CUE

Coping with Unique Experiences

# Clinical high risk for psychosis: An Update

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# What is psychosis?

- Delusions
- Hallucinations
- Disorganized Thought and Communication

# What is psychosis risk?

"Clinical high risk" (CHR)

Attenuated psychosis syndrome DSM-5

- 20% develop psychosis

Persecutory Ideas

Goes to the park and feels like people are staring

Refuses to go outside because they are convinced their neighbor is plotting to kill them

# Developmental trajectory of psychotic disorders

Toddlers: developmental delays in walking and talking

4–6: isolated play, speech problems

7 and 11: some clumsiness;

Teen years: academic decline, social withdrawal; Emergence of psychotic-like symptoms – unusual thought content, suspiciousness, perceptual disturbances, tangential, concrete

*AGE*

# What does psychosis risk look like?

Subthreshold psychotic symptoms" – insight is retained, skepticism remains.

- Overvalued ideas and unusual thought content instead of delusions– fantasizing about having wings, feeling like the color white may have special meaning, worry about seeing dead bodies along the road at night
- Suspiciousness instead of paranoid delusions– feeling like someone is watching you (but not sure), always looking over your shoulder, but not convinced someone is out to get you
- Grandiose thoughts without conviction – feeling like you may have superpowers or a special relationship with God
- Illusions and perceptual disturbances instead of hallucinations – for example, hearing your name in the wind; colors looking different; thinking a mailbox looks like the Grim Reaper
- Subtle language disturbance – tangential, derailment, looseness of association, poverty of speech output and content

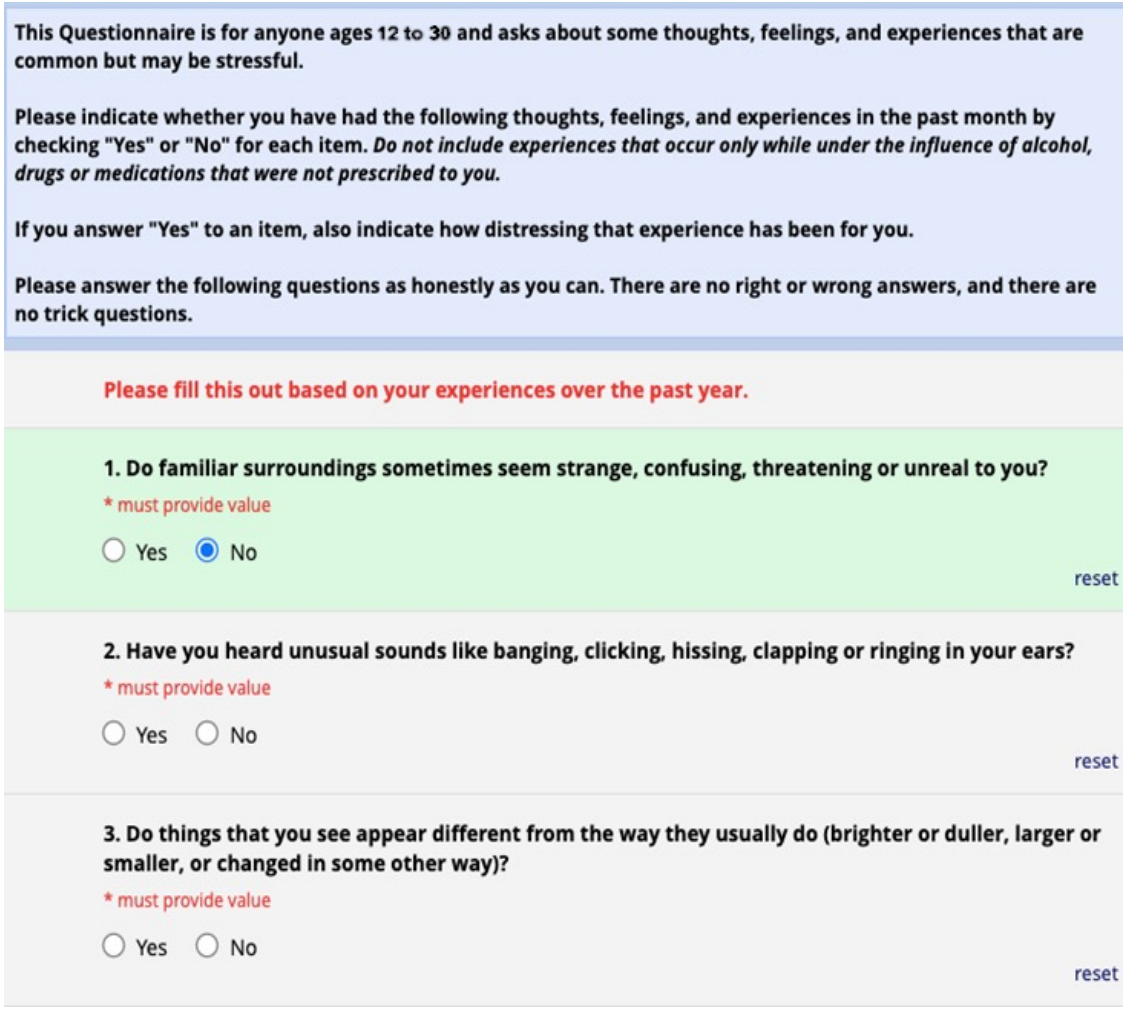
Also: Functional impairment (decline in grades, social withdrawal), Negative symptoms, cognitive deficits, depression, (social) anxiety, suicidal ideation;

# Screening for psychosis risk

**Prodromal Questionnaire-Brief Version (PQ-B)**

- 21 Yes-or-No questions
- 5-point Likert scale of distress
- Covers:
  1. Delusional Ideas
  2. Persecutory Ideas
  3. Grandiosity
  4. Perceptual Abnormalities
  5. Disorganized Communication

Just google “PQ-B”
https://www.semel.ucla.edu/sites/default/files/pdf/High%20Risk%20Psychosis%20Screener.pdf



This Questionnaire is for anyone ages 12 to 30 and asks about some thoughts, feelings, and experiences that are common but may be stressful.

Please indicate whether you have had the following thoughts, feelings, and experiences in the past month by checking "Yes" or "No" for each item. *Do not include experiences that occur only while under the influence of alcohol, drugs or medications that were not prescribed to you.*

If you answer "Yes" to an item, also indicate how distressing that experience has been for you.

Please answer the following questions as honestly as you can. There are no right or wrong answers, and there are no trick questions.

Please fill this out based on your experiences over the past year.

1. Do familiar surroundings sometimes seem strange, confusing, threatening or unreal to you?
* must provide value
Yes No
reset

2. Have you heard unusual sounds like banging, clicking, hissing, clapping or ringing in your ears?
* must provide value
Yes No
reset

3. Do things that you see appear different from the way they usually do (brighter or duller, larger or smaller, or changed in some other way)?
* must provide value
Yes No
reset

# Results from CHR screening with PQ-B: Mount Sinai

| Positive PQ-B Scores | | | | | |
|---|---|---|---|---|---|
| **Clinic** | **# of PQ-Bs Completed** | **# of Positive PQ-Bs** | **% of Positive PQ-Bs** | **Average Positive Score** | **Median Positive Score** |
| **ALL Adolescent[3 5 6]** | 449 | 272 | 60.6% | 10.5 | 10.0 |
| **ALL Adult[1 2 4]** | 523 | 190 | 36.4% | 9.9 | 9.0 |
| **ALL CLINICS** | **972** | **462** | **47.3%** | **10.2** | **9.0** |

**~1000 PQ-Bs completed upon intake in general MH outpatient clinics and nearly 50% of people scored positive**

Yulia Landa, PsyD, MS

# Assessment for psychosis risk

**Structured Interview for Psychosis-Risk Syndromes (SIPS)**

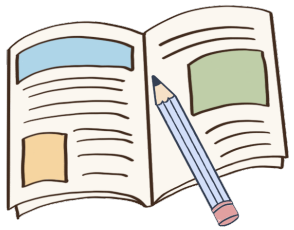
Recommended for anyone who scores ≥6 on the PQ-B

Valid for ages 12 +

60-90 minutes to complete interview

The SIPS helps us to gauge:

- Attenuated vs. threshold psychotic symptoms (reality testing? dangerousness?)
- Frequency, duration, and intensity of experiences
- Timeline (i.e., onset and changes) of these phenomena



# SIPS Unusual thought content

| | |
|---|---|
| 0 Absent | |
| 1 Questionably Present | “Mind tricks” that are puzzling. Sense that something is different. |
| 2 Mild | Overly interested in fantasy life. Unusually valued ideas/beliefs. Some superstitions beyond what might be expected by the average person but within cultural norms. |
| **3 Moderate** | Unanticipated mental events/non-persecutory ideas of reference/ mind tricks/ magical thinking that are not easily dismissed and may be irritating or worrisome. A sense that these experiences or compelling new beliefs are becoming meaningful because they will not go away |
| **4 Moderately Severe** | Notion that experiences may be coming from outside the self or that ideas/beliefs may be real, but skepticism remains intact. Does not usually affect functioning. |
| **5 Severe but not Psychotic** | Belief in reality of “mind tricks”/mental events/external control/magical thinking is compelling but doubt can be induced by contrary evidence and others’ opinions |
| 6 Severe and Psychotic | Delusional conviction (with no doubt) at least intermittently. Usually interferes with thinking, social relations or behavior. |

# SIPS Suspiciousness

| | |
|---|---|
| 0 Absent | |
| 1 Questionably Present | Wariness. |
| 2 Mild | Doubts about safety. Hypervigilance without clear source of danger. |
| **3 Moderate** | Notions that people are hostile, untrustworthy, and/or harbor ill will easily. Sense that hypervigilance may be necessary. Mistrustful. Recurrent (yet unfounded or exaggerated at times) sense that people are thinking of saying negative things about the person. May appear mistrustful with interviewer. |
| **4 Moderately Severe** | Clear or compelling thoughts of being watched or singled out. Sense that people intend to harm. Beliefs easily dismissed. Presentation may appear guarded. Reluctant or irritable in response to questioning. |
| **5 Severe but not Psychotic** | Loosely organized beliefs about danger or hostile attention. Skepticism and perspective can be elicited with nonconfirming evidence or opinion. Behavior is affected to some degree. Guarded presentation may interfere with ability to gather information in the interview. |
| 6 Severe and Psychotic | Delusional paranoid conviction (with no doubt) at least intermittently. Likely to affect function. |

# SIPS Grandiosity

| | |
|---|---|
| 0 Absent | |
| 1 Questionably Present | Private thoughts of being better than others |
| 2 Mild | Mostly private thoughts of being talented, understanding or gifted |
| **3 Moderate** | Notions of being unusually gifted, powerful or special and have exaggerated expectations. May be expansive but can redirect to the everyday on their own. |
| **4 Moderately Severe** | Beliefs of talent, influence and abilities. Unrealistic goals that may affect plans and functioning, but responsive to other's concerns and limits. |
| **5 Severe but not Psychotic** | Compelling beliefs of superior intellect, attractiveness, power or fame. Skepticism and modesty can only be elicited by the efforts of others. Affects functioning. |
| 6 Severe and Psychotic | Delusions of grandiosity with conviction (no doubt) at least intermittently. Interferes persistently with thinking, feeling, social relations or behavior. |

# SIPS Perceptual Abnormalities

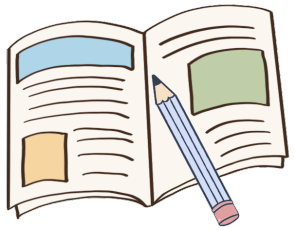
| | |
|---|---|
| 0 Absent | |
| 1 Questionably Present | Minor, but noticeable perceptual sensitivity (e.g. heightened, dulled, distorted, etc.) |
| 2 Mild | Unformed perceptual experiences/changes that are noticed but not considered to be significant |
| **3 Moderate** | Recurrent, unformed images (e.g., shadows, trails, sounds, etc.), or persistent perceptual distortions that are puzzling and experienced as unusual. |
| **4 Moderately Severe** | Illusions or momentary formed hallucinations that are ultimately recognized as unreal yet can be distracting, curious, unsettling. May affect functioning. |
| **5 Severe but not Psychotic** | Hallucinations experienced as external to self though skepticism can be induced by others. Mesmerizing, distressing. Affects daily functioning. |
| 6 Severe and Psychotic | Hallucinations perceived as real and distinct from the person's thoughts. Skepticism cannot be induced. Captures attention, frightening. Interferes persistently with thinking, feeling, social relations and/or behavior. |

# SIPS Disorganized Communication

| | |
|---|---|
| 0 Absent | |
| 1 Questionably Present | Occasional word or phrase doesn't make sense. |
| 2 Mild | Speech that is slightly vague, muddled, overelaborate or stereotype. |
| **3 Moderate** | Incorrect words, irrelevant topics. Goes off track, but redirects on own. |
| **4 Moderately Severe** | Speech is circumstantial (i.e., eventually getting to the point). Difficulty directing sentences toward a goal. Sudden pauses. Can be redirected with occasional questions and structuring. |
| **5 Severe but not Psychotic** | Speech tangential (i.e., never getting to the point). Some loosening of associations or blocking. Can reorient briefly with frequent prompts or questions. |
| 6 Severe and Psychotic | Communication persistently loose, irrelevant or blocked and unintelligible when under minimal pressure or when the content of the communication is complex. Not responsive to structuring of the interview. |

# Resources for screening/assessment (general)

PQ-B
Google search “PQ-B” and download



Mini-SIPS – for clinical purposes

- Only 20-30 minutes to administer
- Only positive symptoms: delusions, hallucinations, disorganized communication
- 0 - within normal; 1 - attenuated; 2– threshold psychosis
- Helps clinicians generate minimum information needed to diagnose DSM-5 Attenuated Psychosis Syndrome
- Online training for mini-SIPS through Yale University

https://campuspress.yale.edu/napls/other-resources/

## Myth 1

*My patients would tell me if they were having psychotic-like symptoms.*


- Patients often do not disclose psychotic-like experiences on their own. They are significantly more likely to report them if asked directly or via a screener (e.g., the PQ-B)

## Myth 2

*Their symptoms look more like depression, anxiety, and/or trauma than psychosis-risk.*

- Common comorbid depression and anxiety

Myth 3

*I will stigmatize my patients if I mention psychosis.*

- Being told one is at risk for psychosis:
  - Does not increase negative emotions
  - Is associated with positive experiences (e.g., relief, validation)

Myth 4

- *These symptoms are only subthreshold, so it's not worth worrying about them yet.*
  - Functional distress – many young people have persistent symptoms
  - ~20% will develop psychosis within 3-4 years

# Treatment of psychosis risk - medications

Antipsychotics???

The evidence base does not support antipsychotic treatment.
2 placebo-controlled studies – some improvement of symptoms

BUT

Olanzapine – prevented psychosis but weight gain 8.8 kg
Aripiprazole – akathisia
Risperidone – prolactin increase

# Antipsychotics for psychosis risk?

- Generally not recommended for routine first-line treatment:
  - Metabolic side effects;
  - Tardive dyskinesia;
  - Sedation and akathisia;
  - Safer alternatives (CBT)
- Sometimes recommended when:
  - Rapid deterioration;
  - Risk of self-harm or aggression;
  - Substantial distress or impairment and other treatments ineffective or unavailable.

# So if not antipsychotics, then which medications?

- Antidepressants – no randomized clinical trials; may help
- D-serine (amino acid) RCT – improved motivation
- Cannabidiol (CBD) – small trials – may decrease anxiety.

