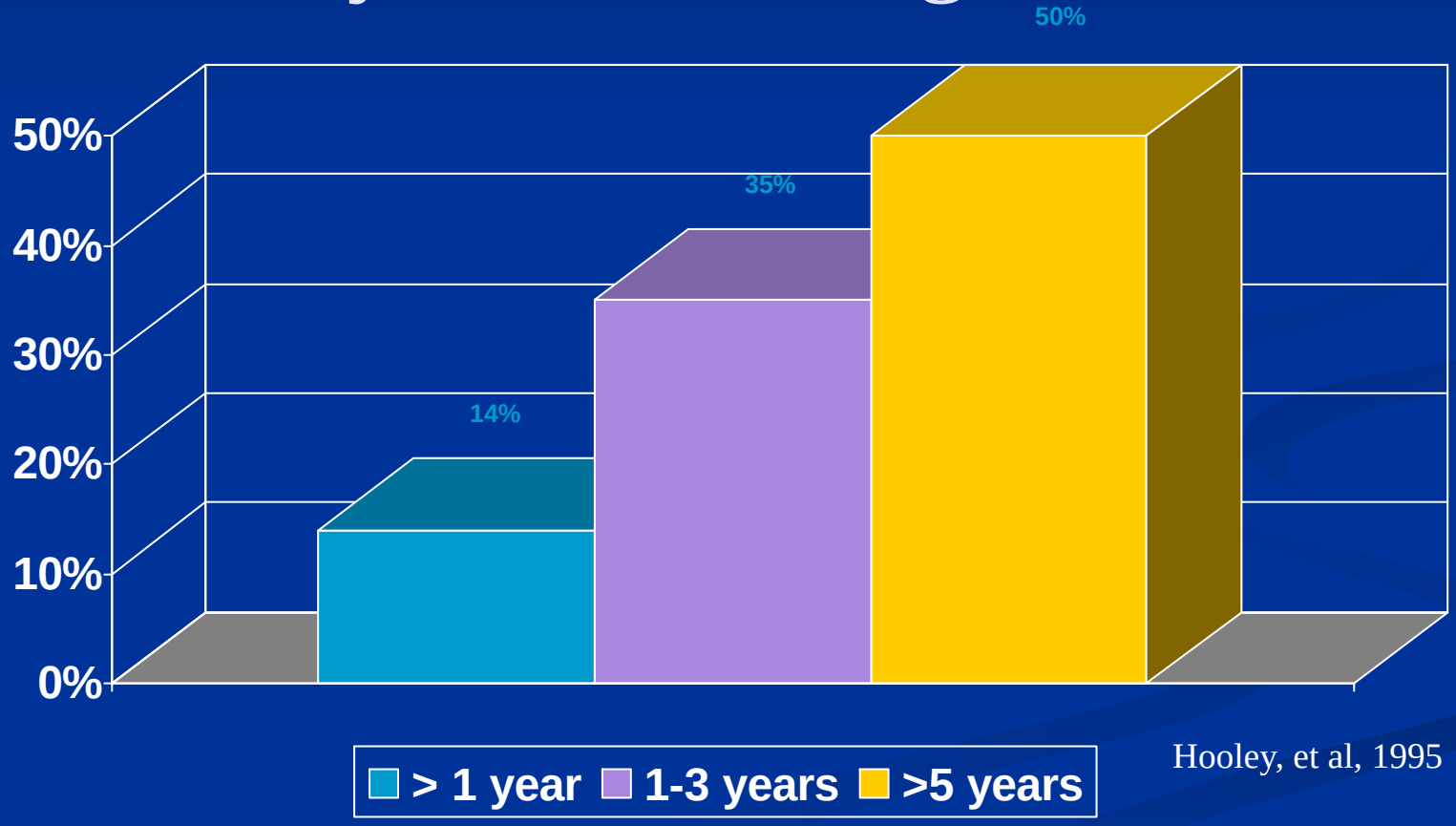
Expressed emotion

- Critical comments
- Hostility
- Over-involvement
- Warmth

Mutual causal effects: Patient symptoms and family interaction



Proportion of families with high EE in years following onset



Hooley, et al, 1995

Therapeutic Processes in Multiple Family Groups

- Stigma Reversal
- Social Network Construction
- Communication Improvement
- Crisis Prevention
- Treatment Adherence
- Anxiety and Arousal Reduction

Multifamily Groups

STAGES OF PMFG INTERVENTION – TIMELINE

Initial Contact	1 weeks	2 weeks	3 weeks	4 weeks	6 weeks	8 weeks	Every other wk 1-2 years
Client & Family Outreach	JOINING Session #1	JOINING Session #2	JOINING Session #3	Family Education WORKSHOP	1st PMFG	2nd PMFG	PMFG Problem Solving

Multifamily Group Format

1. Socializing with families and consumers	15 m.
2. A Go-around, reviewing— a) The week's events b) Relevant biosocial information c) Applicable guidelines	20 m.
3. Selection of a single problem	5 m.
4. Formal Problem-solving a) Problem definition b) Generation of possible solutions c) Weighing pros and cons of each d) Selection of preferred solution e) Delineation of tasks and implementation	45 m.
Socializing with families and consumers	5 m.
Total:	90 m.

Key clinical strategies in family intervention specific to prodromal psychosis

- Minimize internal family stressors
  - Strengthening relationships and creating an optimal, protective home environment:
  - Reducing intensity, anxiety and over-involvement
  - Preventing onset of negativity and criticism
- Buffering external stressors
  - Adjusting expectations and performance demands

Rehabilitation Effects of Multiple Family Groups

- Reducing family confusion and tension
- Focus on functional goals
- Breaking down goals into manageable steps
- Coordinating efforts of family, team, consumer and other supports (work/school)
- Developing formal and informal job leads and contacts
- Cheerleading and ongoing problem solving