How to Assess Individuals for a First Episode Psychosis Program

Kim T. Mueser, Ph.D.

Center for Psychiatric Rehabilitation

Boston University

(*with special thanks to Yulia Landa, Psy.D. and Susan Gingerich, M.S.W.)

Importance of Accurate Diagnostic Assessment

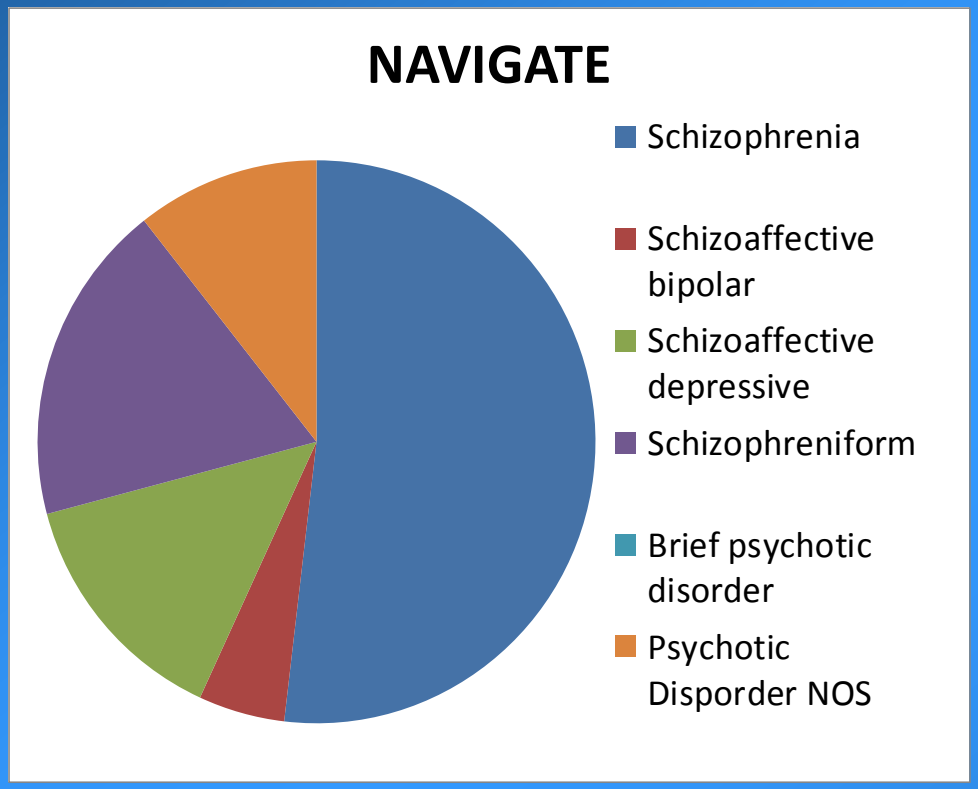
- Comprehensive first episode psychosis (FEP) specialty programs designed for particular populations; they may include treatment elements not beneficial to some clients (e.g., medications)
- Education of clients and family members about psychosis and its treatment require attention to accurate diagnosis
- Need to ensure limited resources for treating FEP are spent on this group, which has the greatest overall need

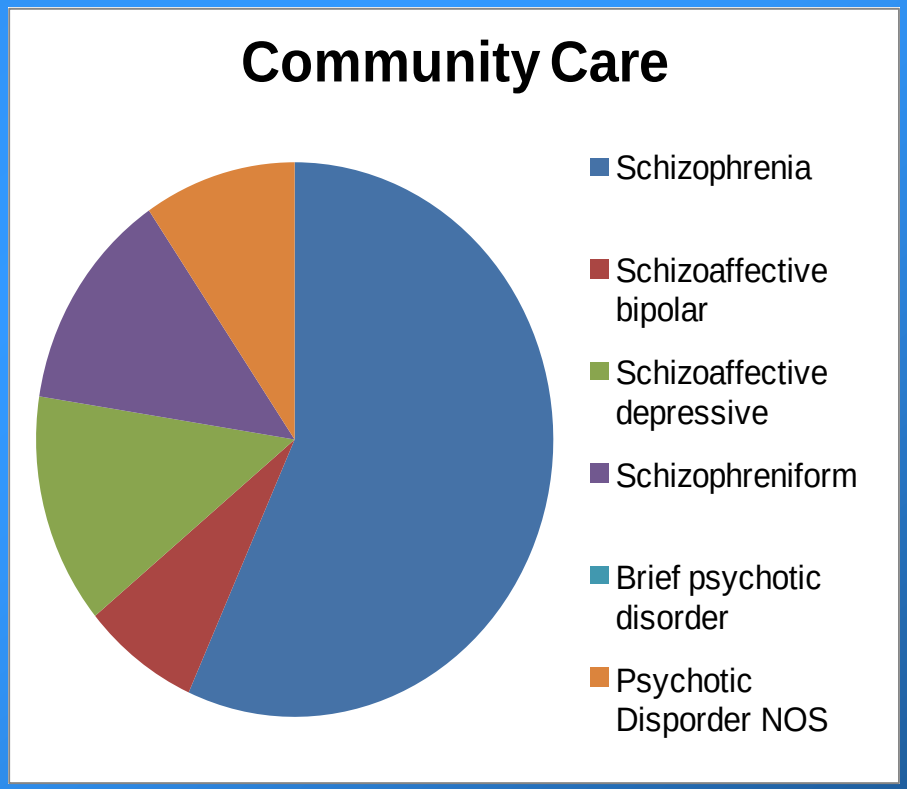
Typical Diagnoses Included in Comprehensive FEP Programs

- Schizophrenia
- Schizoaffective disorder
- Schizophreniform disorder
- Psychosis NOS
- Brief Psychotic Disorder (rare)

Baseline Diagnoses from RAISE-ETP Study

Adjusted for Cluster Design (Kane et al., Am J Psychiatry, 2016)





Common Clinical Presentation of FEP

- Clear presence or recent history of psychotic symptoms (e.g., hallucinations, delusions)
- Negative symptoms (apathy, blunted affect, social avoidance)
- Significant deterioration in social, school/work, self-care functioning, for at least several months, if not years
- Cognitive impairment common
- History of depression common, but psychotic symptoms not limited to depressive states

Schizophrenia-Spectrum vs. Major Mood disorder

- Psychotic symptoms (hallucinations, delusions) may occur in both types of disorders
- Impairment in psychosocial functioning also common in both types of disorders
- Key distinguishing characteristic: in mood disorders psychotic symptoms occur only during episodes of mania or depression; in schizophrenia-spectrum disorders at least some psychotic present have been present when mood is normal

Psychosis NOS and Brief Psychotic Disorder

- DSM-IV Psychosis NOS = DSM-5 Unspecified Schizophrenia-spectrum and Other Psychosis
- Relatively uncommon: used to describe cases with psychotic feature that do not clearly meet diagnostic criteria for other disorders
- Brief psychotic disorder: extremely rare in FEP programs, defined in terms of clear psychotic symptoms that remit within a month
- Low rate of detection may relate to long duration of untreated psychosis in most cases, leading to resolution of symptoms and no treatment seeking

Differential Diagnosis: Substance Abuse and Substance-induced Psychosis

- Substance use/abuse problems high in FEP clients (about 50% lifetime substance abuse)
- Psychotic symptoms can be precipitated by substance abuse
- Drug use associated with earlier age of onset of FEP
- Substance abuse and FEP can both be diagnosed in same person
- Need to distinguish substance-induced psychosis from FEP

Differential Diagnosis: Substance Abuse and Substance-induced Psychosis, cont'd

- In substance–induced psychosis, psychotic symptoms usually remit soon after substance use ceases
- Stimulants (cocaine, amphetamine), cannabis, and hallucinogens most likely to cause psychotic symptoms
- Key strategy: look for a clear pattern of psychotic symptoms closely associated with substance use, which improves when substance use stops
- Most common FEP pattern: gradual deterioration in functioning, sometimes loosely associated with substance use, with minimal change in symptoms or functioning when person stops using

Differential Diagnosis: Substance Abuse and Substance-induced Psychosis, cont'd

- Substance use in FEP often involves relatively minor levels of use, which can precipitate symptoms due to biological vulnerability
- Primary addiction associated with larger amounts of substance use and more physical dependence
- Not always possible to rule out role of substance use in FEP, and it is better to include clients when in doubt
- Use the "Walks like a duck" rule—if pattern resembles typical onset of FEP, with gradual onset of symptoms and deterioration of functioning, assume person has FEP until evidence to the contrary is available

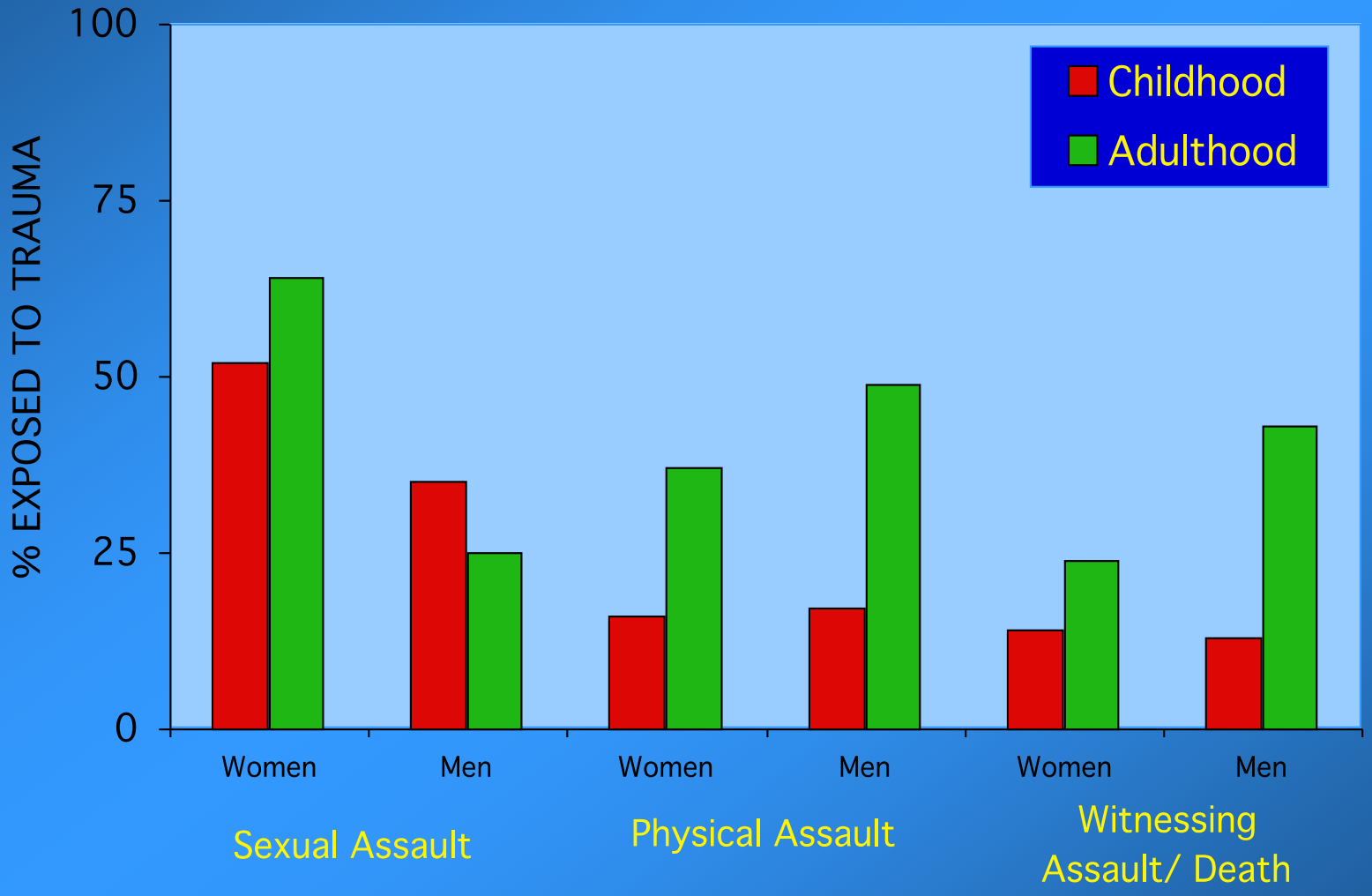
Differential Diagnosis: Autism

- Both are possible, but relatively rare
- Autism is developmental disorder with pattern of social and learning difficulties dating back to childhood
- Impairment in autism is relatively stable, but often improves gradually over time
- Onset of FEP occurs in late adolescence or early adulthood, is reflected by clear deterioration in functioning that often predates onset of psychotic symptoms
- While social problems are common in both disorders, psychotic symptoms are rare in autism

