MCPAP Clinical Conversations: Recognizing Emerging Psychosis in Youth
What the Primary Practitioner Should Know

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Commonwealth Research Center
Beth Israel Deaconess Medical Center
Massachusetts Mental Health Center

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Why talk about psychosis in youth?

Delays to treatment are longest for onsets < 18:

On average: **18.7 Months**!

Stentebjerg-Olesen et al., 2016
Identifying Psychosis in Primary Care

Case Example:

Background:

◦ 16 year old Vietnamese youth. Lived with mother and sister in Dorchester.
◦ Very bright, high achieving kid; attended private parochial school on full scholarship.

Context: Long time primary care provider to Billy and his sister
Initial Presentation

- Always a somewhat quirky kid; not very outgoing.
- Presented at routine exam – little eye contact, very flat affect, difficult to engage in conversation
- Administered PHQ-9, adolescent version
- Scored very high but seemed different
Thinking Beyond Depression

• Some improvement in depressive symptoms but affect was unusual

• Acknowledged strange visual experiences

• Screening using Prodromal Questionnaire (16)
Next Steps

• Consultation with CEDAR program

• Enrolled in research study that provided ongoing monitoring and support to Billy, primary care, and school provider team
Key Learnings

• Cultural challenges

• Team involvement

• Don’t have to be sure to refer
CEDAR

• Mom consented at Emily’s office.

• Persistent oddness, lack of social connectedness, magical thinking, blunted affect

• Increased sense something was “off”
Risk for Psychosis

Age 5: heard ringing in his ears
  ◦ Then “fuzzy music”, then increased sensitivity to light

Age 12: saw brief figures of people or animals, then shadows, formless and scary, then a presence near him

Age 16: began hearing voices (incoherent), often screaming, but lasting only seconds.

Unusual Thinking:
  ◦ others could read his mind
  ◦ that he was being watched/ singled out
  ◦ that his dreams might foreshadow the future
  ◦ “People have no value unless efficient”
We can accurately identify risk

**Predicting Psychosis**

*Meta-analysis of Transition Outcomes in Individuals at High Clinical Risk*

Paolo Fusar-Poli, MD, PhD; Ilaria Bonoldi, MD; Alison R. Yung, PhD; Stefan Borgwardt, PhD;
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**Context:** A substantial proportion of people at clinical high risk of psychosis will develop a psychotic disorder.

**Data Synthesis:** There was a consistent transition risk, independent of the psychometric instruments used, of

- 18% after 6 months of follow-up, 22% after 1 year, 29% after 2 years, and 36% after 3 years. Significant moderation was found at clinical high risk.

**Data Sources:** The electronic databases were searched until January 2011. All studies reporting transition risks in patients at clinical high risk were retrieved.

**Study Selection:** Twenty-seven studies met the inclusion criteria, comprising a total of 2502 patients.

**Data Extraction:** Transition risks, as well as demographic, clinical, and methodologic variables, were extracted from each publication or obtained directly from its authors.

**Conclusions:** The state of clinical high risk is associated with a very high risk of developing psychosis within the first 3 years of clinical presentation, and the risk progressively increases across this period. The transition risk varies with the age of the patient, the nature of the treatment provided, and the way the syndrome and transition to psychosis are defined.

*Arch Gen Psychiatry. 2012;69(3):220-229*
If only the first signs of severe mental illness were this easy to spot.

There are many ‘red flags’ that may signal the onset of psychosis, a form of mental illness. Recognizing these signs can be hard, but it’s key to helping young people at risk. The Portland Identification and Early Referral (PIER) program is here to help. Our goal is to identify and treat those at risk through family intervention, education, and medical therapy. In many cases, early treatment can stop psychosis in its tracks.

The PIER Program

“an ounce of prevention”

For more information, including a list of warning signs, please contact PIER at 1-877-880-3377.

Maine Medical Center

A health place like no place in Maine.
Critical Period for Intervention

Greatest deterioration is in first 2 years of psychosis
- Possible brain deterioration
- Losses in social and role functioning

Early treatment potential
- relieve suffering
- prevent disability
- prevent psychosis
- prevent suicide
Psychosis

“Positive” symptoms:
- Hallucinations (voices, visions)
- Delusions (false beliefs)
- Disorganized speech or behavior

“Negative symptoms”
- Reduced emotional expression
- Low motivation
- Minimal speech

Associated with schizophrenia, bipolar disorder, severe depression, including depression, drug induced psychosis, medical conditions
The CASES Trajectory of Symptom Evolution

Cognitive -> Affective -> Social Isolation -> Educational failure -> Subthreshold Positive symptoms -> Psychosis

Adapted from work by Cornblatt and Keshavan
Risk for Misdiagnosis of ADHD

Many examples of disruptions in attention – these can lead to misdiagnosis of ADHD

• Sleep deprivation
• Fatigue
• Distraction (Noise)
• Anxiety .... Fear.... Terror
• Psychological Trauma
• Medications (e.g., antihistamines) & Street drugs
• Stress

**Need to investigate carefully – what is the cause of attention deficit? Many disorders may cause it**
Attention Dysfunction

Attention dysfunction is found in many developing disorders:

• Schizophrenia and the premorbid period – “at risk stage”
• ADHD
• Depression and Bipolar Disorders
• Petit Mal (Absence) Epilepsy
• Traumatic brain injury (Frontal Lobe Syndromes)
• Other neurodevelopmental disorders (Autism)

**Key issue: When did attention dysfunctions start & how persistent is it (age of onset is important) ?
Neuropsychological Characteristics

Neuropsychological Characteristics of Clinical High Risk Period Prior to Psychosis

• Young people, ages 12-30, with attenuated positive symptoms (e.g., paranoid thinking but not delusional)

• Cognitive impairment is a very common subjective complaint:” I can’t think”, “I can’t remember what I just read”, “my mind is too slow” (or too fast)

• The problems have worsened over time

• Most significant problems are in attention, working memory (the ability to hold things in mind for a few seconds), ability to learn and retrieve

• Looks like ADHD because it has similar consequences in social & role function – but also has psychotic-like features

**Many people come in with attention dysfunctions & often the diagnosis of ADHD. Is that accurate?
Need for Careful, Thorough Evaluation

• Attention problems can originate from many causes

• Misdiagnosis of ADHD for “High Risk” can lead to risky medication choice – stimulants – why problematic?