# Practice Guidelines for APS/CHR/psychosis risk

| Organization | Citation | Recommendations |
|---|---|---|
| American Psychiatric Association | Lehman et al. (2004) | "Careful assessment and frequent monitoring" |
| Canadian Psychiatric Association | Addington et al. (2005a) | "Should be offered monitoring"<br>"May be offered supportive therapy and symptomatic treatment" |
| International Early Psychosis Association | Addington et al. (2005b) | "Offered regular monitoring and support"<br>"Provided with psychoeducation"<br>"Offered family education and support"<br>"Antipsychotic medications not usually indicated" unless "rapid deterioration" or "severe suicidal risk and treatment of depression has proved ineffective" or "aggression and hostility are increasing and pose a risk to others"<br>"If antipsychotics are considered, ideally used in low doses," "may be continued" up to 2 years, and then "a gradual attempt to withdraw the medication should be made" |
| Royal Australian and New Zealand College of Psychiatrists | McGorry et al. (2005) | "Monitored in a context of ongoing support"<br>"Antipsychotic medication not normally prescribed" unless "symptoms are directly associated with risk of self-harm or aggression" |
| Italian National Institute of Health | De Masi et al. (2008) | "Use of antipsychotic medication" "is doubtful"<br>"Behavioural-cognitive therapy is recommended" for treating current state |

# Neuroprotective Strategies

*Long-chain omega-3 polyunsaturated fatty acids (PUFA) (Amminger et al., 2010) looked promising (!),*

*N = 81; 12-week intervention period of 1.2-g/d ω-3 PUFA or placebo*

*Conversion to psychosis 5% (PUFA) vs. 28% (Placebo) within 1 year!*

*But methodological issues*

*- fish oils smell awful (but placebo was coconut oil) ; was the study sufficiently blinded?*

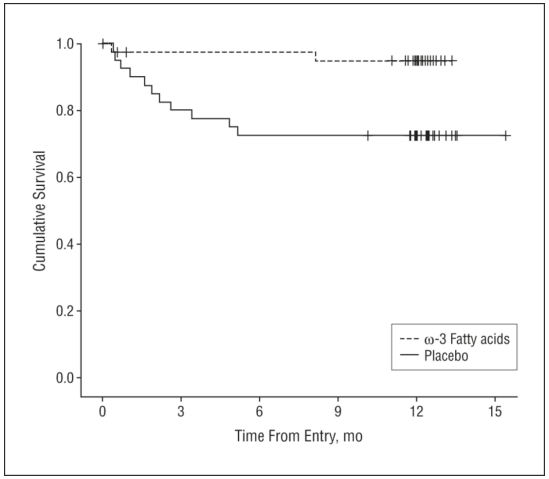
*- unusual cohort (i.e. 70% female)*

*- risk and outcome too similar (< 7 days of psychosis for brief intermittent psychosis (risk) (42% cohort) vs. > 7 days for psychosis transition (outcome))*

*- unusual pattern of survival*

*(Something fishy about this study!)*

*Not replicated!*



# Be careful with stimulants!

In 2007 FDA required warnings be added to stimulant labels for emergent psychosis.

**TABLE 1** Summary of Pediatric ADHD Clinical Trials and Psychiatric Adverse Events

| Drug | No. of Trials | Treatment | Exposure in Trials, Person-Years | Psychosis/Mania Events, *n* |
|---|---|---|---|---|
| Ritalin LA | 3 | Placebo | 8.6 | 0 |
| | | Drug | 9.9 | 0 |
| Modafinil | 5 | Placebo | 32.5 | 0 |
| | | Drug | 75.1 | 2 |
| MTS | 8 | Placebo | 23.8 | 0 |
| | | Drug | 30.3 | 4 |
| Metadate CD | 4 | Placebo | 19.4 | 0 |
| | | Drug | 19.1 | 0 |
| Dextromethylphenidate | 7 | Placebo | 48.5 | 0 |
| | | Drug | 49.7 | 1 |
| Concerta | 4 | Placebo | 10.2 | 0 |
| | | Drug | 12.5 | 0 |
| Adderall XR | 4 | Placebo | 21.0 | 0 |
| | | Drug | 59.0 | 0 |
| Atomoxetine | 14 | Placebo | 256.0 | 0 |
| | | Drug | 487.5 | 4 |

MTS indicates methylphenidate transdermal system.

## Also cannabis

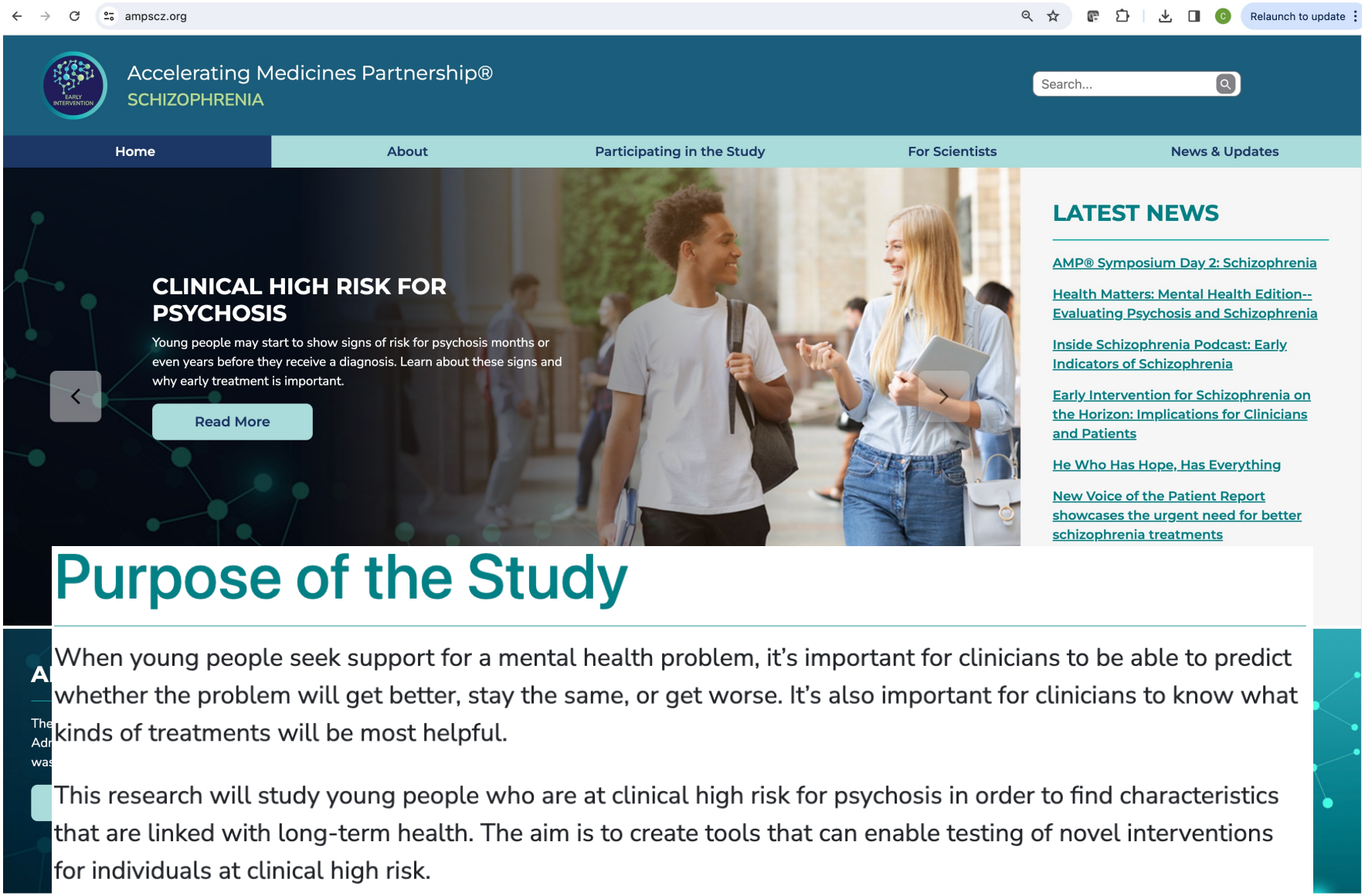
SAMHSA
Substance Abuse and Mental Health Services Administration

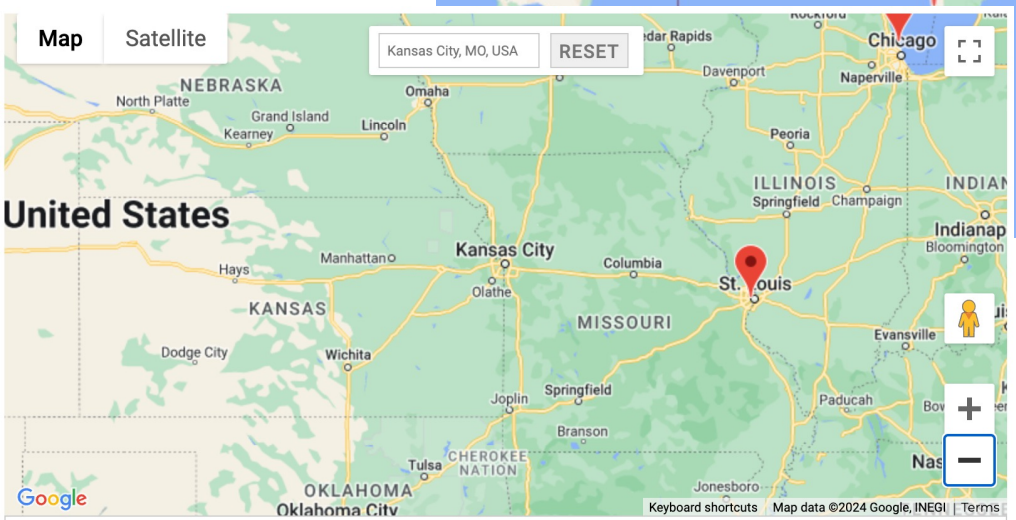
# Summary

There is NO evidence-based pharmacological treatment for psychosis risk, including antipsychotics.

Psychological treatment (cognitive behavioral therapy) has some evidence to support it.

