

Assessment of Psychotic Disorders

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Learning Objectives

- ▶ Understand the importance of early assessment and identification of psychosis
- ▶ Review and develop an understanding of the symptoms of psychosis
- ▶ Learn strategies for enhancing the assessment process to improve differential diagnosis



Importance of Assessing Early: Background

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

Schizophrenia (DSM-5)

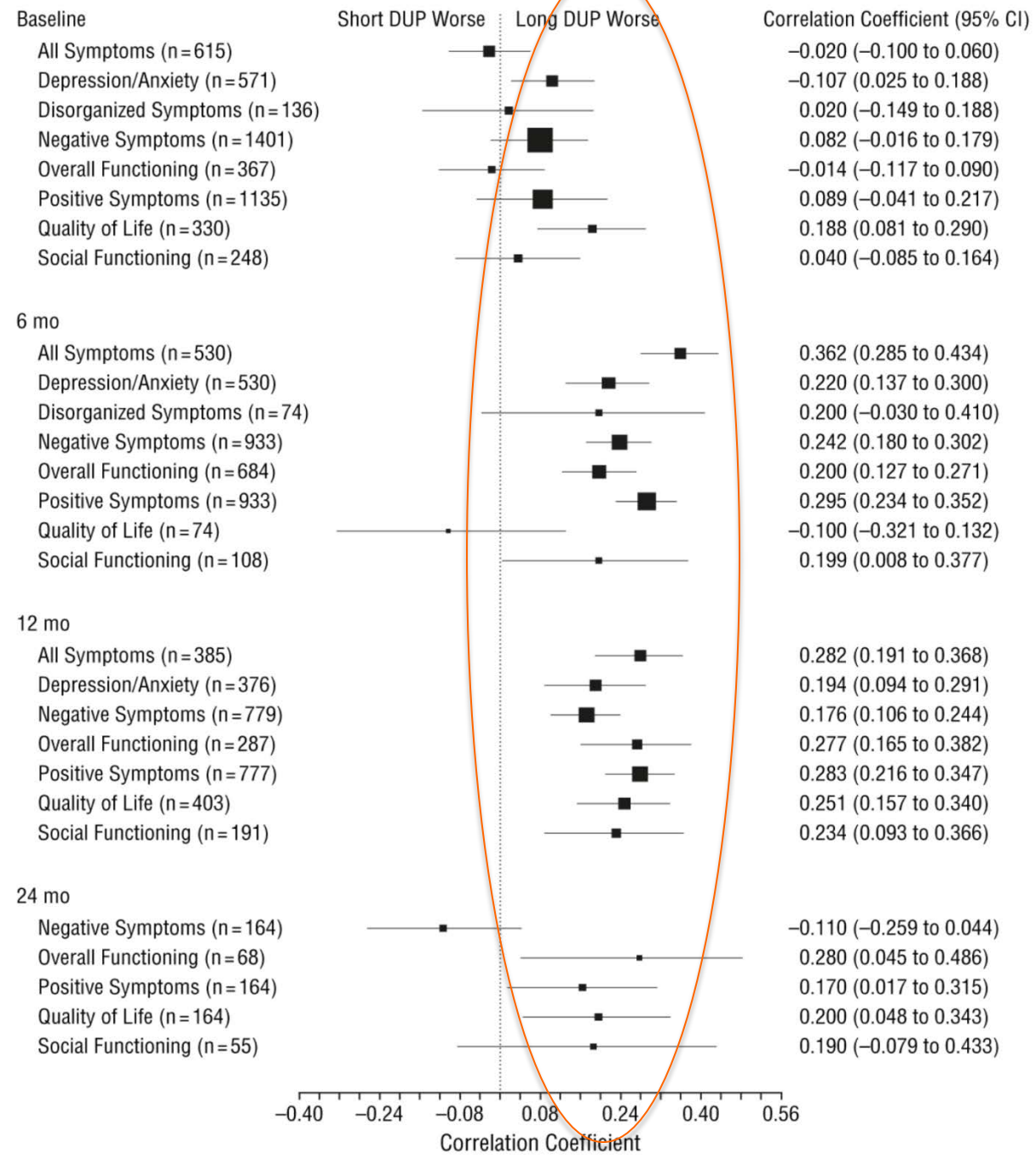
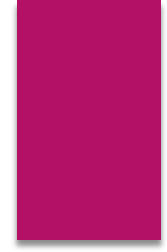
- Symptoms: Delusions; Hallucinations; Disorganized speech; Grossly disorganized or catatonic behavior; Negative symptoms (two or more for a month)
- Level of functioning declines
- Lasts at least six months

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

Key Scientific Finding

- Longer **duration of untreated psychosis (DUP)** is associated with *poorer* short term and long term outcome
- DUP is the time between onset of psychosis and specified treatment (e.g., antipsychotics or CSC)



Association Between Duration of Untreated Psychosis and Outcome in Cohorts of First-Episode Patients: A Systematic Review

Marshall et al. Arch Gen Psychiatry. 2005;62(9):975-983.

Key Scientific Finding

- Treatment with **coordinated specialty care (CSC)** is associated with *better* outcomes

Coordinated Specialty Care

▶ **Clinical Services**

- ▶ Case management, Supported Employment/Education, Psychotherapy, Family Education and Support, Pharmacotherapy and Primary Care Coordination

▶ **Core Functions/Processes**

- ▶ Team based approach, Specialized training, Community outreach, Client and family engagement, Mobile outreach and Crisis intervention services, shared decision making

NIMH RAISE Projects

■ Randomized clinical trial

- John Kane
- Nina Schooler
- Delbert Robinson



■ Implementation study

- Lisa Dixon
- Susan Essock
- Jeffery Lieberman
- Howard Goldman



Duration of Untreated Psychosis in Community Treatment Settings in the United States

Jean Addington, Ph.D., Robert K. Heinssen, Ph.D., Delbert G. Robinson, M.D., Nina R. Schooler, Ph.D., Patricia Marcy, B.S.N., Mary F. Brunette, M.D., Christoph U. Correll, M.D., Sue Estroff, Ph.D., Kim T. Mueser, Ph.D., David Penn, Ph.D., James A. Robinson, M.Ed., Robert A. Rosenheck, M.D., Susan T. Azrin, Ph.D., Amy B. Goldstein, Ph.D., Joanne Severe, M.S., John M. Kane, M.D.

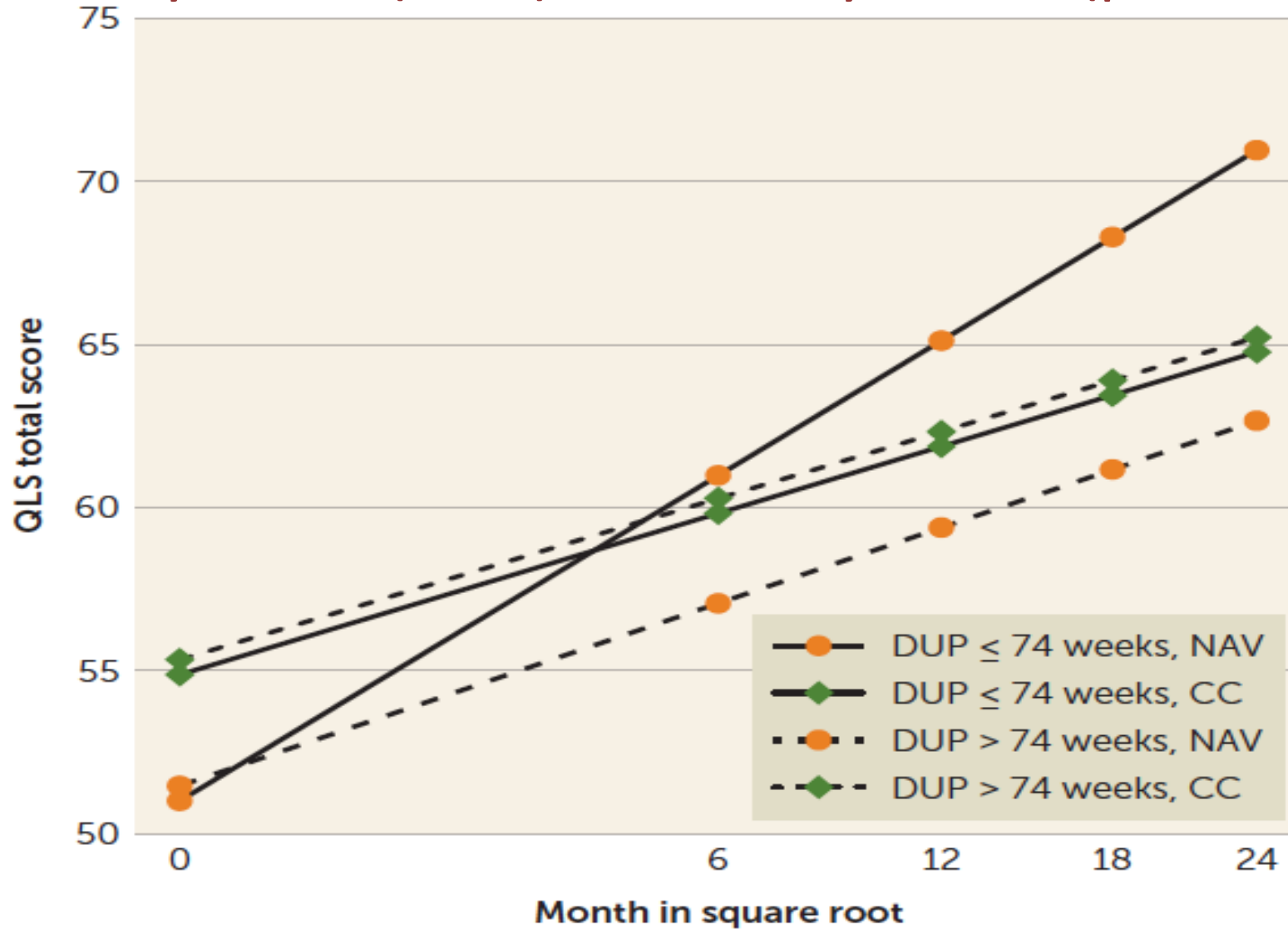
- Methods: Participants were 404 individuals (ages 15-40) who presented for treatment for FEP at 34 nonacademic clinics in 21 states. DUP and individual- and site-level variables were measured.
- DUP was defined as the period between onset of psychotic symptoms and initial treatment with antipsychotic medications



Results: DUP in RAISE ETP Study

- Mean DUP 196 (262) weeks
- Median 74 (1-1456)
- 268 (68%) had DUP of > 6 months

Shorter vs. Longer Duration of Untreated Psychosis (DUP) on Quality of Life ($p < 0.03$)



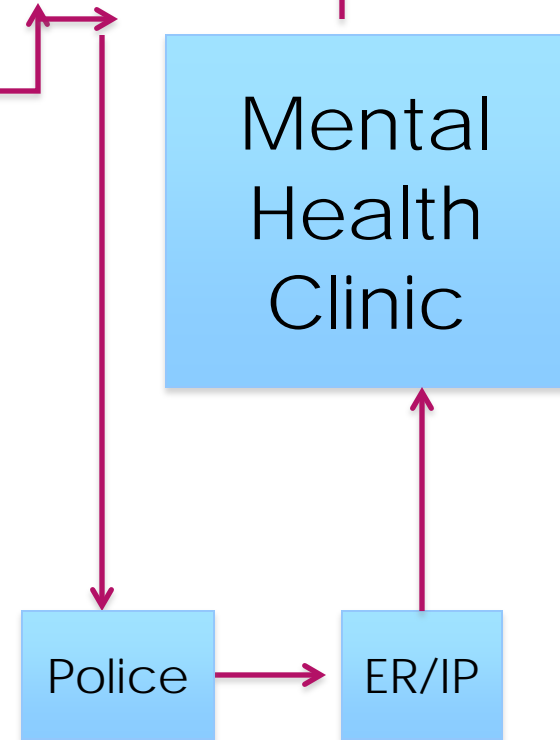
Current System



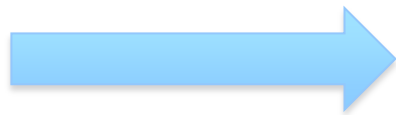
Stigma
Lack of Knowledge
Distrust
Poor Insight
Insidious Onset

Help seeking

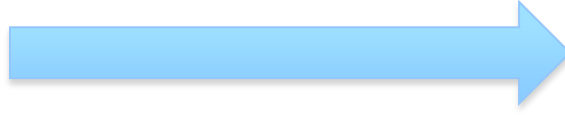
Referral from GP
Lack of Access
Unaffordability and
Inefficiency of health care



Vision: 1.0



Help
seeking



Special
EIS

Vision: 2.0



Help
seeking

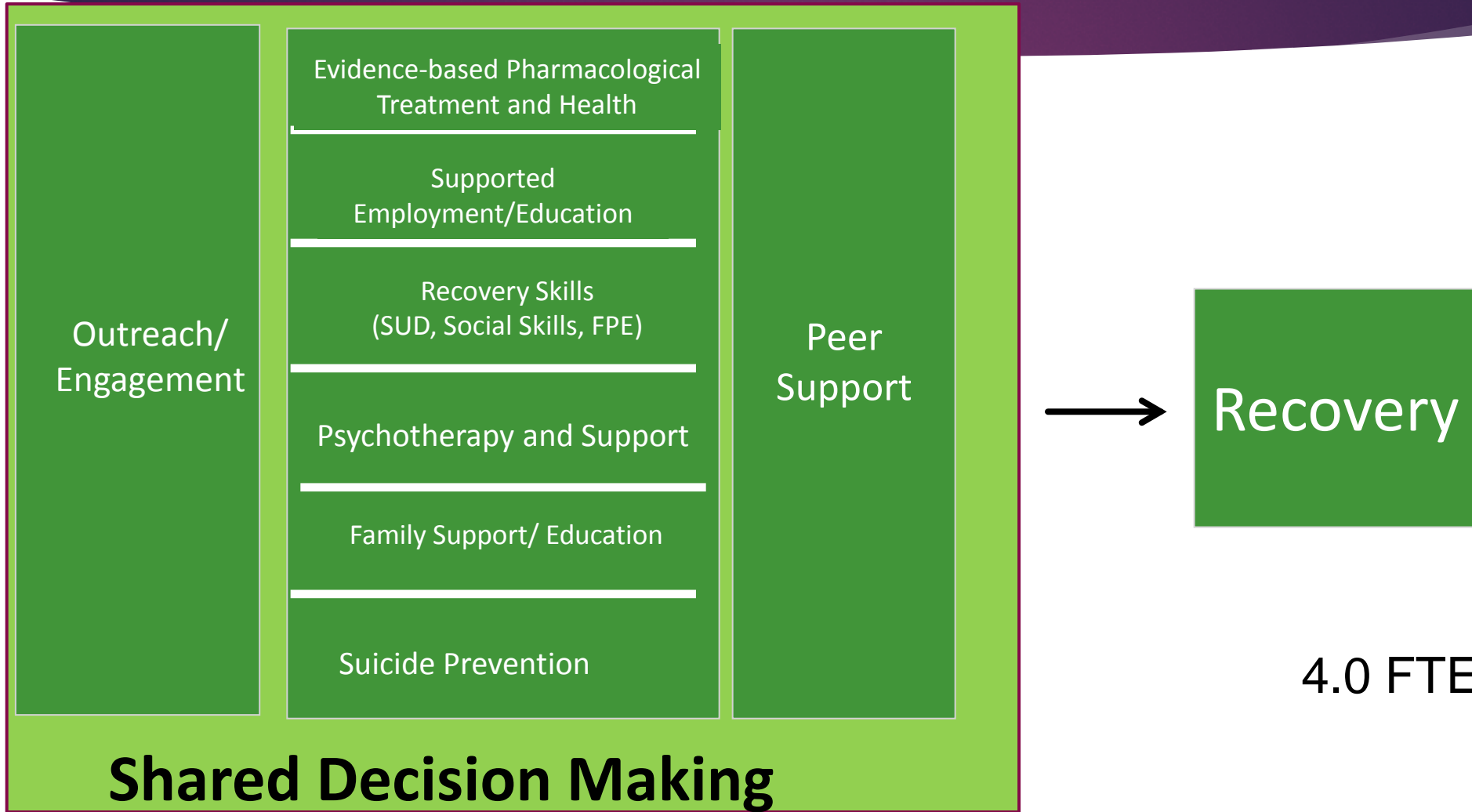


Special
EIS

Big Picture Rationale

- ▶ Goal is to reduce DUP and provide early intervention services to promote long term recovery and reduce disability

OnTrackNY Team Intervention





My health. My choices. My future.

OnTrackNY is an innovative treatment program for adolescents and young adults who recently have had unusual thoughts and behaviors or who have started hearing or seeing things that others don't. OnTrackNY helps people achieve their goals for school, work, and relationships.

Assessment Process



Engagement Strategies: Our Unique Approach

- Initial Call and in-person visit
 - Understand what they are seeking by learning what is going on for them at this time.
 - What programs/kinds of treatment have they already (recently) tried connecting with? What were the challenges?
 - Provide information about our services based on the above
 - Connect such exploration with detailed examples about how your team might be able to help
- ▶ Common traps: Talking about the program too mechanically; asking too many detailed questions in order to begin determining eligibility.

Engagement

- ▶ Validate that the person may not want to see you
- ▶ Psychotic symptoms might change their interaction/communication style and ability to understand
- ▶ Identify common ground
- ▶ Listen actively
- ▶ Take the person seriously
- ▶ Ask clear, simple questions

Potential Challenges

- 1) When a potential client is unable to identify symptoms:
 - Ask how they understood recent events (i.e. leading up to hospitalization, trouble with routine activities)
 - Ask what changes they have noticed within themselves (i.e. changes in relationships/work/school activities)
 - Probe and build upon what they identified as changes in their life; use real examples/stories (i.e. some people have told me that it's sometimes hard to leave the house...)



Potential Challenges *continued*

- 2) When there are different perspectives about treatment:
 - Ask about what's important to client (e.g. going back to school, being able to enjoy hobbies as before, staying out of the hospital)
 - Provide real examples from previous clients and how the team was able to help them (connect to the challenges patient has identified)
 - If onset was acute, and client does not believe it will happen again: validate this notion, while taking a wellness perspective (i.e. explore *with the client* how we can work together to reduce potential triggers, and help them maintain daily activities)

Potential Challenges *continued*

- 3) When family members are not aware of illness/treatment options:
 - “My son is just lazy” – provide psychoeducation about the effects of negative symptoms
 - “Is this happening because of drugs?” – provide some context of biological and environmental factors (be mindful of not saying anything definitively about substance use)
 - “Maybe she should just go to a state hospital/residential facility” – explore parents’ concerns for client returning home; validate concerns, and offer real examples of how the team can help



Example: BD

- Did not initially understand symptoms (thought delusions were due to stress of a new school)
- Did not want treatment/scared of hospital (where he saw his mom coming for treatment on/off for years)
- Did not initially recognize any changes in behavior/how it was impacting daily activities
- Engagement outside of the hospital and conversations lead to BD “giving it a try”

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.

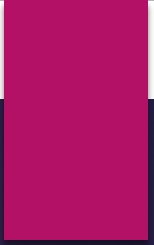



Evaluation: Date of Onset

- 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)

Useful Assessment Tools

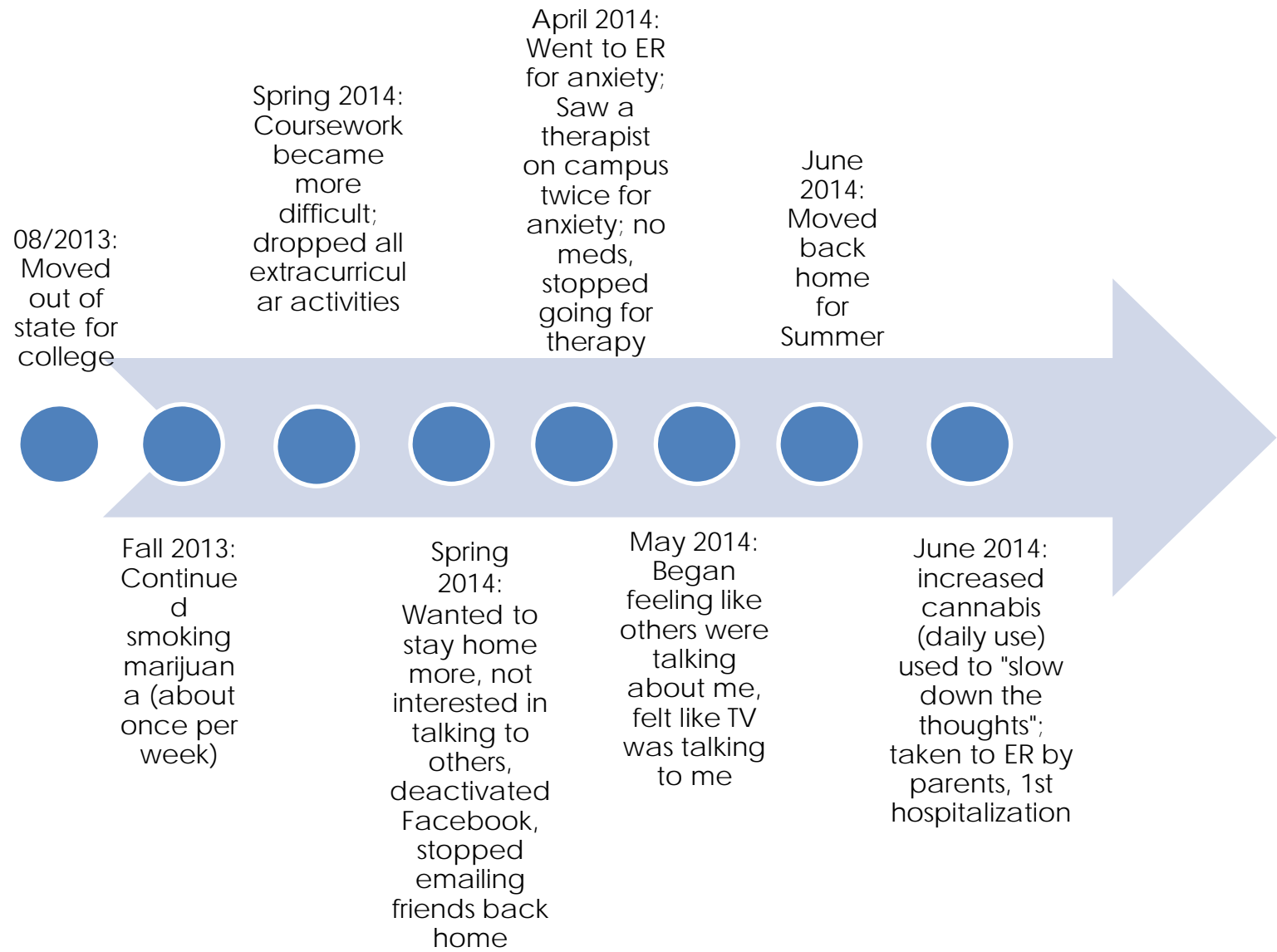
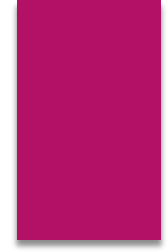
- ▶ Timeline Assessment
- ▶ Positive and Negative Syndrome Scale (Kay, Opler & Fiszbein, 1987)
- ▶ Structured Clinical Interview for DSM-5 (American Psychiatric Association)



Activity: Establishing
qualifying symptoms and
differential diagnosis



Sample Timeline





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 patient.
- Using non-clinical language



Group Discussion

▶ You are about to meet with Katie, a 20yo 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?**



Determining Eligibility

▶ 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

Evaluating Symptoms

- ▶ Things to keep in mind for each psychotic symptom:
- ▶ ASSESS START AND END DATE FOR EACH SYMPTOM
- ▶ Ask about the period of time during which it was present
- ▶ Determine if it is primary or secondary in etiology to a general medical condition or substances.
 - ▶ *Before psychotic symptoms began were you using drugs? Any medications? Did you drink much more than usual? Were you physically ill?*
 - ▶ *Has there been a time when you had psychotic symptoms and were not using drugs? Taking medications? Changing your drinking habits? Felt healthy?*
- ▶ Ask about **insight** (any skepticism present regarding symptoms), **intensity** (symptom is persistent or intermittent), and **impact** (how it affects behavior and functioning).
- ▶ Ask the individual to describe any symptoms endorsed.

Evaluation: Delusions

- ▶ Lack of insight (belief held with delusional conviction) must be present.
- ▶ Either impact on behavior and/or intensity (symptoms occur at least intermittently or a preoccupation with belief) must be evident.
- ▶ Types of delusions:
 - ▶ Delusions of reference—belief that others are taking special notice of them, talking about them, references on TV, reading material, etc.
 - ▶ Persecutory delusions—belief that he or she is being attacked, harassed, persecuted, or conspired against
 - ▶ Grandiose delusions—belief that he or she possesses special powers, exaggerated importance (rich or famous), or relationship with to a deity
 - ▶ Somatic delusions—belief that his or her body is grossly distorted, change or disturbance in appearance or functioning
 - ▶ Other (religious, guilt, jealousy)—unusual religious experiences, belief that he or she must be punished for something (guilt), belief that partner was being unfaithful, or belief that he or she is in a relationship with someone famous
 - ▶ Mind control (insertion/withdrawal)—belief that thoughts and/or actions are under the control of an external force. Individual may experience thoughts being placed into head and/or thoughts being taken out of their head.
 - ▶ Thought broadcasting—belief that others can hear their thoughts or read their mind

Assessing Delusions

- ▶ *Has it ever seemed like people were talking about you or taking special notice of you?*
- ▶ *If yes, were you ever convinced about this or did you think it might have been your imagination?*
- ▶ *Were you ever receiving special messages from the TV, radio, newspaper, internet or from the way that things were arranged around you?*
- ▶ *Has anyone been going out of their way to give you a hard time or trying to hurt you?*
- ▶ *Have you felt that you were especially important in some way or that you had a special power to do things that other people couldn't do?*
- ▶ *Have you ever felt that something was very wrong with you physically even though your doctor said nothing was wrong...like you had cancer or some other terrible disease?*

Assessing Delusions *continued*

- ▶ *Have you ever had any unusual religious experiences?*
- ▶ *Have you ever felt that you had committed a crime or done something terrible for which you should be punished?*
- ▶ *Were you ever convinced that your spouse or partner was being unfaithful to you?*
- ▶ *Did you ever feel that someone or something outside yourself was controlling your thoughts or actions against your will?*
- ▶ *Did you ever feel as if your thoughts were being broadcast out loud so that other people could actually hear what you were thinking?*
- ▶ *Did you ever believe that someone could read your mind?*

Establishing Threshold

- ▶ 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.
- ▶ Distrustfulness is clearly evident and intrudes on the interview and/or behavior, but there is no evidence of persecutory delusions. Alternatively, there may be indication of loosely formed persecutory delusions, but these do not seem to affect the patient's attitude or interpersonal relations.
- ▶ Feels distinctly and unrealistically superior to others. Some poorly formed delusions about special status or abilities may be present but are not acted upon.
- ▶ Patient expresses numerous or frequent complaints about physical illness or bodily malfunction, or else patient reveals one or two clear-cut delusions involving these themes but is not preoccupied by them.

Evaluation: Hallucinations

- ▶ Either impact on behavior and/or intensity (symptoms occur at least intermittently or a preoccupation with belief) must be evident.
- ▶ Is the hallucination perceived as real and distinct from person's thoughts?
- ▶ Types of hallucinations
 - ▶ Auditory- voice, sounds
 - ▶ Visual- visions, shadows, images
 - ▶ Tactile- feeling sensations in body
 - ▶ Olfactory- smelling things others can't smell
 - ▶ Gustatory- food tastes strange

Assessing Hallucinations

- ▶ Did you ever hear things that other people couldn't hear, such as noises, or the voices of people whispering or talking? Were you awake at the time?
 - ▶ Did they comment on what you were thinking?
 - ▶ How many voices did you hear? Were they talking to each other?
- ▶ Did you ever have visions or see things that other people couldn't see? Were you awake at the time?
- ▶ Have you ever felt strange sensations on your body or on your skin?
- ▶ Have you ever smelled or tasted things that other people couldn't smell or taste?

Establishing Threshold

- ▶ Hallucinations occur frequently but not continuously, and the patient's thinking and behavior are affected only to a minor extent.
- ▶ Hallucinations are frequent, may involve more than one sensory modality, and tend to distort thinking and/or disrupt behavior. Patient may have delusional interpretation of these experiences and respond to them emotionally and, on occasion, verbally as well.
- ▶ Hallucinations are present almost continuously, causing major disruption of thinking and behavior. Patient treats these as real perceptions, and functioning is impeded by frequent emotional and verbal responses to them.

Disordered Speech or Behaviors

- ▶ **Catatonic Behaviors:** motoric immobility; excessive motor activity; extreme negativism/mutism; posturing or stereotyped movements; repetitive language or meaningless movements
- ▶ **Grossly Disorganized Behaviors:** childlike silliness; unpredictable agitation; disheveled appearance; dressing unusually; inappropriate sexual behaviors
- ▶ **Disorganized Speech:** loose or irrelevant statements; thinking pattern is not structured to the conversation

Establishing Threshold

- ▶ Able to focus thoughts when communications are brief and structured, but becomes loose or irrelevant when dealing with more complex communications or when under minimal pressure.
- ▶ Generally has difficulty in organizing thoughts, as evidenced by frequent irrelevancies, disconnectedness, or loosening of associations even when not under pressure.
- ▶ Thinking is seriously derailed and internally inconsistent, resulting in gross irrelevancies and disruption of thought processes, which occur almost constantly.

Evaluation: Substance Use

- Type of substance(s) used
 - 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)
 - Other: diet pills, steroids, glue, paint thinners, inhalants

Amount and Pattern of use **see substance use assessment sample



Substance Use Evaluation: Type 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 Evaluation: Amount and Pattern of Use

- ▶ OBJECTIVE: to identify a temporal relationship between the onset of psychotic symptoms and substance use
 - Focus on the date of onset and the presence of substance use
 - Previous pattern of use (prior to date of onset)
 - How is use related to psychotic sx?
 - Periods of sobriety
 - Were any psychotic symptoms present during periods of sobriety?

Substance Use Assessment (sample)

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

Evaluation: Affective Components

- Assess for major depressive episode(s)
- Assess for manic episode(s)
- Identify episodes and the pattern of overlap with psychotic symptoms

Symptoms of Depression

- ▶ Sadness
- ▶ Decreased interest or pleasure
- ▶ Changes in appetite
- ▶ Changes in sleep
- ▶ Psychomotor agitation or retardation
- ▶ Loss of energy
- ▶ Feelings of worthlessness and inappropriate guilt
- ▶ Diminished ability to concentrate
- ▶ Suicidality

Mood Disorder Evaluation: Major Depressive Episode

- Assess for symptoms lasting for ≥ 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

Symptoms of Mania

- ▶ Abnormally elevated mood
- ▶ Expansive or irritable mood
- ▶ Inflated self-esteem
- ▶ Decreased need for sleep
- ▶ Pressured Speech
- ▶ Racing thoughts
- ▶ Distractibility
- ▶ Increased goal-directed activity
- ▶ Excessive involvement in pleasurable activities

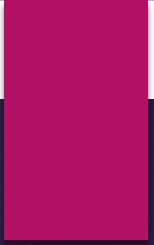


Mood Disorder Evaluation: Manic Episode

- Assess for symptoms lasting for ≥ 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

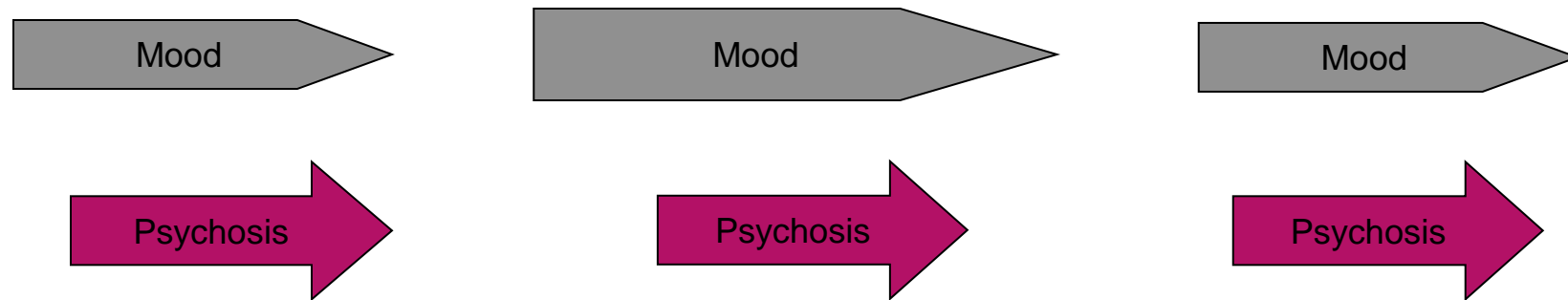
- Schizophrenia/Schizoaffective: Psychotic symptoms during times when person is not suffering from Major Depressive or Manic Episode
- Mood Disorder With Psychotic Features: Psychotic symptoms are confined to Major Depressive or Manic Episodes