• Stimulants can exacerbate psychosis or provoke a psychosis in a vulnerable person

• Underlying biology of risk for psychosis and ADHD biology may be different even though both disorders involve dopamine (too much in High Risk, too little in ADHD)

• ADHD diagnosis importantly related to age of onset

• ADHD Dx may over-simplify the problems to be treated – too much narrow focus on ADHD may miss the other symptoms
What to Do?

• Be cautious in treating kids with attention dysfunction with stimulants. Get a thorough consultation first.

• Consultation includes (often done by a psychologist):

  • Family history of ADHD and/or psychosis in first degree relatives: a family hx of psychosis is a red flag for stimulants.

  • Age of onset of attention problems and high risk psychotic symptoms. Onset of attention disorder < age 12 and well before high risk psychotic symptoms suggests true ADHD.

  • Seek an expert in the high risk for psychosis condition if there is a family hx of psychosis or worrisome signs such as increased withdrawal, poor hygiene, odd statements etc.

  • ADHD can co-exist with high risk for psychosis and consultant should be knowledgeable about both trajectories.
# Attenuated Positive Symptoms

| Unusual Ideas/ Delusional Beliefs | Unanticipated mental events/ ideas of reference/ mind tricks, magical thinking, external control.  

*Believing that they may be able to see events in the future.* |
| Suspiciousness/ Paranoia | Clear or compelling thoughts of being watched or singled out. Sense that people intend to harm. Loosely organized beliefs about danger or hostile intention.  

*Thinking teachers may be spreading rumors about them.* |
| Grandiosity/ Inflated Sense of Self | Notions of being unusually gifted, powerful, or special. Promotes significantly unrealistic plans.  

*Thinking that they may be able to change the weather.* |
| Perceptual Abnormalities/ Hallucinations | Repeated unformed images, recurrent illusions or momentary hallucinations that are recognized as not real but may be worrisome, captivating, or affect thinking or behavior.  

*Men looking in windows? Mumbling from corner?* |
Something is Not Right

Progressive:

• new or worsening

Recurring:

• Roughly weekly, on average

Impact:

• Bothersome
• Lead to behavior change
• Impairing
Practice Implications:

Consider Psychosis when working up all Mental Health Problems:

- Get Family History of Serious Mental Illnesses
- Attend to timing, oddities, clustering of nonspecific symptoms
- Ask about psychotic-like symptoms

Consult with/ Refer to:

- Behavioral health clinician (prompt psychosis consideration if concerned)
- MCPAP
- CEDAR
How to ASK:

About Unusual Thought Content

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

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

• Do you ever feel that your mind is playing tricks on you?

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

Taken from the SIPS (McGlashan, Miller, Woods)
How to ASK:

About Suspiciousness/Persecutory Ideas:

• Have you ever found yourself feeling mistrustful or suspicious of other people?
• Do you ever feel like you are being singled out or watched?
• Do you ever feel like you have to pay close attention to what’s going on around you in order to feel safe?

Taken from the SIPS (McGlashan, Miller, Woods)
How to ASK:

About Perceptual Abnormalities/Hallucinations:

• Do you ever hear unusual sounds or a voice and then realize that there is probably nothing there?

• Do you ever hear your own thoughts as if they are being spoken outside your head?

• Do things you see ever appear different in color, brightness or dullness; or appear changed in some way?

• Do you ever see flashes, flames, vague figures or shadows out of the corner of your eyes? Or see people, animals, or things and then realize they are not really there?
CEDAR Consultation

PHONE:

- **Screening**
  - for signs of risk for psychosis
  - to rule out full psychosis
  - to assess context / clinical needs
- Guidance talking to youth or family
- Considerations for next steps/ services

IN-PERSON:

- Specialized structured interview of risk for psychosis
- General clinical and diagnostic interview
- Feedback, recommendations, referrals as needed
Other CEDAR Programming

**TRAINING & RESOURCES:**
In-Service Training, Website, Conferences, Clinician Training

**SPECIALIZED ASSESSMENT, PATIENT/PARENT PSYCHOEDUCATION, AND MONITORING**

**TREATMENT**

- Treatment Trials: Cognitive Remediation and Social Skills Training
  Family Biofeedback Videogame Therapy

- Clinic Services: Individual, family, psychopharmacology
CEDAR Eligibility

AGE:
Research: 12-35
Clinic: 14-30

CLINICAL RISK SYNDROME:
Self-reported Symptoms
Collateral Information
Internationally Accepted Criteria

When you call, we will do our best to assess for likely eligibility for clinic or research programs.

**For children <12 years old or outside of Greater Boston, we can help you find appropriate resources.**
Worried about someone?

Megan Graham, LMHC
- 617-754-1223
- mgraham1@bidmc.harvard.edu

Looking for resources?

www.cedarclinic.org

Family Handouts on Psychosis and Risk:
