Identification and Intervention for Psychosis-Risk

What do we know and what can schools, families and individuals do to mitigate risk?

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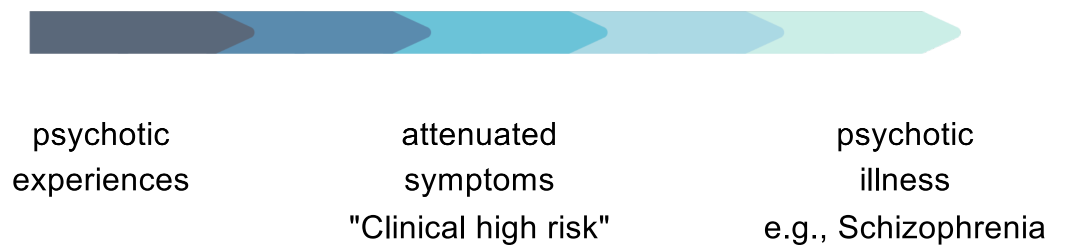
UCLA Health

Psychosis as a Spectrum



psychotic
experiences

attenuated
symptoms
"Clinical high risk"

psychotic
illness
e.g., Schizophrenia

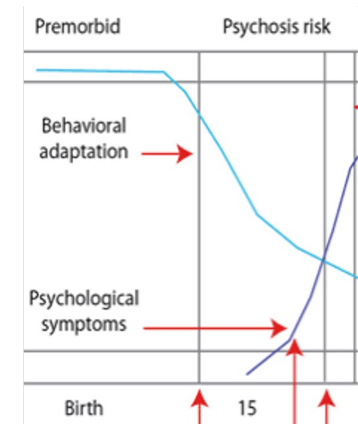
CAPPS Research & Treatment

Longitudinal and cross-sectional studies since 2002 demonstrate:

- Rates of conversion to psychosis decline with increased access to screening services & targeted interventions
- Treating depression effectively improves overall symptoms, functioning and prognosis
- Antipsychotics are not the usual treatment (Yung et al., 2019)
- Improved understanding of how psychosis develops (e.g., role of HPA hormones, immune system, cellular inflammation, oxidative stress) towards development of improved medications & a blood test for risk syndrome
- Ability to refine screening & assessment tools to be sensitive and specific
- Identifying key treatment targets based on new knowledge about the prodrome (stress sensitivity, specific social cognitive deficits, family stress)
- Developing & testing best practice therapies like FFT-HR

Psychosis-Risk Considerations

- Screen ASAP
  - Earlier, targeted intervention = best prognosis
- Indicators of Risk:
  - Decline in social and/or role functioning in the past 12 months
  - Negative symptoms (decreased drive or emotionality, anhedonia)
  - Family history of psychosis
  - Substance abuse history
  - Endorsed positive symptoms on screeners or in clinical assessments



Psychosis-Risk Considerations

Screeners

- Prodromal Questionnaire Screener (Loewy et al., 2011)
  - 21 items, risk cutoff score = 6, considers impact of distress

Have you felt that you are not in control of your own ideas or thoughts?

☐ **YES** ☐ **NO** ***If YES:*** When this happens, I feel frightened, concerned, or it causes problems for me:

☐ Strongly disagree ☐ disagree ☐ neutral ☐ agree ☐ strongly agree

- Structured Interview for Psychosis-Risk Syndromes (McGlashan et al, 2014)
  - In depth assessment conducted at each UCLA CAPPS assessment time point (biannually up to monthly)

Positive Symptoms

Structured Interview for Psychosis-Risk Syndromes (Miller et al. 2004)

Unusual thoughts

- Odd, suspicious, or grandiose/mighty
- Non-normative for age, family, religion, or peer group

Perceptual (sensory) abnormalities

- Hearing confusing buzzing, ringing, clapping, muffled voices, whispers
- Seeing confusing flashes, flames, shadows, vague figures
- Confusion about skin sensations like bugs

Diminished ability to think & communicate clearly

- Illogical reasoning; confused, rambling speech; blanking out
- Harder time tracking or engaging in conversation or expressing ideas

*__Consider Frequency__ (at least weekly) & __Severity__ (absent to psychotic; confusion/conviction, distress, & behavior change)

High Risk Syndromes

- **Attenuated Positive Symptoms:** 1+ symptom in prodromal range past month
- **Brief Intermittent Psychotic Symptoms:** 1+ symptom reached psychotic level within the past 3 mos. -- no more than an hour per day, a few days per week. Never seriously dangerous or disorganizing.
- **Genetic Risk & Deterioration:** 30% drop in GAF this year AND 1st degree relative with psychosis

Medical Condition Rule Out Considerations:

Psychotic Disorder Due To Another Medical Condition

- No diagnosis if they reality test & understand source of symptoms
- 3% of new psychosis cases; .2-.5% Lifetime (higher in seniors)

Associated Conditions (often undertreated)

- Temporal lobe epilepsy (hallucinations)
- Autoimmune disorders (systemic lupus erythematosus, HIV, encephalitis)
- Metabolic disorders (Wilson disease, porphyria variegate)
- Chromosomal abnormalities (22q11 deletion syndrome)
- CNS illness/lesions (MS, Huntington's) or TBI

Substance-Induced:

- **Substances:** heavy use, THC, opioids; amphetamines/cocaine; hallucinogens; alcohol (rare)
- **Medications**: opioids, anti-inflammatories, antivirals/antibiotics, antihistamines, anticholinergics, cardiovascular meds, some antidepressants/anticonvulsants/stimulants

Best Practices

- Individual CBT
- Family Intervention/Therapy
- Interventions for comorbid disorders (e.g. anxiety, depression, substance use)
- Lifestyle Interventions (e.g. physical activity, managing stress)
- Monitoring symptoms

National Institute of Clinical Excellence (2014) NICE guidelines 178: Psychosis and schizophrenia in adults: treatment and management. Available at http://www.nice.org.uk/guidance/CG178.

Stigma

- Cross-culturally, most people with CHR have a history of mental health treatment (Woodberry et al., 2018) and are likely to have a past and current nonpsychotic diagnosis (Solakandas et al., 2012) with associated distress and impairment -> need for treatment
- Stigma associated with symptoms is more salient than stigma associated with the risk label (Yang et al., 2015)
- Interventions have incorporated psychoeducation directly addressing CHR stereotypes into treatment, both with patients and family members (Friedman-Yakoobian et al., 2018)
- Interventions aimed at empowerment may be prime for Latinx CHR individuals (Ruiz et al., 2020)

Psychosis Diagnosis Disparities

- African American & Latinx American youth & adults > Euro-Americans to be dx with psychotic disorder (Heun-Johnson et al., 2020; Schwartz & Blankenship, 2014)
- 1st and 2nd gen immigrants > risk for psychosis (Hennsler et al., 2020)
- Transgender people 3-49.7x more likely to be dx with schizophrenia spectrum disorder than cisgender persons (Barr et al, 2021)
- African Americans > severity of positive symptoms (auditory hallucinations and delusional ideations) (Arnold et al., 2004)
- REM individuals may attribute psychosis sx to spiritual causes, personality features, or social problems (e.g., life hardships) (Esterberg & Compton, 2006; Singh et al., 2015)

Psychosis Treatment Disparities

- REM populations less likely to receive mental health treatment (van der ven et al., 2020), receive less intensive treatment (Barrio & Yamada, 2010) and experience longer delays (van der ven et al., 2022)
- African Americans < trust for their physicians than White patients trust for their physicians (Boulware, Cooper, Ratner, LaVeist, & Powe, 2003)
- REM youth with early psychosis often enter mental health treatment via police or hospitalizations (Myers et al., 2019)
- Family cohesion and involvement may be particularly important in REM populations (Weisman, Rosales, Kymalainen, & Armesto, 2005)

Cultural Considerations Across Assessment Process

Initial Contact

- Thank them for making call
- Establish relevant details (e.g., primary lang, educational background, general referral problem)
- Determine who will be involved (e.g., family members)
- Have referral lists available
- Logistical considerations: scheduling, translation services, technical literacy

Assessment

- Invite client and family to share their understanding of experiences
- Consider sociocultural context and minoritized experiences in symptom presentation
- Approach q's with curiosity
- Be aware of clinician bias
- Incorporate cultural formulation

Feedback

- Provide relevant referrals
- Be mindful of language used and be prepared to address questions and potential misconceptions
- Strengths-based
- Include family where possible and relevant
- Consider integration of psychological and culturally-appropriate supports (e.g., faith based)

Informed by: Leany, 2020;
Novacek et al., 2019

Sample Assessment Items

- Do you know what it means to be superstitious? Are you superstitious? (PSYCHS P1 – Unusual Thoughts and Experiences)
- Do you believe that you deserve to be punished in some way? (PSYCHS P4 – Ideas of Guilt)
- Are you very religious? (PSYCHS P6 – Unusual Religious Ideas)
- Do you feel or think that there is a problem with some part, or all of your body? (PSYCHS P14 – Somatic Perceptual Abnormalities)

Case Example: “Mark”

Mark is a 16 year old cisgender Black male living with mother and stepfather in a poor urban neighborhood. He was diagnosed with ADHD in elementary school. No other notable medical or substance use history. Mark is a 10th grader. His grades trended downward over the past academic school year (A-Cs to C average student), stating that he has difficulty paying attention

No known family history of mental illness.

About 6 months ago, Mark began to feel that he could predict events in the future (e.g., he recently entered the cafeteria at lunchtime and felt strongly that there would be a fight, and then a fight did take place). Over time, his predictions have become more specific and frequent occurring about 2x/week. He finds this phenomenon weird rather than scary. He states that he does not behave any differently due to these predictions but finds them absorbing, and they occupy his attention.

Mark also states that “I can never let my guard down. That’s just my opinion.” His mother describes him as “vigilant” without any particular focused concern about his safety. She also stated that she feels their neighborhood is somewhat dangerous, and at times she wishes he was more (rather than less) vigilant.

Mark reports hearing three voices that occur on and off daily. He hears them outside his head as actual sounds but is aware that no one else can hear them. He is not sure where the voices are coming from; it could be his mind playing tricks on him or maybe spirits. He has noticed that he tends to hear the voices more when he is stressed out or upset and that he rarely hears them when he is relaxed and hanging out with friends.

Drawn from Shapiro et al., 2019

Case Example: “Rio”

Rio (they/them/he/his) is a 17 year old, non-binary, multiracial teen. No notable medical history or substance use. Rio’s paternal grandfather was diagnosed with schizophrenia. Rio has a therapist who they meet with weekly and was recently prescribed Lexapro for depression.

At the assessment, Rio endorsed suicidal ideation without a plan or intent. Rio had a suicide attempt 8 months ago. Rio's parents are highly concerned about his safety. Their parents are also concerned about Rio’s drop in grades and reluctance to go to school. He disclosed to you privately that he was being bullied by peers at school about his gender presentation, which he had not discussed with his parents.

During the PSYCHS clinical assessment, Rio described a longstanding feeling that there was something wrong with their body that they could not explain. He indicated significant associated distress. Rio also reported suspiciousness and a need to be “on alert” when out in public that began about 4 months ago. Rio denied that the suicide attempt was related to the suspiciousness or discomfort with their body.

Case Example: “Leslie”

Leslie (he/him) is a 20 year old, Latina cisgender female. She endorsed having a few close friends although her parents noted that she is socially reserved and spends a lot of time alone in her room. She is taking classes at a local community college and recently dropped from full time to part time enrollment due to little interest or motivation in academics. She has some trouble with hygiene and needs reminders from parents to shower and brush her teeth. Leslie was in individual therapy in the past but is uninterested in resuming care. No notable medical history was reported. Leslie endorsed marijuana use “once in a while” with none in the past month. She was reluctant to open up during the remote interview and refused to turn on her camera.

During the clinical interview, Leslie discloses that she sees figures and shadows that she describes as "ghosts,” mostly at home but sometimes at school. She denies feeling threatened by the experience but described it as annoying. Leslie’s mother reports that she has also seen ghosts and believes their home may be haunted.

Additionally, Leslie reported hearing whispers nightly that are unsettling and make it difficult for her to fall asleep. She has on occasion heard her mother call her name while driving. Leslie’s mother was unaware of the whispers/voices and did not identify any attributions.

Final Recommendations

- Practice cultural humility throughout assessment process and reflect on potential biases
- Review and utilize culturally informed resources & tools (e.g., CFI) when possible
- Look for ways to collaborate with family and elicit their narratives during assessment
- Consider the sociocultural context and background in your conceptualization of symptoms
- Consult with/refer to CAPPS

UCLA CAPPS: Providing specialty and adjunct care for patients at-risk for psychosis

Available to all community members	Available to enrolled CAPPS participants
Screening assessment	Patient consultations and medication management
Community referrals	Comprehensive diagnostic evaluations
Skills groups for teens and parents	Brief therapeutic interventions
Treatment provider consultations	Family Focused Therapy
Education and trainings	Regular assessment and updated referrals

UCLA CAPPS Services

Regular (monthly to biannual) clinical assessments:

- Symptom progression or improvement, & updated recommendations
- Safety screening
- Reports with feedback & tailored recommendations
- Collaborative updates for family, providers & school

- Assistance for clients/families/treatment teams to create an early intervention plan & facilitate communicate about symptoms, risk/protective factors & health
  - Consider cannabis, sleep, medication, structure, social support, stress
- Crisis intervention support
- Psychiatry consultation to provider or patient
- Support ongoing therapy with additional handouts, CBT/FFT resources, intervention recs
- Virtual groups for teens & parents combine skills & support

Collaborative Referrals

Eligibility to CAPPS Assessment and adjunct services:

- Clients must be 12-30 with IQ >70
- Clients must be English speaking; Not required of guardian – Spanish speaking services available
- Voluntary participation in a research clinic. Compensation: $20/hour
- Not eligible if history of seizures, neurological disorder, major head injury, if affective/non-affective psychotic disorder or heavy substance use
- No insurance needed
- Many sessions conducted virtually via secure UCLA Zoom platform
- Assessment, monitoring, referral and adjunct therapy provided for up to two years

Collaborative Referrals

CAPPS clinic referrals can be made for:

- comprehensive screening assessments
- second opinion/diagnostic clarity
- provider consultation and training
- tailored recommendations for individual therapeutic care and community programs

CAPPS clinic also provides extern and intern level doctoral practicum training opportunities for clinicians and researchers

Resources

- PEPPNET: http://med.stanford.edu/peppnet.html
  - national network of programs providing services to those at risk for or experiencing early psychosis
- Epi-CAL: nationalepinet.org
  - Part of EPINET, national network of early psychosis clinics
- MAPNET: mapnet.online
  - Lots of resources, catalogued presentations/slide decks.
  - Materials for patients and families in various languages
- SMI Advisor: smiadvisor.org
  - Expansive site with resources for families, patients, and clinicians
  - Many courses available on SMI

Contact Info

Referral Line: (310) 206-3466

Questions or Consult:
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UCLA Health

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