Activity: Affective Disorders (assessing for primary psychosis)

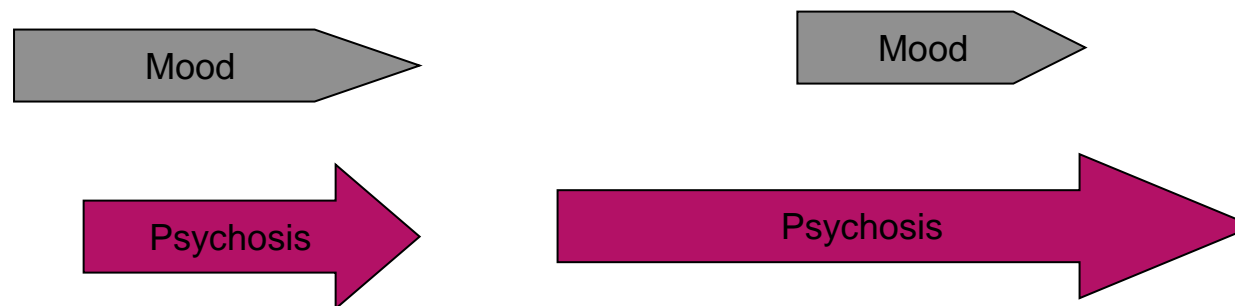
Mood Disorder with psychotic features

Psychosis only present with mood symptoms



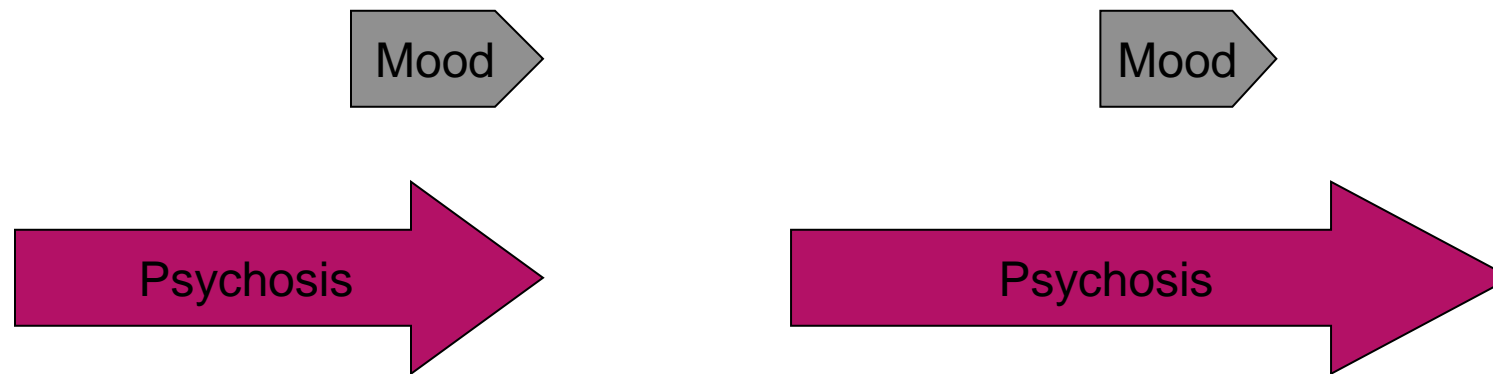
Schizoaffective Disorder

Psychosis exists without major mood symptoms; and mood symptoms are not brief relative to the duration of the disorder.



Schizophrenia

Psychosis present without mood symptoms, but mood symptoms are brief!
Not Schizoaffective Disorder





Evaluation: General Medical Conditions

▶ Examples include:

- Epilepsy or other seizure disorders
- Head trauma (assess for loss of consciousness)
- Metabolic conditions and nutritional deficiencies

▶ Refer to the Outreach and Recruitment Manual for a comprehensive list of general medical conditions that may be associated with psychotic symptoms.

Conclusions

- ▶ Important to assess FEP early and accurately in order to connect individuals to services that might improve outcomes.
- ▶ FEP doesn't require a diagnosis of schizophrenia so important to assess at the symptom level with a focus on frequency, intensity and functional impairment
- ▶ At the beginning focus on engagement and rapport building
- ▶ Useful assessment strategies/tools include a timeline assessment and questions for the SCID and PANSS
- ▶ Differential diagnosis can be tricky and can change/evolve over time

Thank You