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Psychiatry and Addictions Case Conference
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06/20/2019

WELCOME!

Today's Topic:

Psychosis in primary care: Assessment of psychosis and behavioral interventions

Lydia Chwastiak, MD, MPH, and Sarah Kopelovich, PhD

PANELISTS:

MARK DUNCAN, MDRICK RIES, MD, KARI STEPHENS, PHD, AND BARB MCCANN, PHD

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MANAGEMENT OF PSYCHOSIS IN PRIMARY CARE

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GENERAL DISCLOSURES

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GENERAL DISCLOSURES

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PLANNER DISCLOSURES

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SPEAKER DISCLOSURES

Northwest (HHS Region 10)

MHTTC

Mental Health Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

✓ No conflicts of interest

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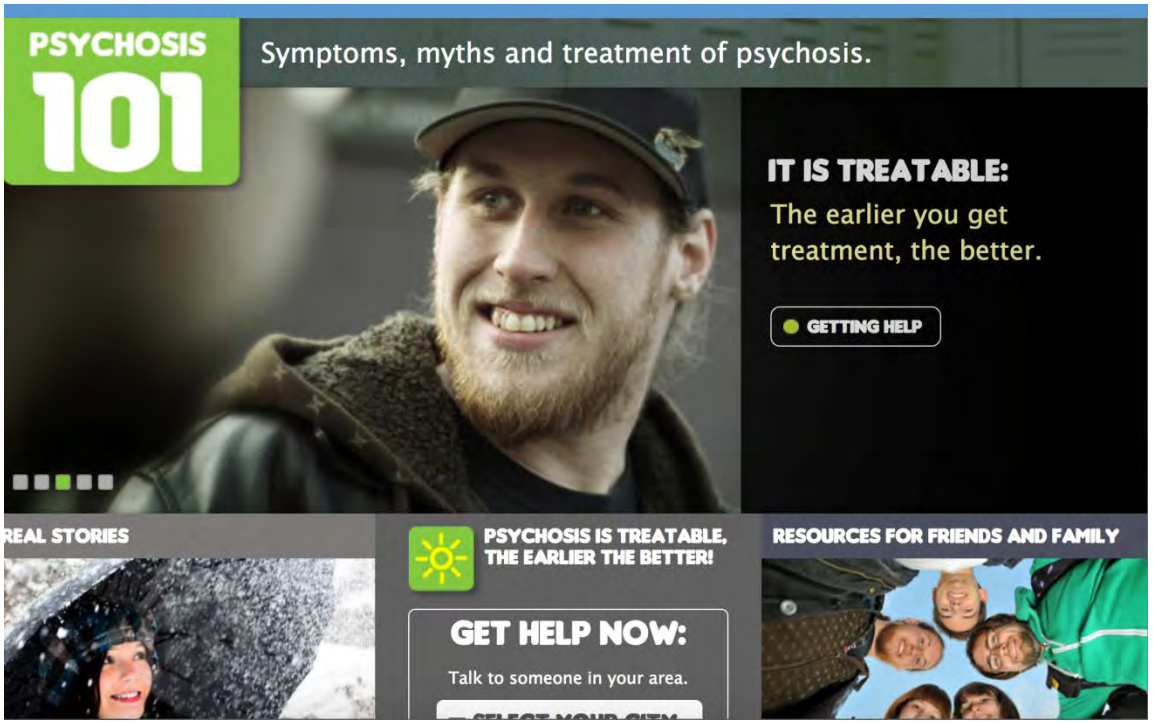
OVERVIEW OF SESSIONS



- Medical management
- Diagnosis
- Addressing disparities in quality of care
- Therapeutic style

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TREATING PSYCHOSIS IN PRIMARY CARE: ASSESSING AND MANAGING PSYCHOSIS USING KEY COGNITIVE BEHAVIORAL STRATEGIES

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OBJECTIVES

1. Review updated facts and figures concerning psychosis outcomes to enable more accurate psychoeducation.
2. Review key considerations relevant to differential diagnosis in a primary care setting.
3. Review core practical skills for a clinical encounter of any nature.
4. Learn high-yield behavioral interventions and the steps to skill building.

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Scientific knowledge has a half-life.[1-2]

What you last learned about the trajectory, treatment, and outcomes associated with schizophrenia spectrum disorders may be outdated…

…even if what you last learned was published as recently as 2012.

[1-2] *Bailey, Ronald (2 October 2012). "Half of the Facts You Know Are Probably Wrong". reason.com; Arbesman, S. (2012). The Half-Life of Facts.*

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CHECKPOINT

What thoughts or images come to your mind when you hear the word schizophrenia?

How do you approach (or do you approach) psychoeducation for psychosis or schizophrenia spectrum disorders with your patients?

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ELYN SAKS, 1977

- First psychotic break as a Marshall Scholar at Oxford University
- Inpatient psychiatrist told her she would be lucky to get work at McDonalds
- She is currently the Dean of the Law School at University of Southern California

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JENNY, 2017

- First break as an undergrad in Washington State
- Psychiatrist told her she would not work again; recommended she initiate paperwork for SSDI.
- She is currently employed full-time as a peer specialist and is taking college classes to complete her BA.

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WORKING EFFECTIVELY WITH INDIVIDUALS WITH PSYCHOSIS REQUIRES MORE THAN JUST THE CLASSIC TRIFECTA…

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ATTITUDES MATTER…

- Provider beliefs about psychosis can affect client outcomes[1,2]

- Clients' beliefs about the causes, persistence and controllability of psychosis also predict clinical response[3]

[1] Brabban, Byrne, Longden, & Morrison (2017). The importance of human relationships, ethics and recovery-oriented values in the delivery of CBT for psychosis. P*sychosis*. doi: 10.1080/17522439.2016.1259648
[2] http://www.wholescience.net/2017/03/believe-you-are-healthy-a-ted-talk-on-the-placebo-effect/
[3] Freeman, Dunn, Garety…Bebbington (2013). Patients' beliefs about the causes, persistence and control of psychotic experiences predict take-up of…*Psychological Medicine, 43*, 269-277.

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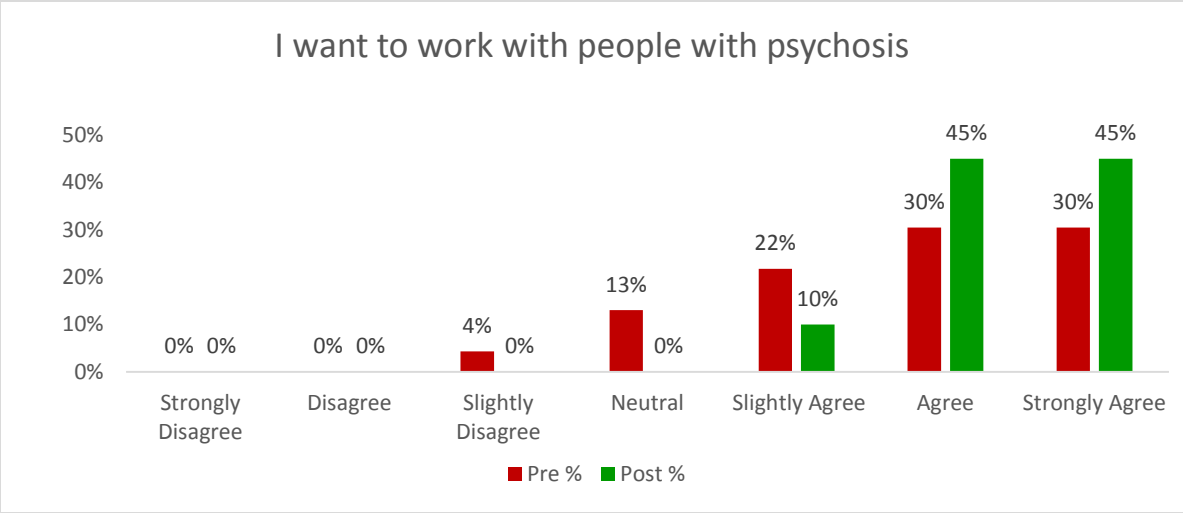
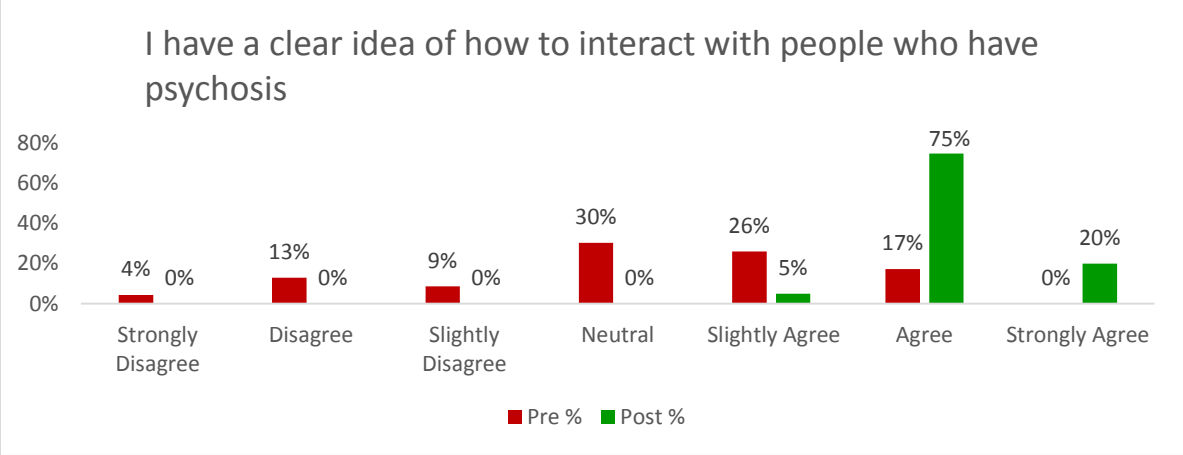
TRAINING CAN HELP…





Source: Best Practices for Schizophrenia Treatment Center, Northeast Ohio Medical University (2018). Unpublished Program Evaluation.

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PSYCHOSIS OUTCOMES

Recovery is the norm.

Rule of quarters:

- 20-25% will not experience a psychotic relapse
- 25% will experience subsequent episodes but maintain community tenure
- 25% require intensive treatment and support, with intermittent hospitalizations
- Of the final ~25%
  - 10% will die by suicide
  - 15% will require long-term, residential care and/or suffer severe impairment

Source: https://www.ncbi.nlm.nih.gov/books/NBK333029/

RESEARCH-DEFINED RECOVERY RATES

TABLE 1. Level of Recovery Achieved by Patients (N=118) Prospectively Followed After Their First Episode of Schizophrenia or Schizoaffective Disorder

Recovery Definition and Follow-Up Year[a]	Patients Fulfilling Recovery Criteria (cumulative)	Patients Still in Study Not Yet Meeting Recovery Criteria	Cumulative Recovery Rate	
			Rate	95% CI
Symptom remission for 2 years or longer				
3	23	66	24.8	16.0–33.5
4	29	53	32.3	22.5–42.0
5	39	32	47.2	36.0–58.4
6	41	7	56.7	41.1–72.3
Adequate social/ vocational functioning for 2 years or longer				
3	15	73	16.3	8.7–23.9
4	19	59	21.3	12.8–29.9
5	22	53	25.5	16.1–34.7
8[b]	23	5	37.9	14.3–61.4
Full recovery for 2 years or longer				
3	9	83	9.7	3.7–15.8
4	11	66	12.3	5.4–19.1
5	12	61	13.7	6.4–20.9

Robinson et al 2004

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PREDICTORS OF RECOVERY

TABLE 3. Prediction of Recovery Outcome in Patients (N=118) Prospectively Followed After Their First Episode of Schizophrenia or Schizoaffective Disorder

Recovery Component[a] and Model Covariate	Model[b]					Contribution of Variable		
	Variance		Analysis			Beta Weight	Analysis	
	R^2	Adjusted R^2	F	df	p		t	p
Symptom remission	0.27	0.24	9.29	3, 74	<0.0001			
Duration of psychotic symptoms at entry						−0.36	−3.59	<0.001
Cognition (global)						0.31	3.11	<0.01
Diagnosis (schizoaffective)						0.20	2.04	<0.05
Adequate social/vocational functioning	0.25	0.23	12.74	2, 75	<0.0001			
Cognition (global)						0.42	4.18	<0.0001
Torque[c]						0.32	3.16	<0.01
Full recovery	0.32	0.29	11.42	3, 74	<0.0001			
Cognition (global)						0.41	4.30	<0.0001
Torque[c]						0.31	3.20	<0.01
Duration of psychotic symptoms at entry						−0.23	−2.39	<0.05

[a] See text for specific component criteria.
[b] Determined by regression analyses that used a backward elimination procedure. Results were confirmed with both stepwise and forward selection procedures.
[c] Composite index of cortical asymmetry.

Robinson et al 2004

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SUMMARY OF RECOVERY KEY FINDINGS

- The severity of psychotic symptoms at baseline does not predict long-term outcomes[1]
- Duration of Untreated Psychosis, global cognition, and specific psychotic diagnosis does appear to meaningfully predict prognoses.
- Additional predictors:
  - Resilience, support systems, clinician and client expectations, and the type of interventions utilized[2]

[1] Addington & Heinssen, (2012). Prediction and prevention of psychosis in youth…*AnnRev ClinPsychol, 8*, 269-289.
2 Pradhan & Pinninti (2016). In Pradhan et al (Eds) *Brief Interventions for Psychosis: A Clinical Compendium*.

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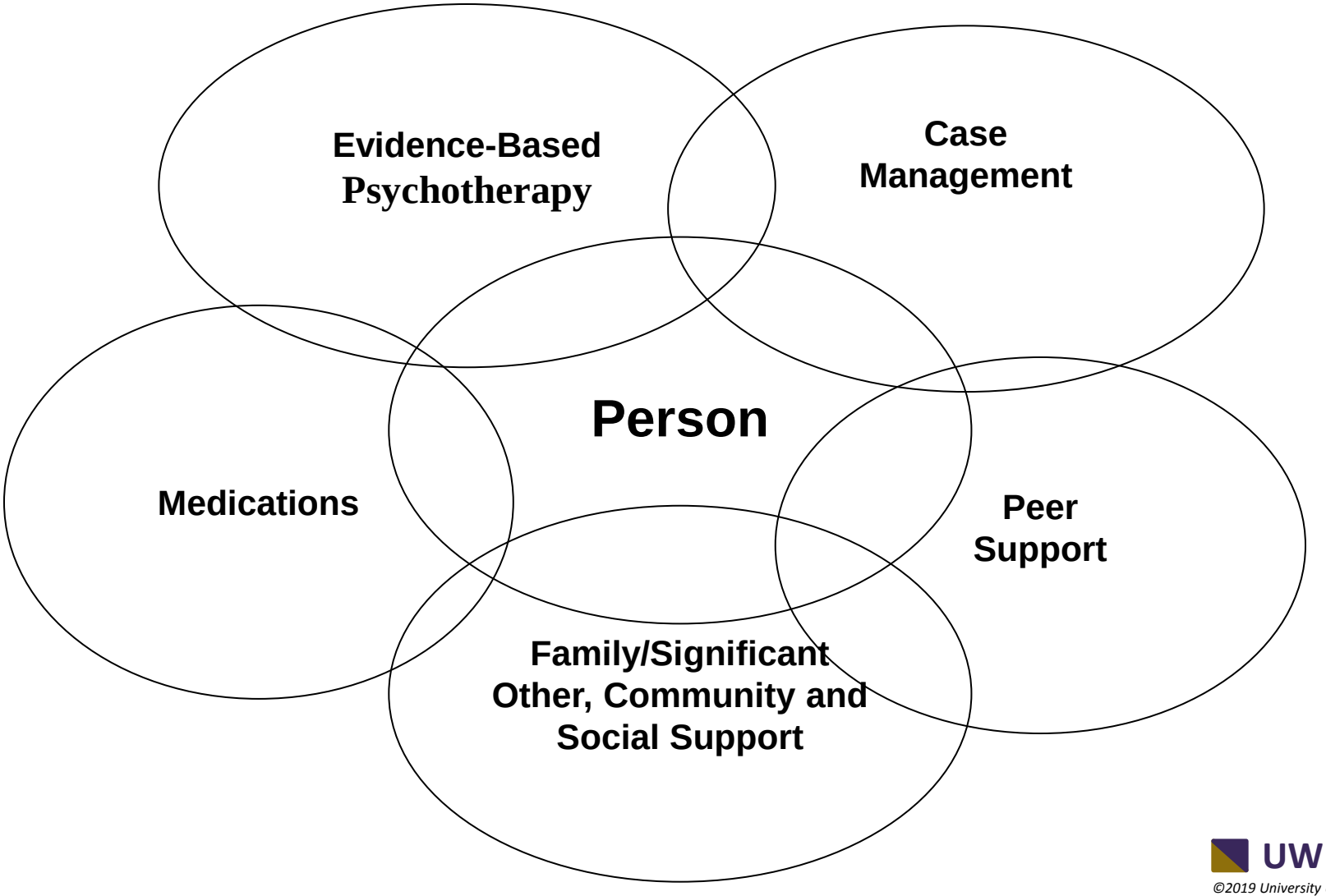
NATIONAL SCHIZOPHRENIA TREATMENT GUIDELINES (PORT; Dixon et al. 2009)



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WHAT DO SERVICE USERS WANT?

- To be listened to[1, 2]
- To have their concerns taken seriously[1]
- To have their concerns validated[2]
- To be given hope[2]
- To be given more information, choice, and collaboration in treatment decision-making[3]
- To be seen as a person, not just a set of symptoms[3]
- To improve in social and functional domains (versus symptom remission)[4]

[1] National Health Service (2015). The 5-Year Forward View Mental Health Taskforce. London. [2] Schizophrenia Commission Executive Summary (2012). [3] Byrne & Morrison (2014). Service users' priorities and preferences for treatment of psychosis. *Psychiatric Services, 65.* [4] Shumway et al (2003). Preferences for schizophrenia treatment outcomes among public policy makers..*Psychiatric Services, 54*.

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PSYCHOSIS IN PRIMARY CARE

- Primary care is often the point of first contact for patients exhibiting psychotic symptoms.[1,2]

- Which of the following is the leading cause of new-onset psychosis in primary care settings?
  A. Primary psychotic disorder (first break or psychosis risk state)
  B. Secondary to another psychiatric condition
  C. Secondary to medical condition, delirium, or toxic exposure
  D. Substance-induced psychosis

[1] Miller BF, Druss B. The role of family physicians in mental health care delivery in the United States: implications for health reform. J Am Board Fam Med. 2013;26(2):111–113.
[2] Griswold et al Recognition and differential diagnosis of psychosis in primary care. https://www.aafp.org/afp/2015/0615/p856.html

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PSYCHOSIS IN PRIMARY CARE

- Most often, a constellation of psychotic symptoms is secondary to a schizophrenia spectrum disorder
- However, psychotic symptoms are also commonly associated with[1]
  - Depressive disorder (42.4%)
  - Anxiety disorders (38.6%),
  - Panic disorders (24.8%)
  - Substance Use Disorders (13.8%)
- Postpartum psychosis[2]: 1 in 500--1,000 births

[1]Olfson M, Lewis-Fernández R, Weissman MM, et al. Am J Psychiatry. 2002;:1412–1419.
2 Topiwala A, Hothi G, Ebmeier KP.. *Practitioner*.2012; 15–18, 22.

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SUBSTANCE-INDUCED PSYCHOSIS

- Presence of active substance use
  - Toxicology
  - Clinical interview in absence of parents
- Complicated and challenging presentation
- Quite common
  - Late adolescent to young adult
- Very similar to the quality of psychosis seen in major thought and mood disorders
- Can be co-morbid
- Acute onset and speedy resolution
- Hallmarks:
  - Visual hallucinations, disorientation, labile mood and affect

SUBSTANCE-INDUCED PSYCHOSIS

- 1st episode differentials (premorbid):
  - Family HX of substance abuse/dependence
  - DX of substance abuse/dependence
  - Antisocial personality traits or DX
  - Social functioning intact
  - Acute onset of symptoms
  - Positive sx more likely to be
    - VH
    - Paranoid delusions
  - Less likely to experience negative symptoms
  - Increased insight into psychosis

PRIMARY PSYCHOTIC DISORDERS

- Prodrome goes by many terms:
  - Clinical High Risk (CHR), Ultra High Risk (UHR), Psychosis Risk Syndrome (PRS), At Risk Mental State (ARMS).
- Defined as the period between the most valid estimate of the departure from the person's normal level of functioning and the onset of psychosis.
- Age 12-25 (85% by age 25)