Differential or Comorbid Diagnosis: PTSD

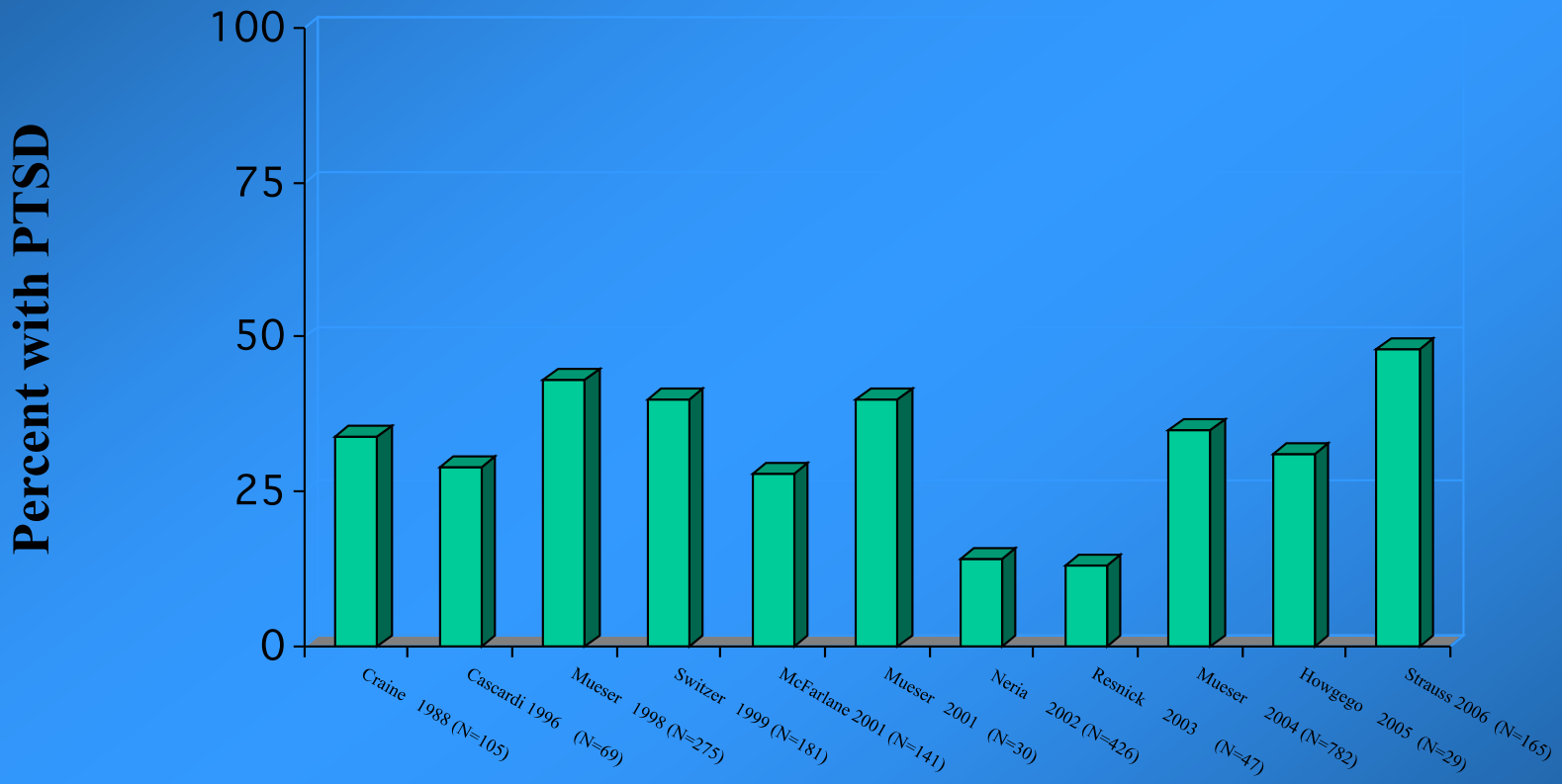
- Trauma common in SMI population
- Trauma in childhood increases risk of developing mental illnesses, including schizophrenia
- Rates of PTSD are elevated in persons with SMI:
  - 10% lifetime prevalence in general population vs.
  - 25-50% in SMI populations
  - About 20% in FEP populations
- PTSD can be diagnosed as a comorbid disorder, but there is also potential overlap between PTSD and FEP symptoms and need for differential diagnosis
- Can be identified by brief trauma screen followed by PTSD screen (e.g., PTSD Checklist-5; PCL-5)

TRAUMA IN SMI (N=275)



Source: Mueser et al. (1998)

Rates of PTSD in Clients with SMI



Differential or Comorbid Diagnosis: PTSD, cont'd

- Trauma common in SMI population
- Trauma in childhood increases risk of developing mental illnesses, including schizophrenia
- Rates of PTSD are elevated in persons with SMI:
  - 10% lifetime prevalence in general population vs.
  - 25-50% in SMI populations
  - About 20% in FEP populations
- PTSD can be diagnosed as a comorbid disorder, but there is also potential overlap between PTSD and FEP symptoms and need for differential diagnosis

Symptoms of PTSD

- Exposure to DSM-V traumatic event
- Symptom criteria:
- Intrusion symptoms (e.g., intrusive memories, flashbacks)
- Avoidance of trauma-related stimuli (e.g., avoiding memories, situations related to trauma)
- Over-arousal (e.g., hypervigilance, difficulty sleeping, anger outbursts)
- Negative alterations in cognition or mood (e.g., inability to remember parts of event, persistent negative feelings, detachment from others)

Other Common Symptoms in PTSD

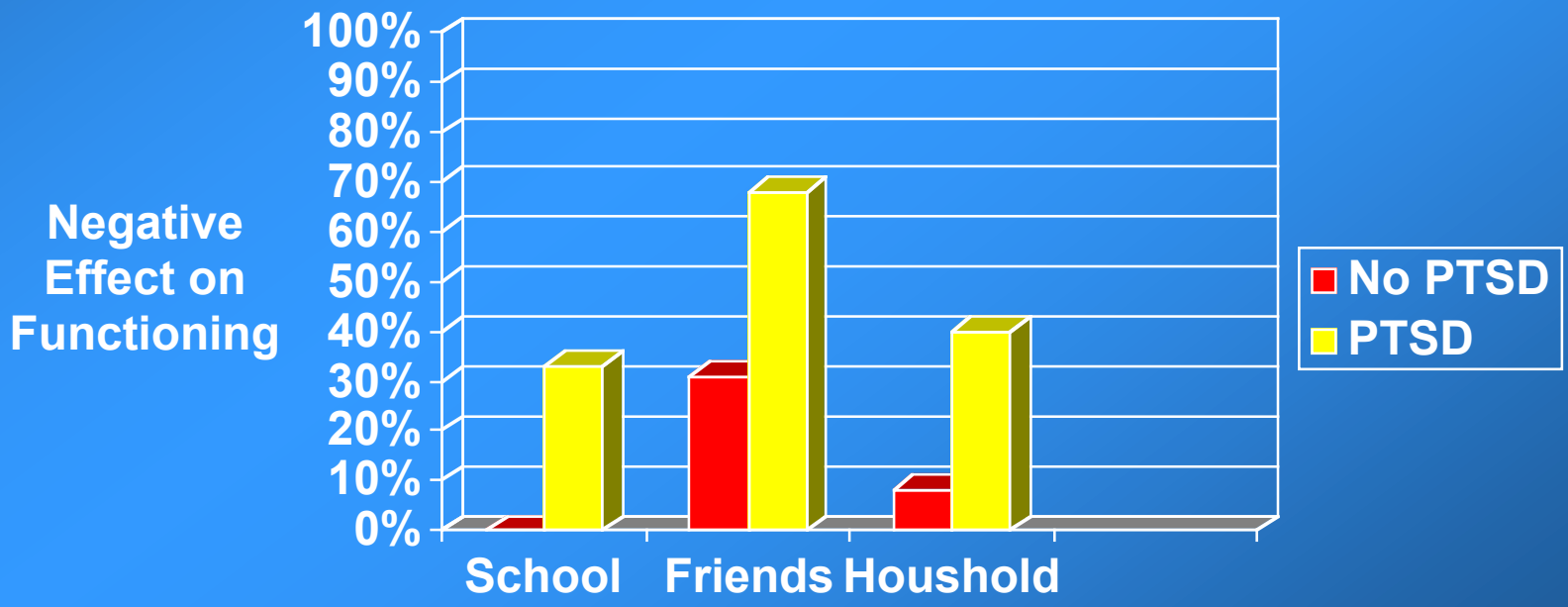
- Depression
- Guilt
- Suicidality, self-injurious behavior
- Substance abuse
- Psychotic symptoms (usually mild)
  - Hallucinations
  - Delusions (e.g., paranoia)

Trauma of Psychosis

- Experience of psychosis traumatic for client & relatives
- Posttraumatic stress disorder (PTSD) reactions common to psychotic symptoms and treatment experiences (e.g., involuntary hospitalization, seclusion and restraints): 31-46% PTSD syndrome
- PTSD reactions to first episode psychosis related to increased distress and decreased functioning

Impact of PTSD Related to Psychosis on Functioning in First Episode Psychosis

(N = 38; Mueser et al., Schizophrenia Research, 2010)



Differential or Comorbid Diagnosis: PTSD, cont'd

- Re-experiencing symptoms in PTSD are usually intrusive memories that appear as thoughts, but less commonly are brief flashbacks; by definition they are related to a specific traumatic event
- Re-experiencing symptoms can also present as hallucinations (e.g., voices or visions) that are directly related to traumatic event (and rated as both), but this is less common
- In PTSD avoidance symptoms are clearly related to specific traumatic events, as distinguished from negative symptoms
- Delusional elaboration on trauma-related themes possible in PTSD; such individuals have the usual PTSD symptoms, but also delusions that are directly related to the trauma experienced
- Although not formally recognized in DSM-5, usually mild psychotic symptoms not uncommon in PTSD

Differential or Comorbid Diagnosis: PTSD, cont'd

- Differential diagnosis: if person has PTSD and all psychotic symptoms are related to traumatic event, consider diagnosis of PTSD; otherwise, probably PTSD and FEP
- Re-experiencing symptoms can also be hallucinations if memories appear as voices or visions directly related to traumatic event, but this is relatively uncommon
- Delusional elaboration on trauma-related themes possible in PTSD; such individuals have the usual PTSD symptoms, but also delusions that are directly related to the trauma experienced
- Although not formally recognized in DSM-5, usually mild psychotic symptoms not uncommon in PTSD

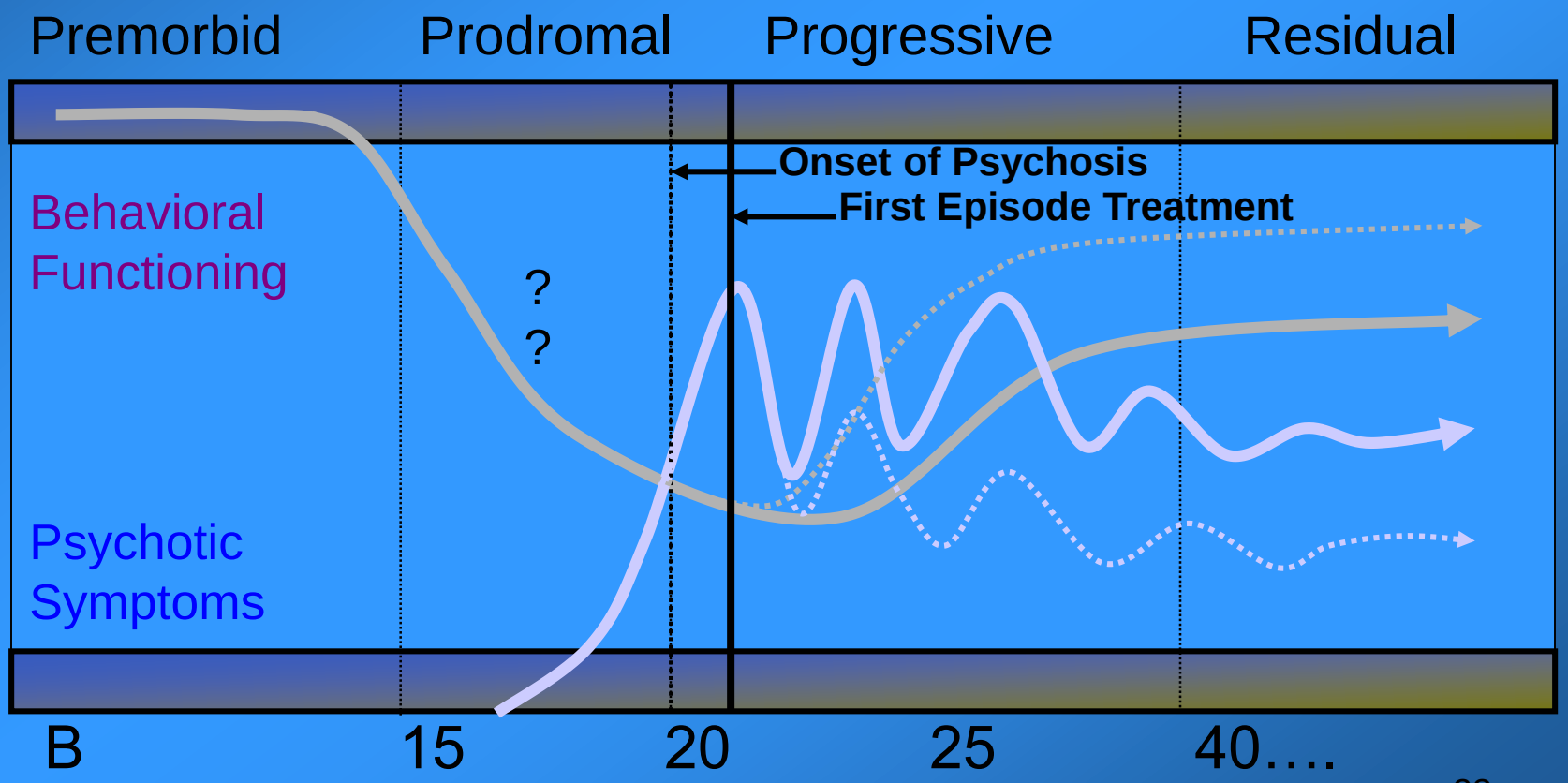
Duration of Untreated Psychosis (DUP)

- Duration between onset of psychosis and treatment critical to stabilization and social functioning
- Longer DUP associated with longer time to stabilize symptoms and poorer social outcome (multiple studies)
- Possible more gradual onset is correlated with later DUP and contributes to worse outcome
- Long DUP (e.g., average > 1 year) common before initiation of FEP program
- Comprehensive FEP programs do not usually exclude clients with long DUPs
- Reduction in DUP is major goal of first episode psychosis programs (e.g., < 6 months)

Early Intervention Is Key

National Institute of Mental Health

Clinical Course of Schizophrenia



Schizophrenia Prodrome: Common Symptoms and Signs:

Increased difficulty at school or work
Withdrawal from friends or family
Difficulty concentrating or thinking clearly
Suspiciousness or mistrust of others
Changes in the way things look or sound
Odd thinking or behavior
Emotional outbursts or lack of emotion
Poor personal hygiene

Prodromal Syndromes

- Identified by a structured interview
  - Structured Interview for Prodromal Syndromes (SIPS)
    Miller, T. J., McGlashan, T. H., Woods, S. W., Stein, K., Driesen, N., Corcoran, C. M., ... & Davidson, L. (1999). Symptom assessment in schizophrenic prodromal states. Psychiatric Quarterly, 70(4), 273-287.
  - Comprehensive Assessment of At Risk Mental States (CAARMS) Alison R. Yung, Alison R. Yung, Hok Pan Yuen, Patrick D. Mcgorry, Lisa J. Phillips, Daniel Kelly, Margaret Dell'olio, Shona M. Francey, Elizabeth M. Cosgrave, Eoin Killackey, Carrie Stanford, Katherine Godfrey & Joe Buckby (2005) Mapping the onset of psychosis: the Comprehensive Assessment of At-Risk Mental States, Australian and New Zealand Journal of Psychiatry, 39:11-12, 964-971
- Syndromes
  - Attenuated positive symptom syndrome
  - Brief intermittent psychotic syndrome
  - Genetic risk + deterioration syndrome

Prodrome vs. FEP

- Antipsychotics recommended for FEP, but not generally for prodromal state
- 20-40% of prodromal clients develop psychosis
- Key distinction is presence of clear psychotic symptoms in FEP, compared to more transient psychosis-like symptoms in prodrome (e.g., suspiciousness, odd thinking or behavior)
- Difficulties concentrating or thinking clearly common in prodrome, as are problems in functioning, but problems usually less severe and more recent than FEP

Improving Diagnostic Accuracy

- Rule out medical factors or substance abuse
- Screening instruments may help detect FEP in some settings
- Develop a timeline of the onset of different problems and symptoms to understand chronology
- Use a structured clinical interview with standard questions and prompts to improve reliability
- Obtain collateral reports from family members, other treatment providers, friends, teachers, etc.
- Review all available medical records, especially any inpatient psychiatric treatment

Screening Instruments for Prodromal/FEP

- Prime Screen-Revised
- Prodromal Questionnaire-Brief
- Youth Psychosis At-Risk Questionnaire

- Instruments range in # of items (16-92), time to complete 10-20 min.), with brief versions of several available
- Include distinction between prodrome and FEP

Clinical Interviews to Assess Prodromal and Psychotic Symptoms

- Comprehensive Assessment of At Risk Mental State (CAARMS)
- Structured Interview of Prodromal Symptoms/Scale of Prodromal Symptoms (SIPS/SOPS)
- Bonn Scale of Basic Symptoms (BSABS)
- Positive and Negative Syndrome Scale (PANSS)
- Brief Psychiatric Rating Scale-Expanded (BPRS)
- Psychotic Symptoms Rating Scale (PSYRATS)
- Structured Clinical Interview for DSM-5

Measurement of Duration of Untreated Psychosis

- Royal Park Multidiagnostic Instrument for Psychosis
- Comprehensive Assessment of Symptoms and History (CASH)
- Symptom Onset Schizophrenia Scale

Comprehensive Assessment of Clients with FEP

- Role functioning
  - Work (interest, competitive work, job type, hours/wages, etc.)
  - School (interest, involvement in, degree working towards, courses completed
  - Parenting
- Social functioning
  - Loneliness
  - Friends
  - Leisure/recreation
  - Family relationships

Comprehensive Assessment of Clients with FEP, cont'd

- Motivation/drive
  - Sense of purpose
  - Goal striving
  - Curiosity, sense of humor
  - Humor
- Positive psychology
  - Well-being
  - Self-determination
  - Resiliency
  - Recovery

Quality of Life Scale (QLS; Heinrichs et al., 1984)

- Semi-structured interview
- Designed to tap psychosocial functioning
- Subscales include:
  - Interpersonal relations
  - Instrumental functioning (work, school, parenting)
  - Intrapsychic foundations (sense of purpose, curiosity, motivation, anhedonia)
  - Common objects and activities (e.g., routines)
- QLS has been included in other FEP programs
- Was the primary outcome for the RAISE-ETP study (Kane et al., 2016)

Comprehensive Assessment of Clients with FEP, cont'd

- **Self-Care/Self-Management**
  - **Grooming and hygiene**
  - **Cooking, shopping**
  - **Home/apartment maintenance**
  - **Use of transportation**
  - **Finances: budgeting, paying bills, etc.**
  - **Telephone/mobile device skills**
  - **Medication adherence**

Comprehensive Assessment of Clients with FEP, cont'd

- Substance abuse
  - Types of substances used
  - Amounts, frequencies
  - Motives for use
- Positive psychology
  - Well-being
  - Self-determination
  - Resiliency
  - Recovery

Comprehensive Assessment of Clients with FEP, cont'd

- Health
  - Weight, BMI
  - Smoking status
  - Diabetes
  - Lifestyle: diet & exercise
- Family
  - Engagement
  - Caregiver burden
  - Quality of relationship/satisfaction

Comprehensive Assessment of Clients with FEP, cont'd

- Illness Self-management
  - Knowledge of mental illness
  - Relapse prevention plan
  - Medication adherence strategies
  - Strategies for coping with stress and symptoms
  - Social support
- Symptoms
  - Psychotic
  - Negative
  - Depression, suicidality
  - Agitation/excitement
  - Anxiety/PTSD

Suicidal Ideation and Command Hallucinations

- Suicidality
  - Suicide risk highest for younger people (including FEP)
  - Previous suicide attempts predict future attempts
  - Suicidal ideation or thoughts of being better off dead should trigger more detailed assessment
  - Evaluation of specific plans, methods, and intent needed to inform how to respond
  - Consideration of CBT and clozapine for high risk clients
- Command hallucinations
  - Voices instruct person to do things, including hurting self or others
  - Associated with aggression
  - If present, need to evaluate related delusional beliefs, perceptions of control, and distress
  - Potential referral to CBT for psychosis