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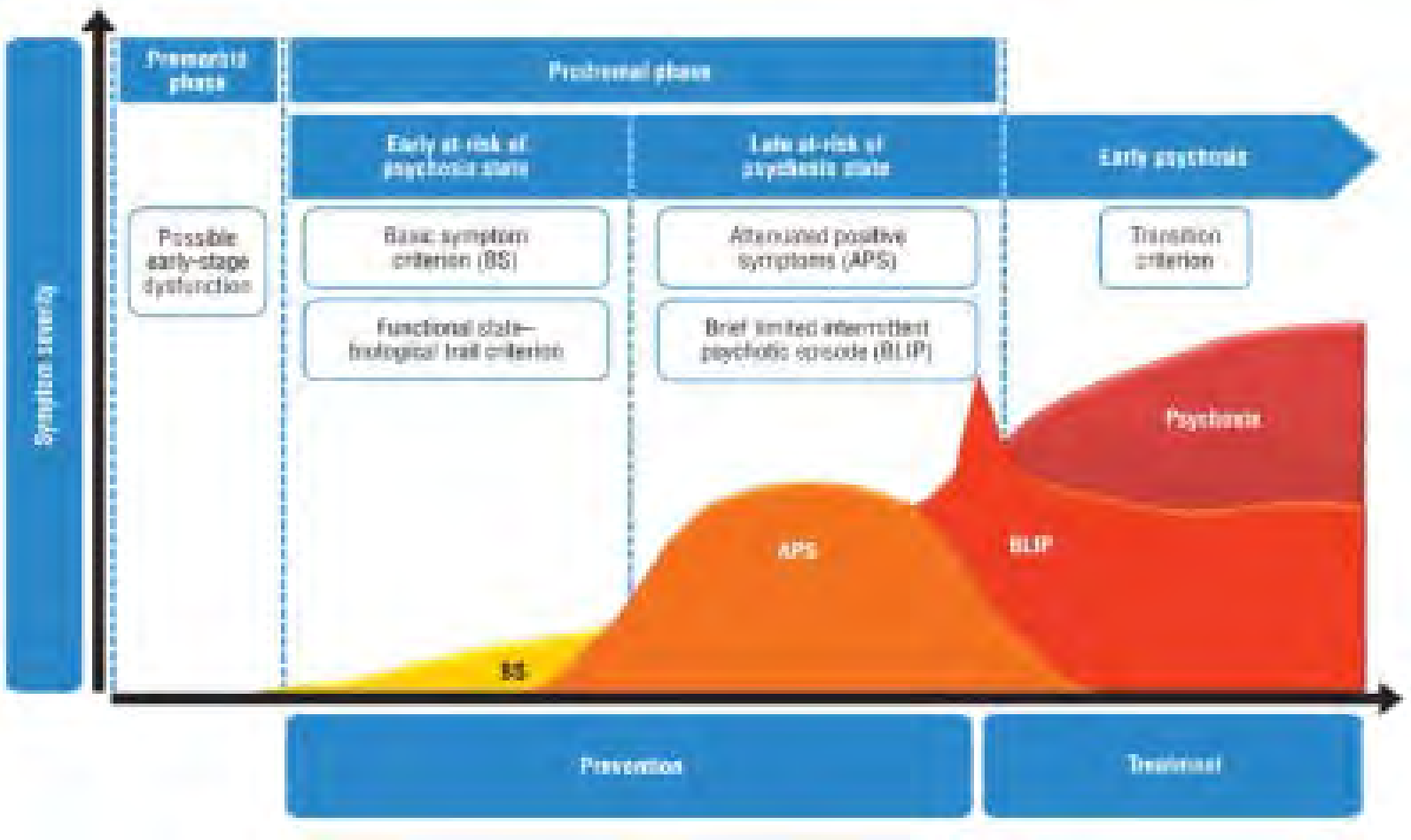
PRIMARY PSYCHOTIC DISORDERS



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CLINICAL HIGH RISK (CHR)

- Individually-matched case control study[1]
  - 93,483 patients across 530 primary care practices in UK
  - 11,690 diagnosed with Schizophrenia Spectrum D/o
  - 7 controls per case = 81,793 control participants
  - General Practice Research Database cohort (2000-2009)
- Key findings:
  - Patients who progressed to a psychotic diagnosis consulted their PCP an average of **14 times more often** than controls prior to index diagnosis.
  - Presence of AMI increases risk of SMI[2]
  - Symptoms associated with eventual psychotic dx…

[1] Sullivan SA…Lewis G. (2018) Association of primary care consultation patterns with early signs and symptoms of psychosis. *JAMA Netw Open*. 2018;1(7):e185174. doi:10.1001/jamanetworkopen.2018.5174

[2] Addington et al. (2014)

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ASSOCIATED BETWEEN CHR SYMPTOMS AND PSYCHOSIS DIAGNOSIS

Table 2. Multivariable Conditional Logistic Regression of the Association Between Symptoms Recorded During Primary Care Consultations and a Diagnosis of Psychosis

	Study Group, No. (%)			
Symptom	Cases (n = 11 690)	Controls (n = 81 793)	OR (95% CI)[a]	*P* Value
Bizarre behavior	16 (0.1)	5 (0.01)	21.70 (7.94-59.28)	<.001
Suicidal behavior	762 (6.5)	326 (0.4)	19.06 (16.55-21.95)	<.001
Cannabis-associated problems	90 (0.8)	37 (0.04)	15.92 (11.23-22.58)	<.001
Depressive symptoms	7639 (65.4)	13 256 (16.2)	12.11 (11.53-12.72)	<.001
Blunted affect	17 (0.1)	16 (0.02)	7.69 (3.83-15.44)	<.001
ADHD-like symptoms	216 (1.8)	237 (0.3)	7.22 (5.96-8.74)	<.001
OCD-like symptoms	143 (1.2)	144 (0.2)	6.91 (5.50-8.69)	<.001
Social isolation	68 (0.6)	61 (0.1)	6.64 (5.05-8.74)	<.001
Role functioning problems	90 (0.8)	132 (0.2)	5.60 (4.39-7.15)	<.001
Symptoms of mania	2457 (21.0)	5122 (6.3)	4.66 (4.39-4.93)	<.001
Sleep disturbance	846 (7.2)	2424 (3.0)	3.22 (2.94-3.54)	<.001
Personal hygiene problems	3 (0.02)	9 (0.01)	2.60 (0.66-10.26)	.17
Smoking-associated problems[b]	3170 (27.1)	13 820 (16.9)	2.00 (1.90-2.10)	<.001

Sullivan SA…Lewis G. Association of primary care consultation patterns with early signs and symptoms of psychosis. *JAMA Netw Open*. 2018;1(7):e185174. doi:10.1001/jamanetworkopen.2018.5174

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DIFFERENTIAL DIAGNOSIS

- Collaterals are key
  - Recent changes in behavior (home, school/work, social/familial), especially bizarre behavior
  - Paralogical or illogical ideation
  - Affective flattening or blunting
- Acute or gradual?
- Previous diagnoses and related medications?
- Family history?

ENGAGING PATIENTS IN TREATMENT

- The earlier, the better[1]
- In standard care, 80% drop-out within first year of treatment[2]
- Three-stage model[3]
  1) Communities outreach & early detection
  2) Engage individuals and families with person-centered, goal-driven treatment
  3) Peer involvement

[1] Breitborde et al., 2017. Optimizing psychosocial interventions in first episode psychosis: Current perspectives and future directions. *Psychol Res, 10, 119-128.*

[2] Dixon et al (2016). Treatment engagement of individuals experiencing mental illness: Review and update. *World Psychiatry, 12,* 13-20.

[3] Lynch, Jaynes, Machar (2019). Engaging families and individuals in care. In *Intervening Early in Psychosis: A Team Approach* (Hardy, Ballon, Noordsy, Adelsheim).

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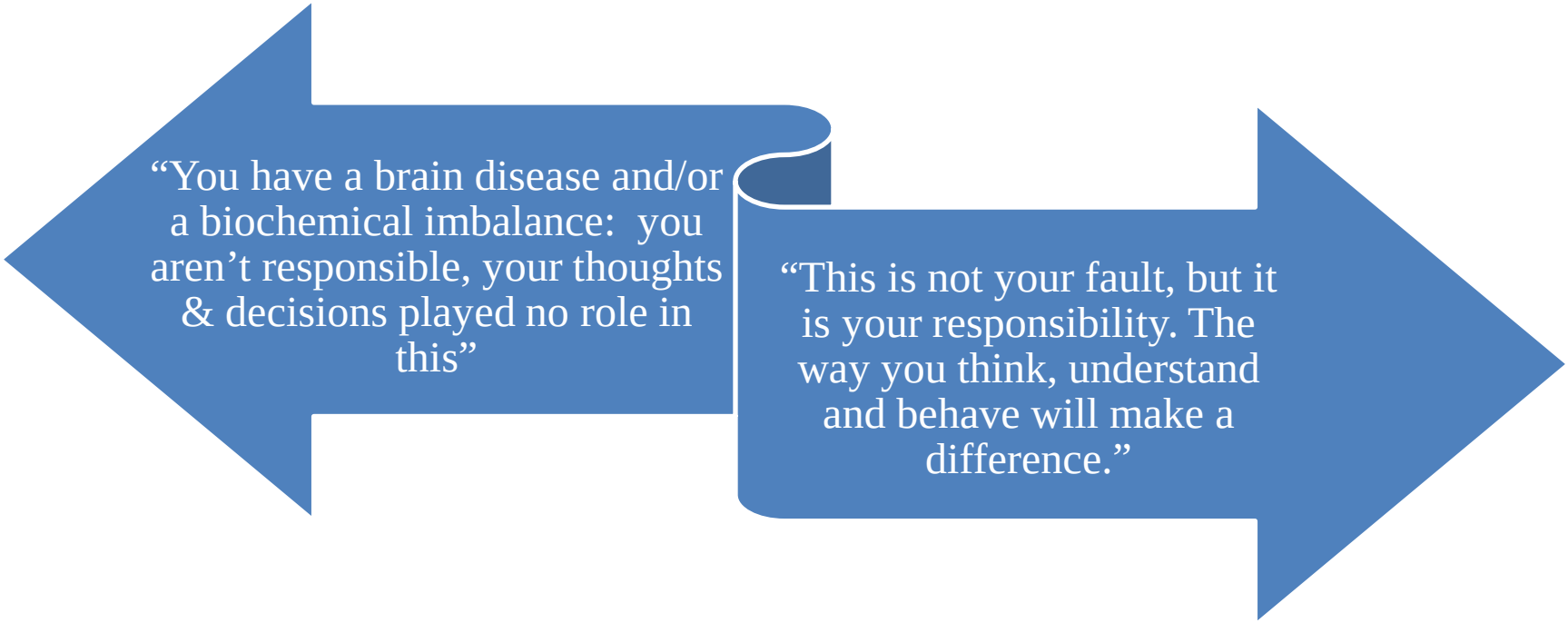
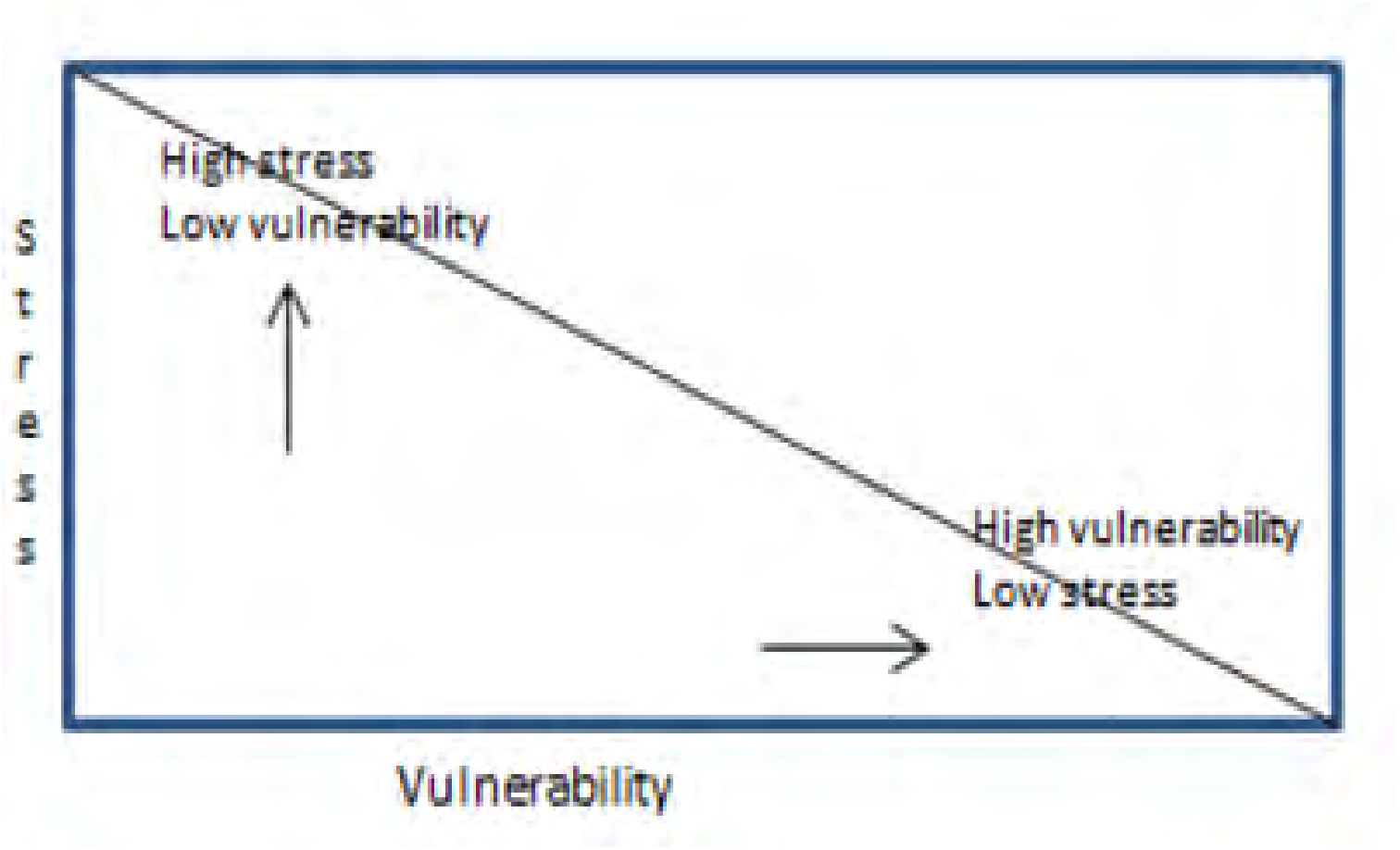
COGNITIVE MODEL VERSUS BIOMEDICAL MODEL:

How we understand a problem will dictate how we treat it (and the person).



STRESS-VULNERABILITY MODEL



Source: Zubin & Spring (1977); Neucterlein et al. (2008)

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THE TEN COMMANDMENTS OF A THERAPEUTIC ENCOUNTER

1) Active listening
   - Remember, 80% of communication is non-verbal!
   - Listening with an open mind
2) Empathy
   - The ability to perceive another's experience and then to communicate that perception back to the individual (***not*** "I know how you feel!")
   - Nonverbal and verbal attending
   - Paraphrasing
   - Reflecting feelings and implicit messages

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THE TEN COMMANDMENTS OF A THERAPEUTIC ENCOUNTER

3) Warm, genuine, positive regard

- non-hierarchical; *two* experts
- collaborative
- respectful
- acceptance of the person
- sincere belief that every person possesses the inherent strength and capacity to be autonomous

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THE TEN COMMANDMENTS OF A THERAPEUTIC ENCOUNTER

4) Concrete, specific, and direct

- Assisting the client to identify and work on a specific problem
- Reminding the client of the intent and structure of the session
- Using questions and suggestions to help the client clarify goals and tasks
- Staying focused on the present
- Minimal use of abstractions, metaphors, jargon
- Collaborating on a concrete, specific action plan
- All parties are accountable for following through
- Don't avoid discussing delusions. When in doubt, *ask*

THE TEN COMMANDMENTS OF A THERAPEUTIC ENCOUNTER

5) Open questions

Used to (a) facilitate exploration of thoughts, feelings, and behaviors (staying focused on target behavior!), and (b) model curiosity.

Socratic dialogue facilitates insight

- Clarifying questions
- Probing clients' assumptions
- Probing rationale
- Questioning viewpoints
- Probing consequences
- Question the question

6) Therapeutic self-disclosure

With the purpose of normalizing, advancing the therapeutic relationship, modeling, or illustrating a point that cannot be made another way.

THE TEN COMMANDMENTS OF A THERAPEUTIC ENCOUNTER

7) Be transparent; promote choice and collaboration

- "I'm asking because..." "I write notes to help me remember."
- "Of these two options, which do you think could have the bigger positive impact?"

8) Provide accurate information

- Psychoeducation
- Normalization
- "I don't know the answer to that. Let me look that up and get back to you."

9) Provide person-centered care

- Assess and leverage values, strengths, assets, resources, treatment goals, recovery goals

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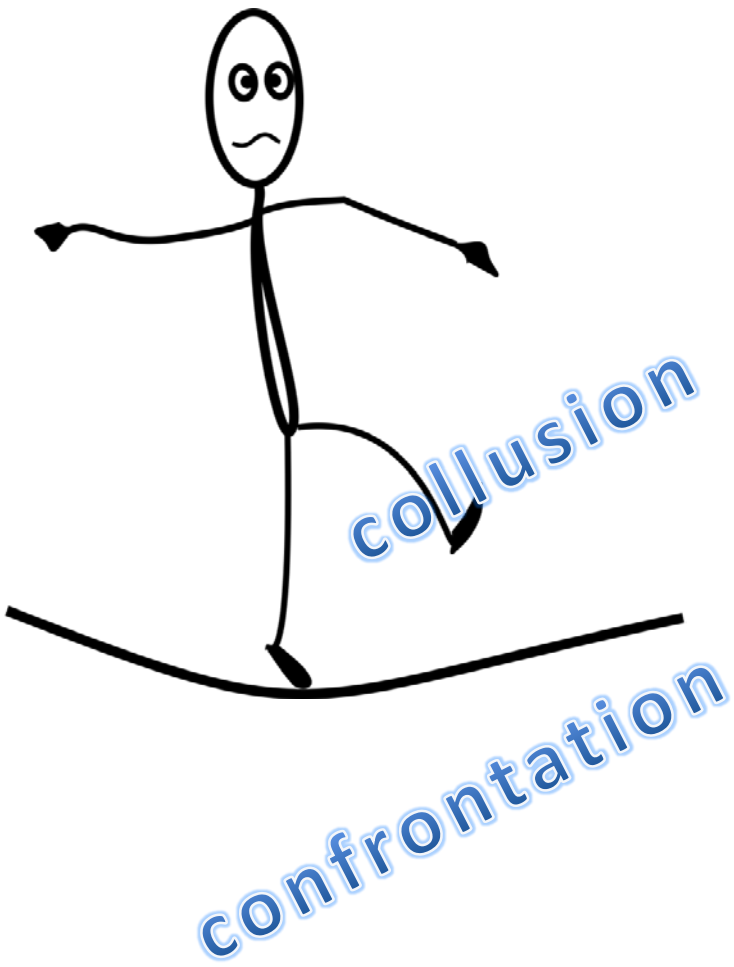
THE TEN COMMANDMENTS OF A THERAPEUTIC ENCOUNTER



10) Avoid confrontation and collusion.

- Empathize with distress
- Label strongly held beliefs “concerns”
- “I want to make sure I’m getting this right…Help me understand…I may be missing something”
- Don’t be afraid to put it on the shelf

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EMPATHIC DISAGREEMENT

"You're totally right; this is really happening."

"That is impossible. Stop thinking that!"

"It's hard for me to see that you're being threatened because I can't hear the voices. But I can see the distress that you're experiencing and I want to help with whatever is causing that!"

Slide Credit: Dimitri Perivoliotis, PhD, UCSC | Veterans Administration

RECOVERY-ORIENTED PSYCHOEDUCATION

- The main messages to convey:
  - *You are not alone*
  - *You are not responsible for developing psychosis*
  - *What you do and how you think can have a big impact on your symptoms*
  - *I understand/I will do my best to understand*
  - *I support you in your personally-defined recovery*
  - *People with this diagnosis go on to live full, meaningful, productive lives*
  - *Let's help you better understand what's happening*
  - *Let's help you better cope with what's happening*

RECOVERY-ORIENTED PSYCHOEDUCATION

IF A PICTURE'S WORTH A THOUSAND WORDS, HOW MANY IS A VIDEO WORTH?

https://depts.washington.edu/ebpa/what-we-do/cognitive-behavioral-therapy-psychosis-cbtp/cbtp-resources/consumers

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LOOKING THROUGH A CBT LENS.

Consider the range of behaviors that we as clinicians are concerned with…

attending appointments
taking medications as prescribed
trying a new medication
engaging in daily hygiene
altering sleep patterns
increasing physical activity

CBT guides us to formulate *hypotheses*, based on what we know about the client, about what is getting in the way before jumping in with education or engaging in problem solving.

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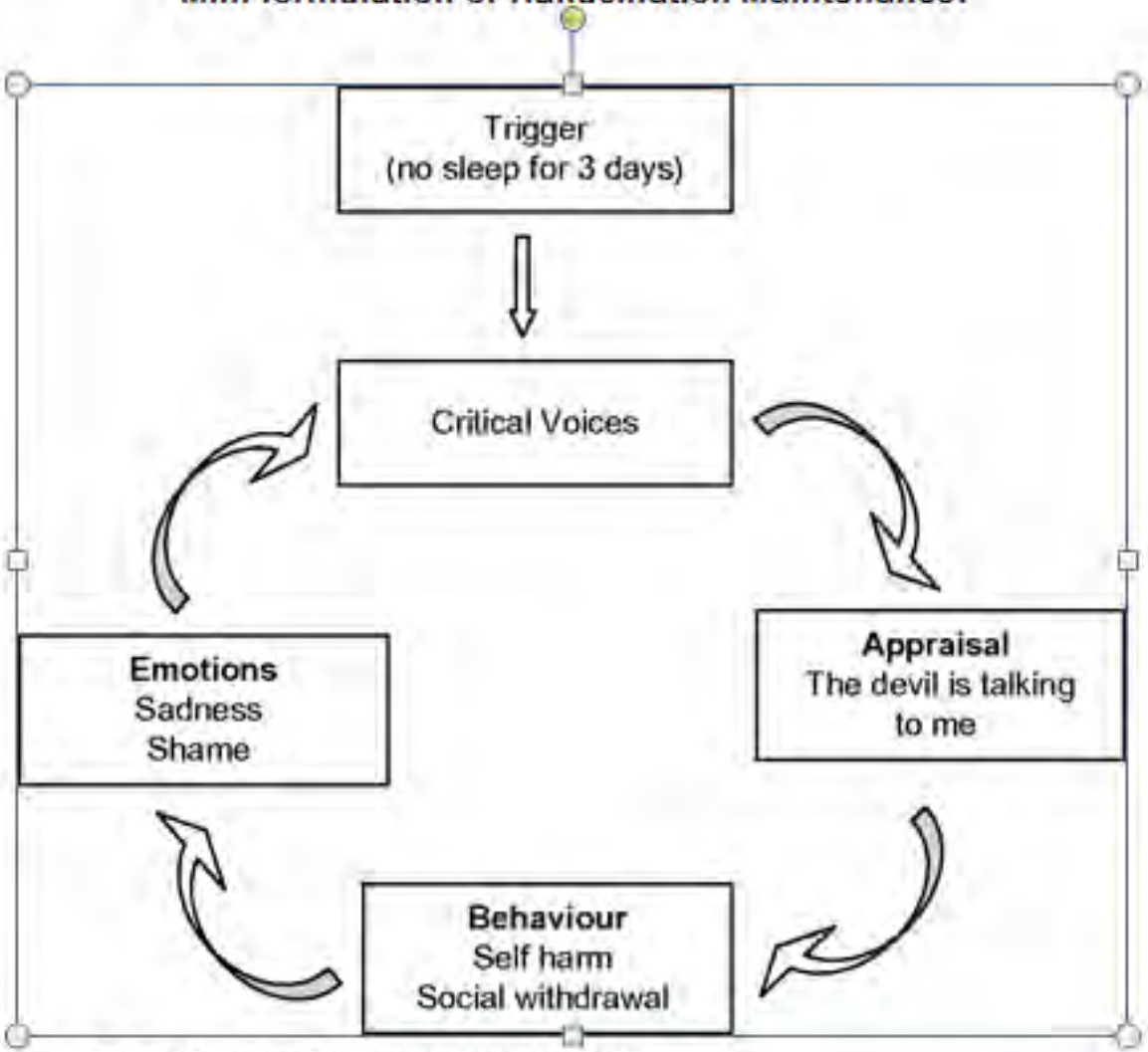
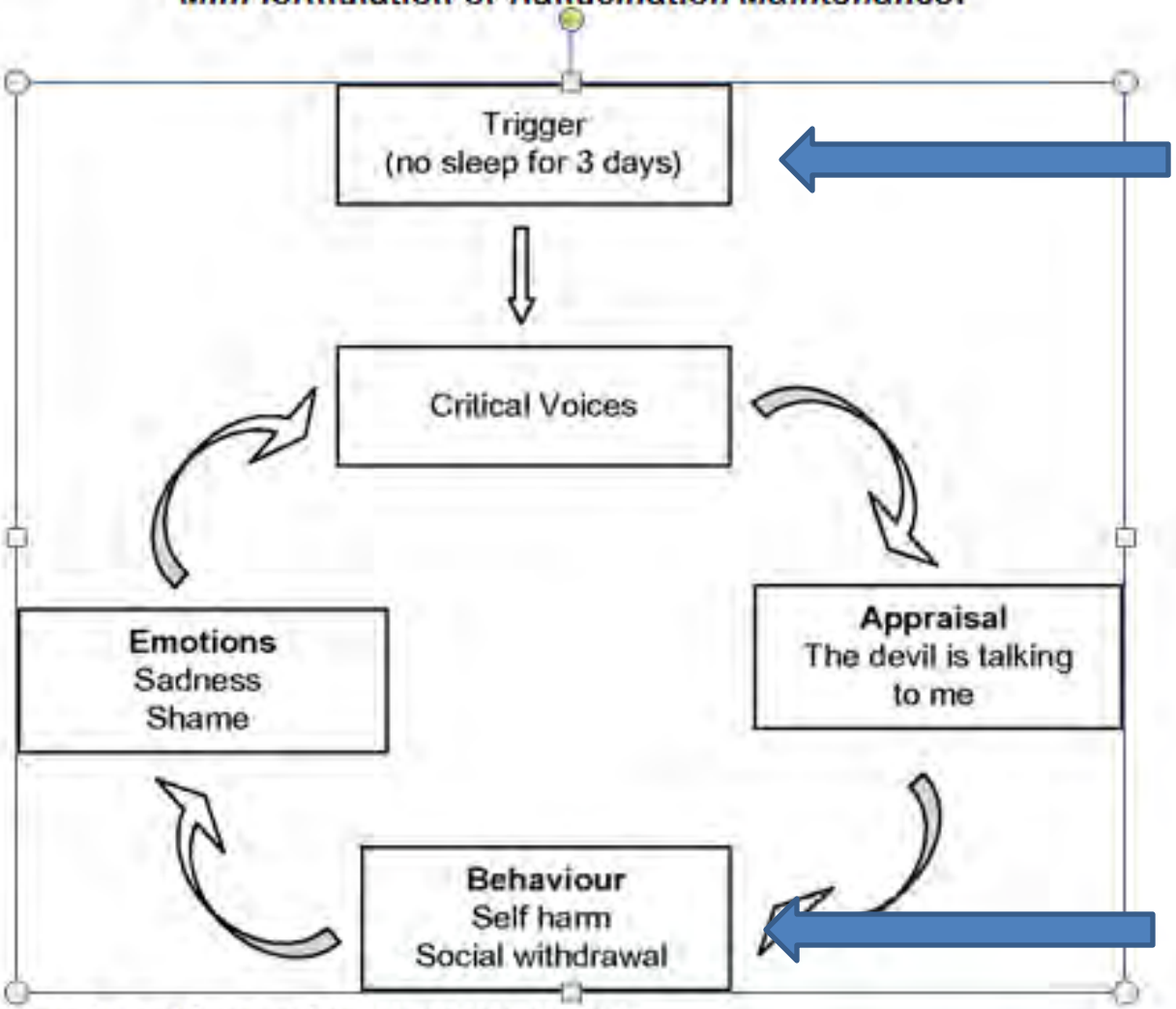
Mini-formulation of Hallucination Maintenance.



Sara Tai, and Douglas Turkington Schizophr Bull 2009;35:865-873

Schizophrenia Bulletin

Mini-formulation of Hallucination Maintenance.



Sara Tai, and Douglas Turkington Schizophr Bull 2009;35:865-873

Schizophrenia Bulletin

CORE SKILLS FOR ALL CLINICAL ENCOUNTERS

http://www.psychiatrictimes.com/special-reports/brief-cognitive-behavioral-therapy-interventions-psychosis

	Strategies	Outcome
C: The deeper the connection, the more effective the intervention	Engage in water cooler conversation; build on a previous positive interaction you had; identify common interests such as sports, music, etc; validate feelings; use humor, particularly self-deprecating type; appropriate self-disclosure	Enhances engagement
U: Understand and break down the problem	Prioritize problems when there are multiple ones; break a problem into small parts; create different time frames for each problem; identify barriers to action steps and problem solve	Clarifying problems creates an actionable plan and reduces barriers to action
T: Teach	New information; simple CBT skills such as rating emotions, self-monitoring, activity scheduling; teach more adaptive perspective; teach or instill hope	Patient learns self-management and life skills and is more hopeful
P: Practice	Practice work should be manageable; have patient buy-in and ask him or her to help; ask patient for feedback about utility of the work and ability to do the work	Learned skills are generalized to real-world situations
A: Ask	Get feedback about degree of comfort in session, the intervention used, barriers to homework assigned, or therapist's style	Helps collaboration and helps the therapist to fine-tune interventions
R: Review	Patient summarizes and then therapist adds to it	Reinforces what is learned in session

HIGH-YIELD BEHAVIORAL INTERVENTIONS FOR PSYCHOTIC SYMPTOMS

- Keep a voice diary (time of day, intensity, content, what makes them better/worse)
- Promote sleep health!
  - Sleep hygiene
  - Sleep apps
- Anxiety management skills
  - Paced breathing (4-7-8, Breathe2Relax app)
  - Guided imagery
  - Increase self-care when stress levels increase
- Fight isolation
  - WARM Line (877-500-WARM)
  - Talk to a trusted loved one
  - In-person group on online forum (Hearing Voices Network, paranoidthoughts.com, Icarus Project)

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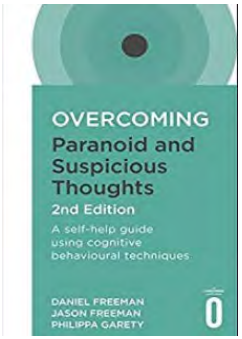
HIGH-YIELD BEHAVIORAL INTERVENTIONS FOR PSYCHOTIC SYMPTOMS

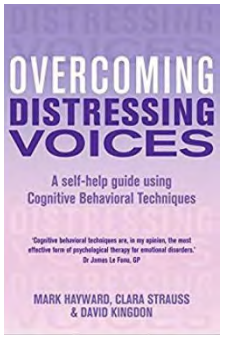
- Cognitive tasks
  - Count backward
  - Subvocalization
  - 54321
  - Crossword puzzle
  - Positive coping statements/mantras (“This too shall pass.” “Just because they said it doesn’t make it true.”)
- Distraction
  - Listen to music or audiobook
  - Talk to someone
  - Go for a walk. Label what you see.
- Behavioral Activation
  - *The more you do, the better you feel…*
  - Activities should promote mastery, competence, pleasure, and—if possible—*meet the function of the delusion.*

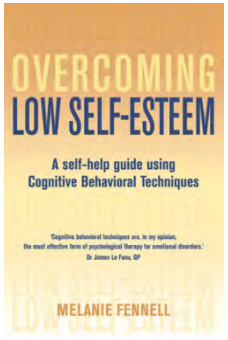
RESOURCES FOR PATIENTS

- Apps: www.psyberguide.org/apps

- Self-Help Books:







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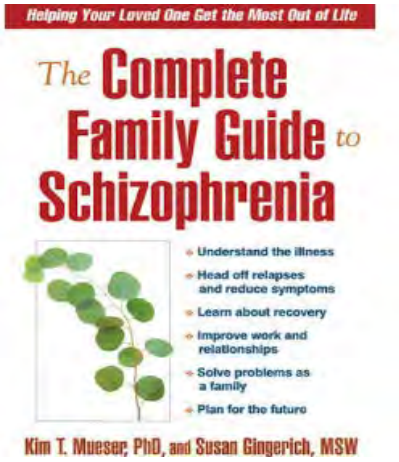

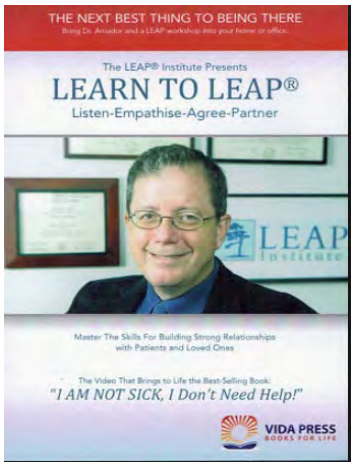

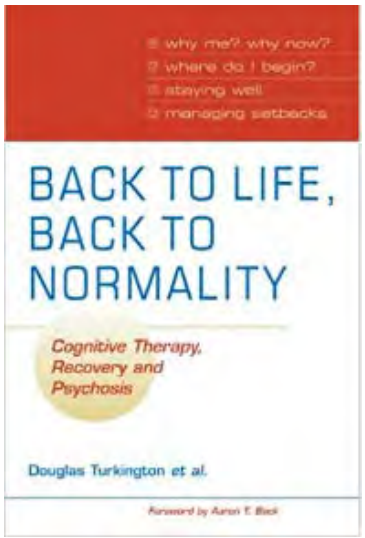

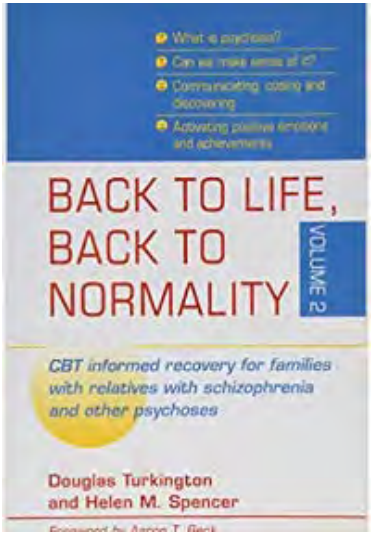

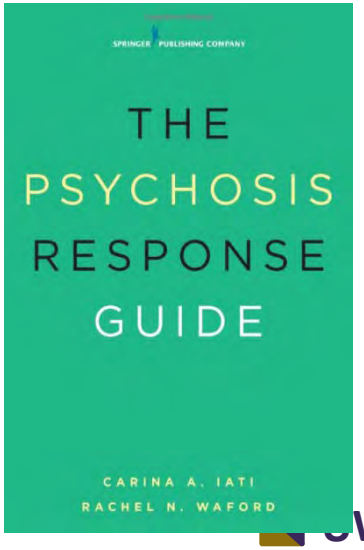

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