# International consortium to study biomarkers of psychosis risk



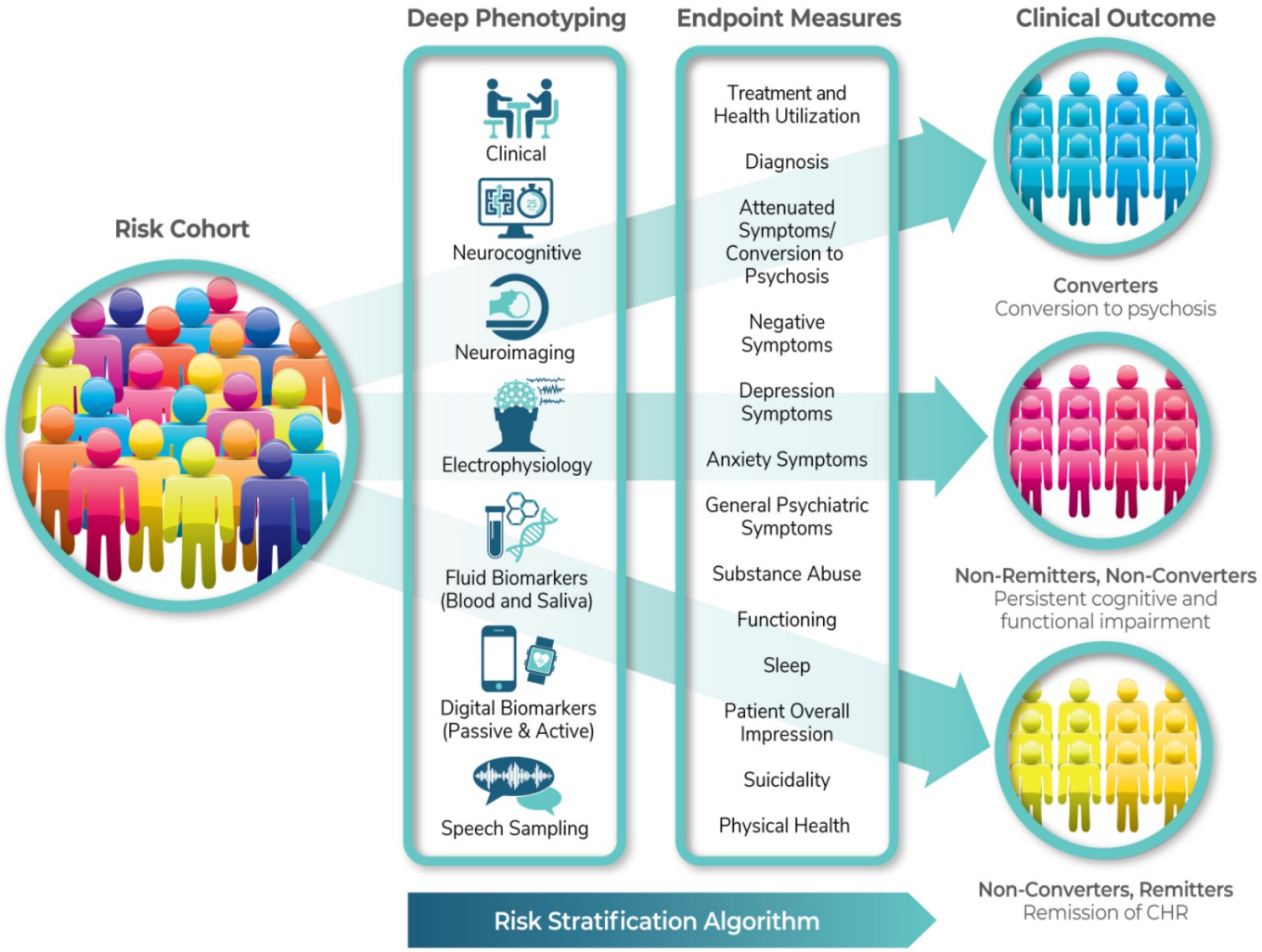



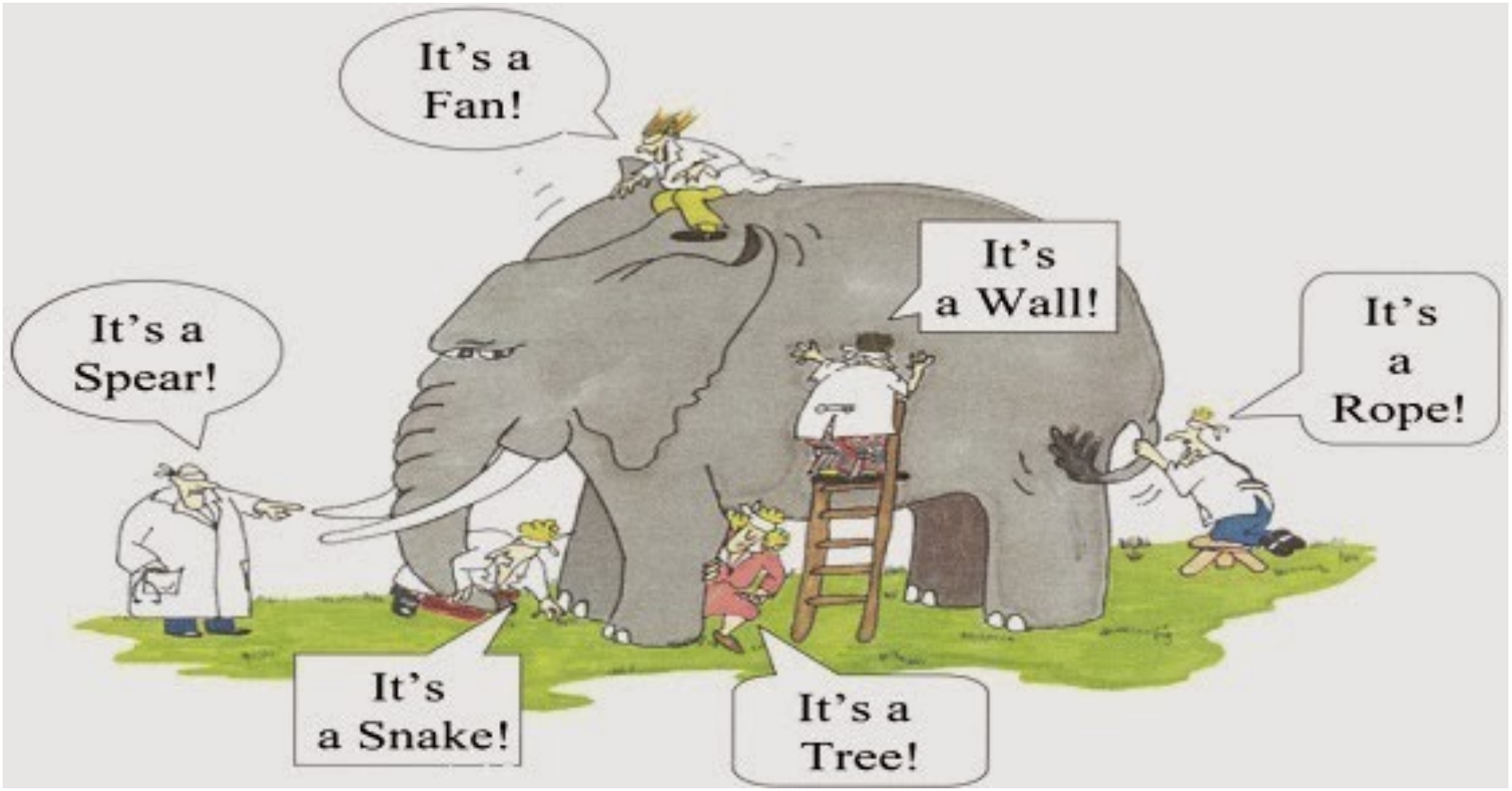

Washington University

4525 Scott Ave, St. Louis, MO 63110, USA

| | |
|---|---|
| **Principal Investigator** | Dr. Daniel Mamah |
| **Phone** | 314-273-4329 |
| **Email** | malana@wustl.edu |
| **Address** | East Building<br>4525 Scott Ave, Suite 1153<br>St. Louis, MO 63110, USA |

- Ages 12-30
- CHR
- No past threshold psychosis, intellectual disability, TBI
- No antipsychotic meds


Risk Cohort
Deep Phenotyping
Clinical
Neurocognitive
Neuroimaging
Electrophysiology
Fluid Biomarkers (Blood and Saliva)
Digital Biomarkers (Passive & Active)
Speech Sampling
Endpoint Measures
Treatment and Health Utilization
Diagnosis
Attenuated Symptoms/ Conversion to Psychosis
Negative Symptoms
Depression Symptoms
Anxiety Symptoms
General Psychiatric Symptoms
Substance Abuse
Functioning
Sleep
Patient Overall Impression
Suicidality
Physical Health
Clinical Outcome
Converters
Conversion to psychosis
Non-Remitters, Non-Converters
Persistent cognitive and functional impairment
Non-Converters, Remitters
Remission of CHR
Risk Stratification Algorithm


It's a Fan!
It's a Spear!
It's a Wall!
It's a Rope!
It's a Snake!
It's a Tree!

# Speech and language

“Language is a window into the mind” (Pinker)

Primary source of data for diagnosis and treatment of mental disorders

Easy and inexpensive to capture and transcribe, requiring only a microphone and recording device (smart phones, tablets, laptops)

“Big data” at the level of the individual

**Psychosis** as an example of language (and communication) disturbance. Predicts psychosis (schizophrenia) in risk cohorts

# Psychosis-Risk Services at Mount Sinai

# Assessment and feedback re psychosis risk

**General principles:**

- Provide information in a **clear**, **concise**, and **empathic** way.
- Use the **individuals' own language**.
- Focus on **symptoms and experiences**, NOT diagnoses.
- **Check with individual** which information would be helpful.
- When discussing research, clarify that statistics and researchfindings provide only **general information and averages**.
- Maintain **recovery-orientation** and instill **hope**.
- Focus on **strengths**.

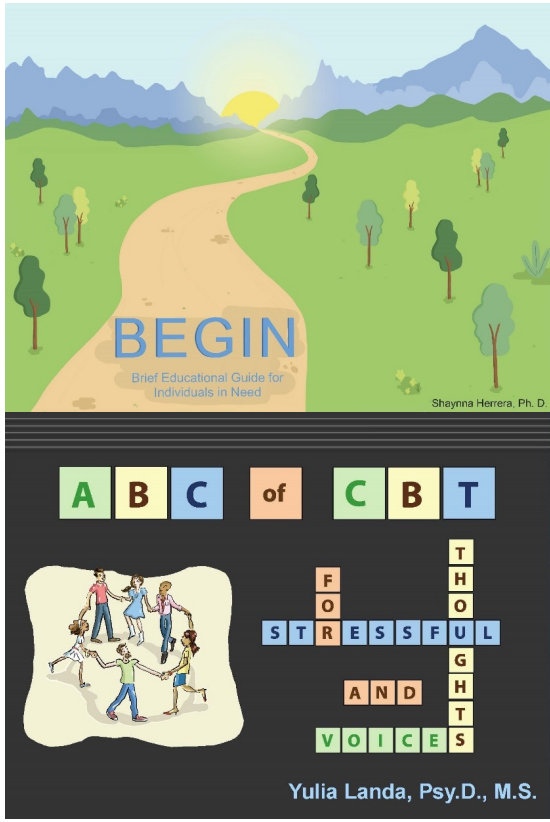
# Clinical Services at Mount Sinai

**Psychoeducation (BEGIN)**

- A structured, 5-session intervention
- Educates patients and family members about psychosis-risk and treatment options

**Group and Family-based CBT for Psychosis**

- GF-CBT is an empirically supported treatment,
  which aims to:
  - Facilitate psychosocial recovery
  - Decrease symptoms
  - Prevent psychosis in youth



# Ethical considerations in CHR communication

| Ethical Principle | Description |
|---|---|
| Beneficence and Nonmaleficence | Beneficence = do good<br>Nonmaleficence = do no harm |
| Fidelity and Responsibility | Moral obligation to ensure that all in the profession uphold ethical principles |
| Integrity | Avoid deceiving and misrepresenting, strive for transparency and honesty |
| Justice | Treat individuals equitably, be fair and impartial |
| Respect for People's Rights and Dignity | Respect individuals' rights to make choices, to privacy, and confidentiality |

Ethical Principles of Psychologists
American Psychological Association

# Respect for People's Rights and Dignity


- Providers do not consistently communicate about diagnosis
  - Why? Fear of increasing stigma, provider's own stigmatizing beliefs, lack of knowledge/training, unsure how to talk about it
- Individuals with CHR/psychosis and their families report unmet needs for diagnostic information
  - Long periods of time, sometimes years, before being given diagnostic information
  - Significant difficulties receiving any further information about the illness, including treatment options
- CHR individuals desire this information:
  - The treatments that CHR reported as most likely to participate in were psychoeducation (63%) & CBT (63%)
  - Communication about symptoms eases the emotional challenges of caregivers who support CHR individuals

*(Brummitt & Addington, 2013; Izon et al., 2020; Farooq, Naeem, & Singh, 2016; Loughland, et al., 2015; Outram et al., 2015; Gerson et al., 2009)*

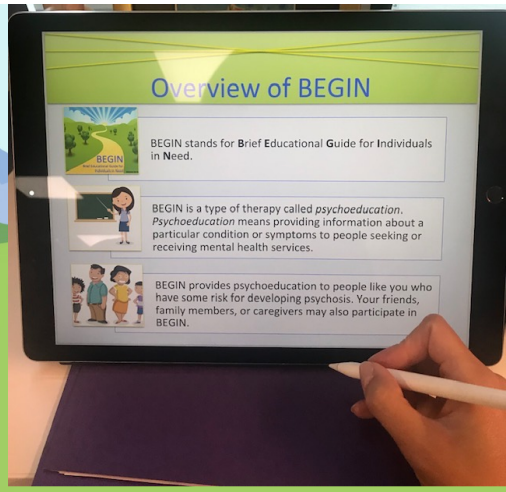
# Respect for People's Rights and Dignity


<u>Our scoping review of CHR psychoeducation suggests…</u>

- Methods, content, and quality of CHR psychoeducation are largely unknown
- CHR education likely not being delivered in a systematic or standardized way
- Communication models and psychoeducation interventions are not widely implemented or disseminated yet.

# Psychoeducation!

Shaynna N. Herrera, PhD




BEGIN

Brief Educational Guide for Individuals in Need

- 5 sessions, 45-60 minutes per session
- Specifically designed for CHR
- Can include caregiver(s) if desired
- Structured via slideshow presentation on iPad
- Includes education, discussions, activities, and homework
- Apple pencil to record notes, engage with activities (in person)
- Screen share (via telehealth)

Illustrations by: Kayla Lim

# Principles of CHR Communication

- *Understandable:* provide information in a clear, concise, and empathic way. focus on gist messages
- *Individualized:* use the individual's own language, focus on their symptoms and experiences, not diagnoses.
- *Well-informed:* incorporate what is known in the field, and be honest about what is unknown
- *Empowering:* focus on strengths, maintain recovery-orientation, instill hope
- *Interactive:* ask the youth/young adult what would be most helpful to know, ask questions, ask about emotional reactions.

# Development of BEGIN

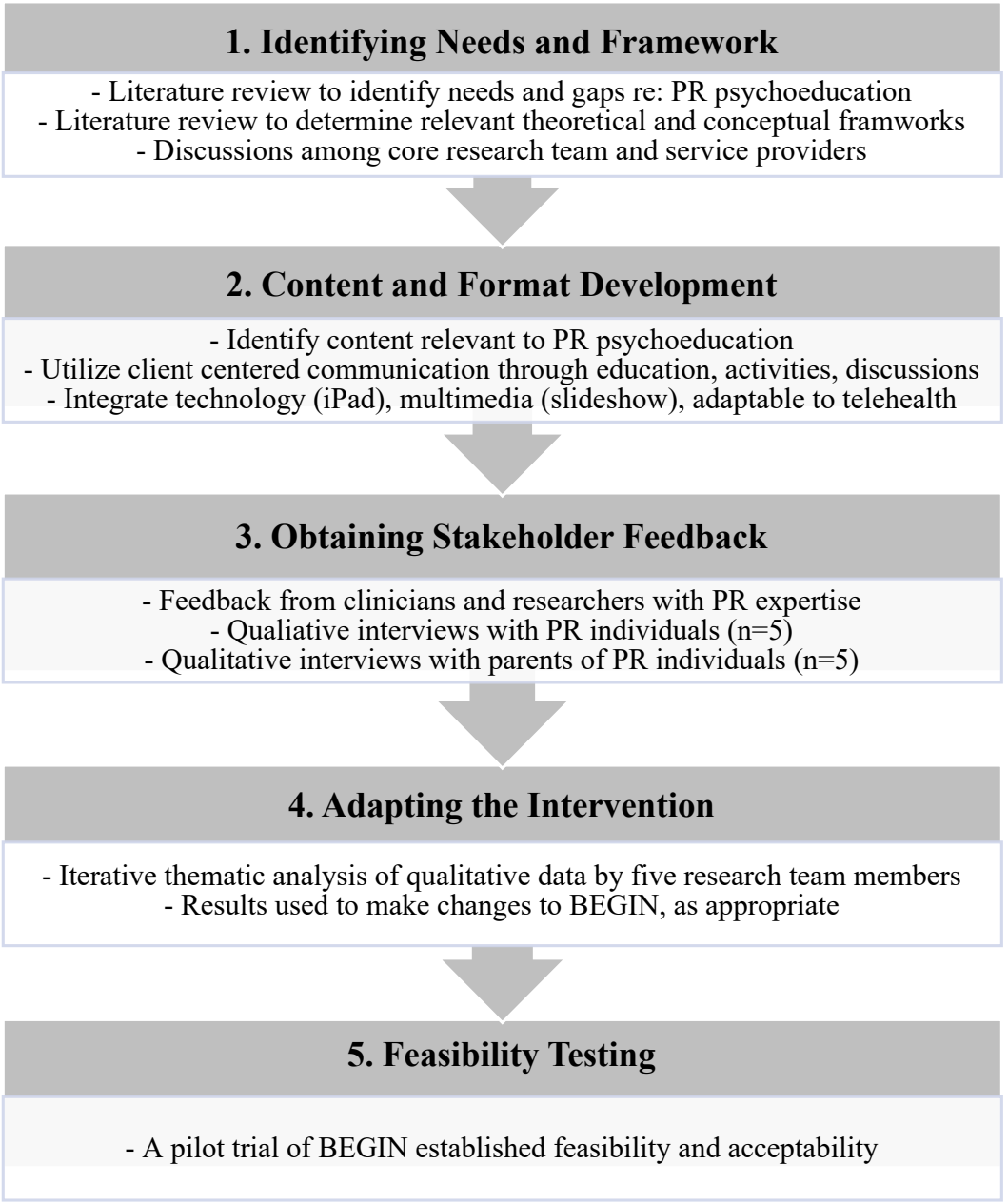



Figure 2. BEGIN's development process

*Herrera et al., 2021*

# Goals of BEGIN

- Increase one's knowledge and understanding of CHR (mental health literacy)
- Bolster autonomy and self-determination
- Facilitate therapeutic alliance
- Enhance (subsequent) treatment engagement

**Knowledge → competence → options → decision-making → action**

# Conceptual Framework


**Self Determination Theory (SDT)**

**Competence**: effectiveness in dealing with the environment

**Autonomy**: Volition to self-organize experiences and behaviors in accordance with one's sense of self.

**Relatedness**: desire to feel connected to others

**BEGIN psychoeducation targets**

- ↑ Mental health literacy
- ↑ Attitudes about illness and treatment
- ↓ Stigma
- ↑ Sense of agency
- ↑ Therapeutic alliance
- Develop personalized goals and treatment plan

**Treatment Engagement Factors**

- ↑ ***Attitudes*** about treatment
- ↑ ***Knowledge*** to seek out treatment
- ↑ ***Motivation*** for treatment

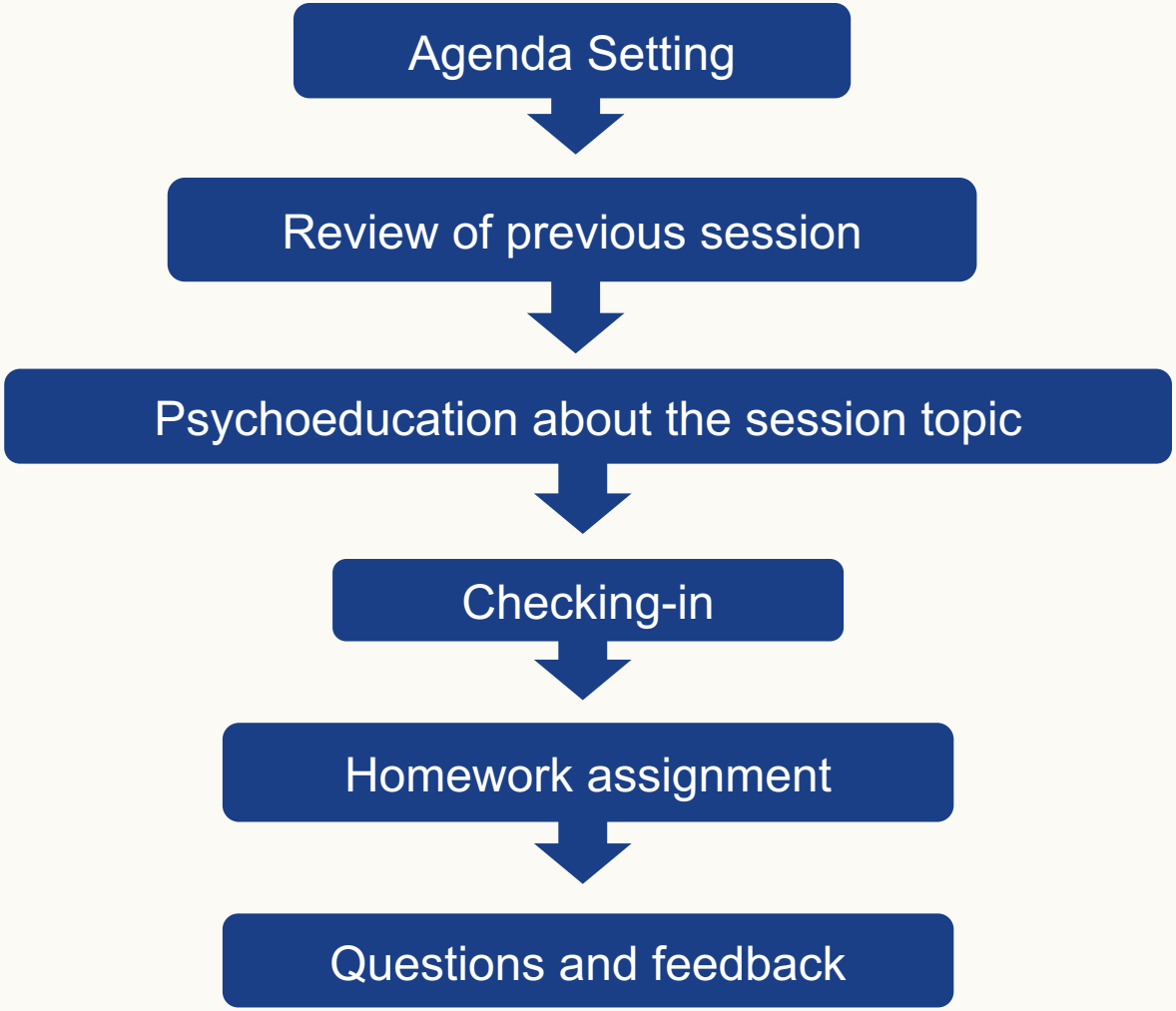
**Treatment Engagement Behaviors**

**Theoretical Foundation** → **Proposed Mechanisms** → **Primary Outcome**

# Overview of BEGIN

| | |
|---|---|
| **Session 1** | Psychosis-Risk Education |
| **Session 2** | Self-Assessment of Symptoms |
| **Session 3** | Individual Goals |
| **Session 4** | Options for Treatment |
| **Session 5** | Decision-Making and Next Steps |

# BEGIN Session Structure



# Today's Agenda

Learn the meaning of "risk for psychosis"

Learn how we identify if someone may be having psychosis-risk symptoms

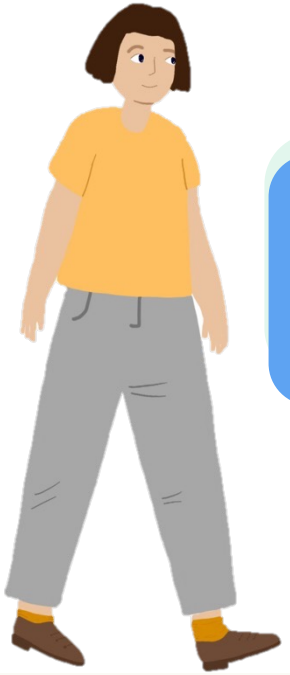
**Session 1**

Discuss possible outcomes of these symptoms

Discuss the possible causes of these symptoms

Would you like to add anything to today's agenda?

# What is psychosis-risk?



What comes to mind when you hear psychosis-risk?

How do you understand psychosis based on your culture or background?

# How common are these experiences?

How many people in the general population report experiencing…

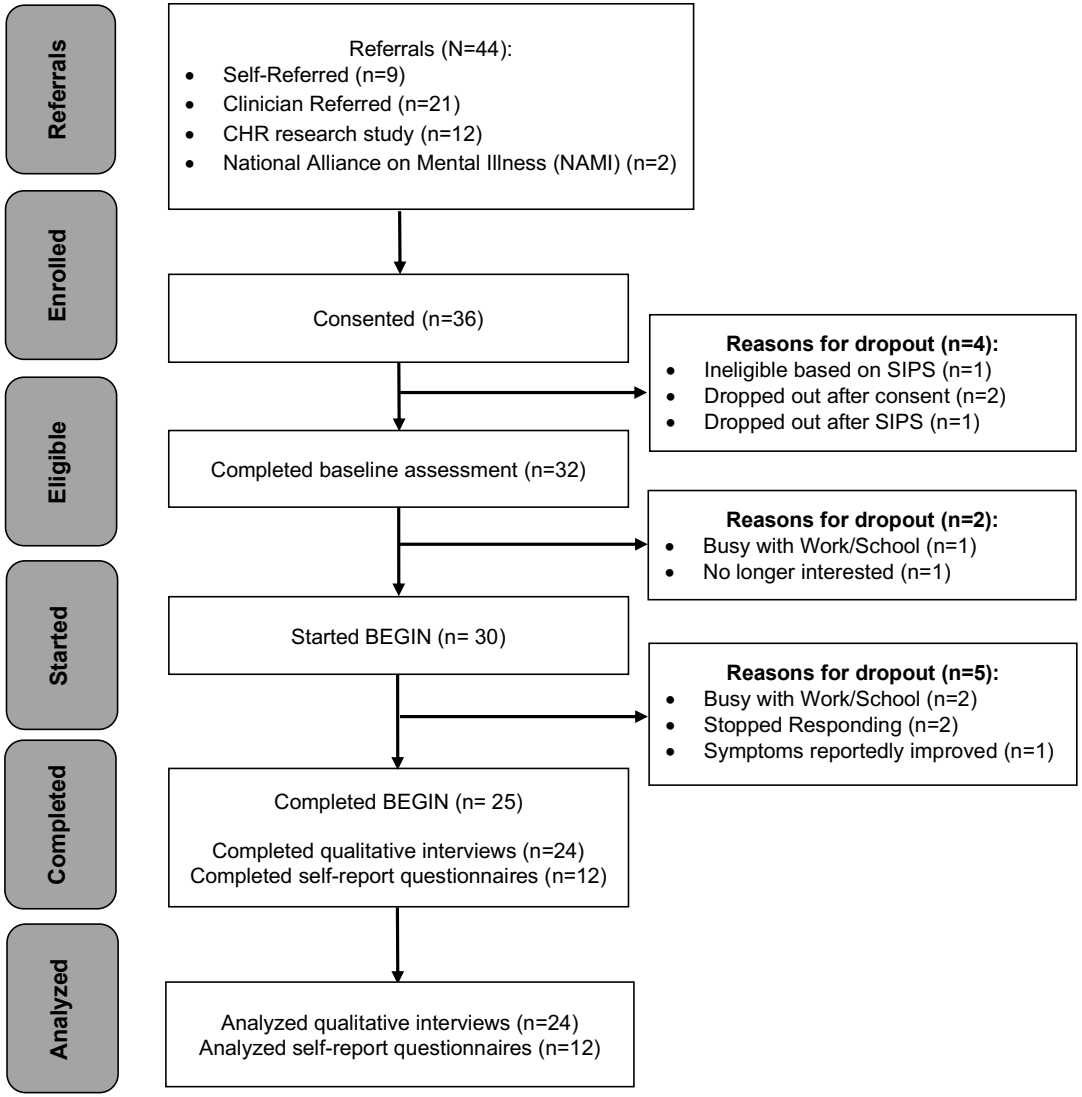
| | |
|---|---|
| *Hallucinations* | _____% |
| *Paranoid/suspicious thoughts* | _____% |
| *Delusional ideas* | _____% |

# Checking-In

| What are your *thoughts* about this information? | What are your *emotional reactions* to this information? | How have things been going for you since the last session? |
| --- | --- | --- |
| | | |
| | | |
| | | |
| | | |

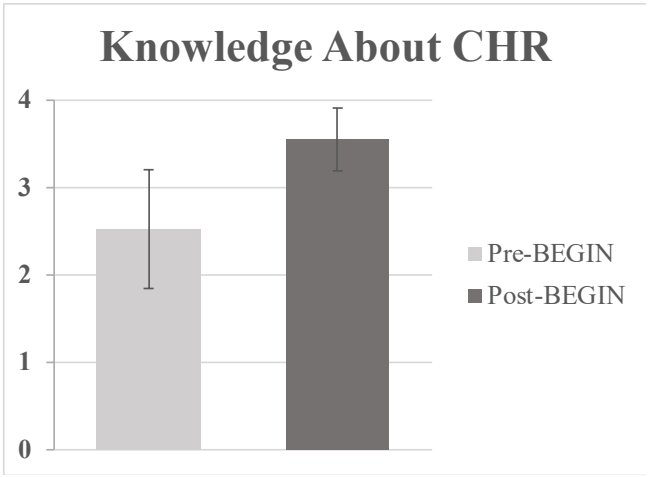
# BEGIN Feasibility and Pilot Trial

- Eligibility rate = 97%
- Study completion rate = 83%
- 60% female
- Mean age = 20.6, range = 12 to 34
- 80% from a minoritized racial/ethnic group
- Similar rates of in-person and telehealth
  - Telehealth: 10/25 (40%)
  - In person: 12/25 (48%)
  - Hybrid: 3/25 (12%)
- Majority elected to participate alone
  - No caregiver: 21/25 = 84%
  - With caregiver: 4/25 = 16%




*Herrera et al., in press*

# BEGIN Pilot Trial Results

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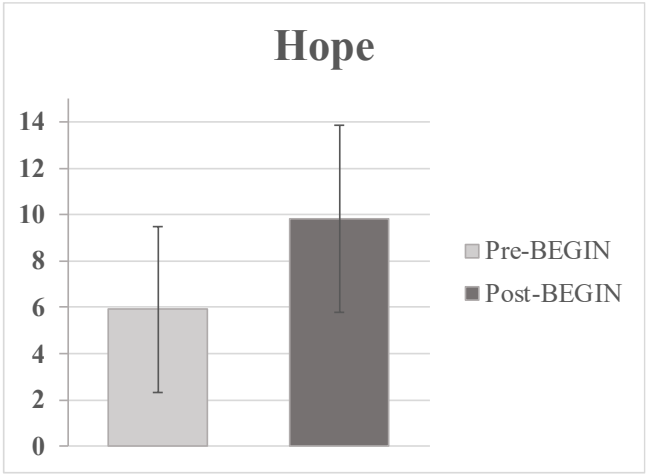
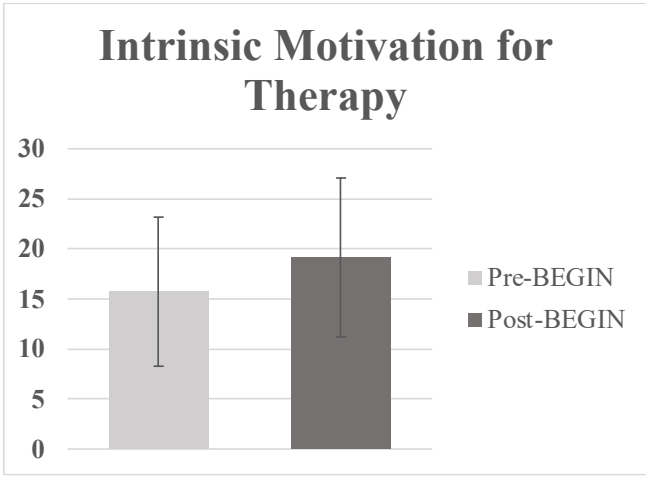



d)




*Herrera et al., in press*

# BEGIN Pilot Trial Qualitative Results (N=24)

Semi-structured qualitative interviews were conducted to learn about CHR participants' experience with BEGIN. Thematic Analysis of transcripts revealed:

- Self-awareness and clarification of CHR experiences (100%, n = 24)
- Sense of agency (88%, n = 21)
- Value of the structure and presentation of BEGIN (79%, n = 19)
- Positive therapeutic relationship with BEGIN therapist (75%, n = 18)
- Changed attitudes about mental health treatment (67%, n = 16)
- Destigmatizing process of learning about CHR (67%, n = 16)
- Normalization of psychotic-like experiences (62.5%, n = 15)
- Communicating with others about mental health (38%, n = 9)
- Desire for broader availability of psychoeducation (20.8%, n = 5)



*Herrera et al., in press*

# Psychoeducation: CHR youth perspective

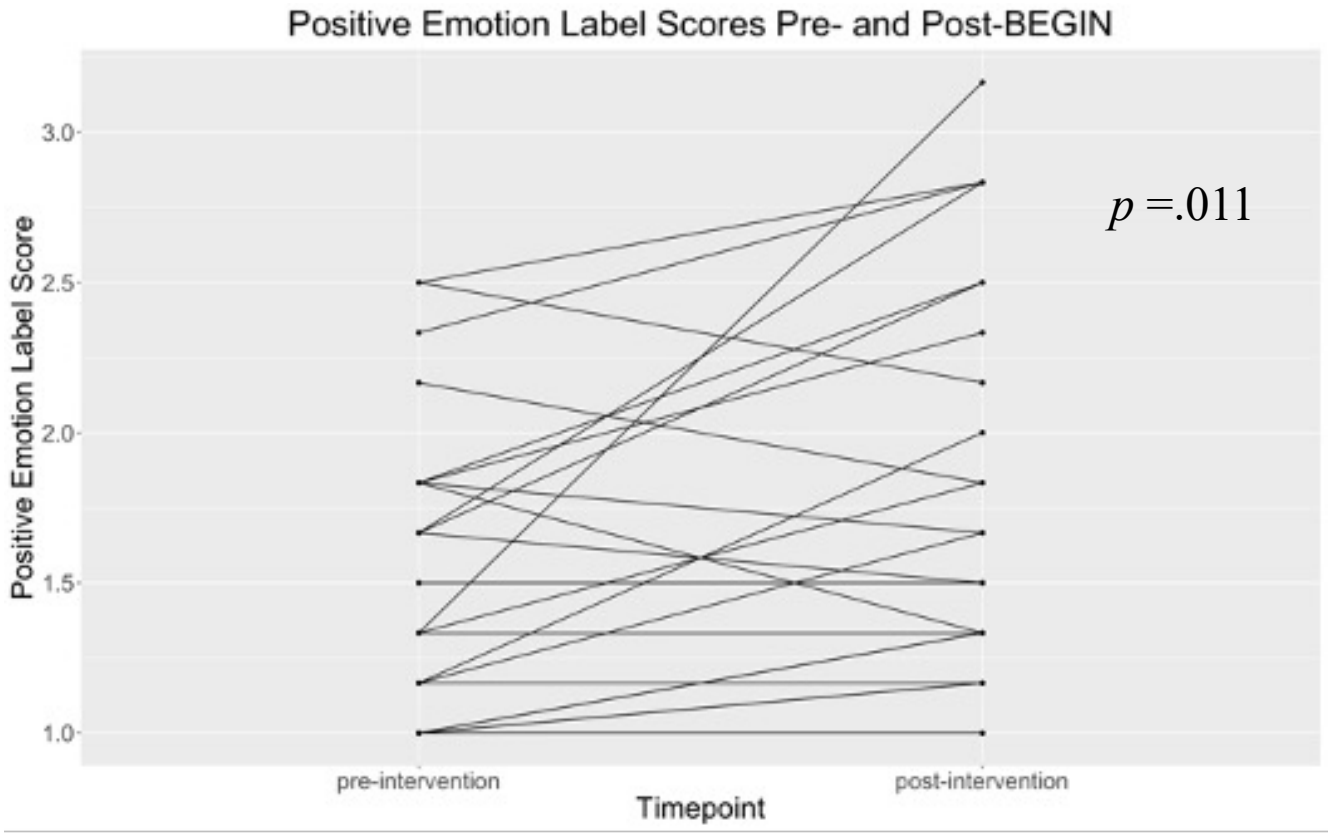
“That really kind of cleared things up for me knowing that even though I have the risk, I may not develop psychosis and that a lot of people are experiencing what I'm experiencing. There's not enough people that tell you that in your life and not enough people who tell you you're fine the way you are, and especially with some of the symptoms as extreme as they are. So definitely after knowing psychosis and at-risk psychosis, it really kind of made me less worried.”

# Stigma: CHR youth perspective

"It was actually super positive and, like I said, empowering because when you're diagnosed with something like psychosis risk, there's that stigma behind the word psychosis. So you kind of get into this little space where it's like I don't even know how to handle this, don't know what to do with this, don't know how to feel about it. I had depression and anxiety for a really long time, but psychosis, it feels like that next level. So going through this [psychoeducation] really helped break it down, helped make it manageable and make me not fearful of it, worried about it, not as anxious about it, that kind of thing."

# Is there CHR Label-Related Stigma?

N=26 CHR youth

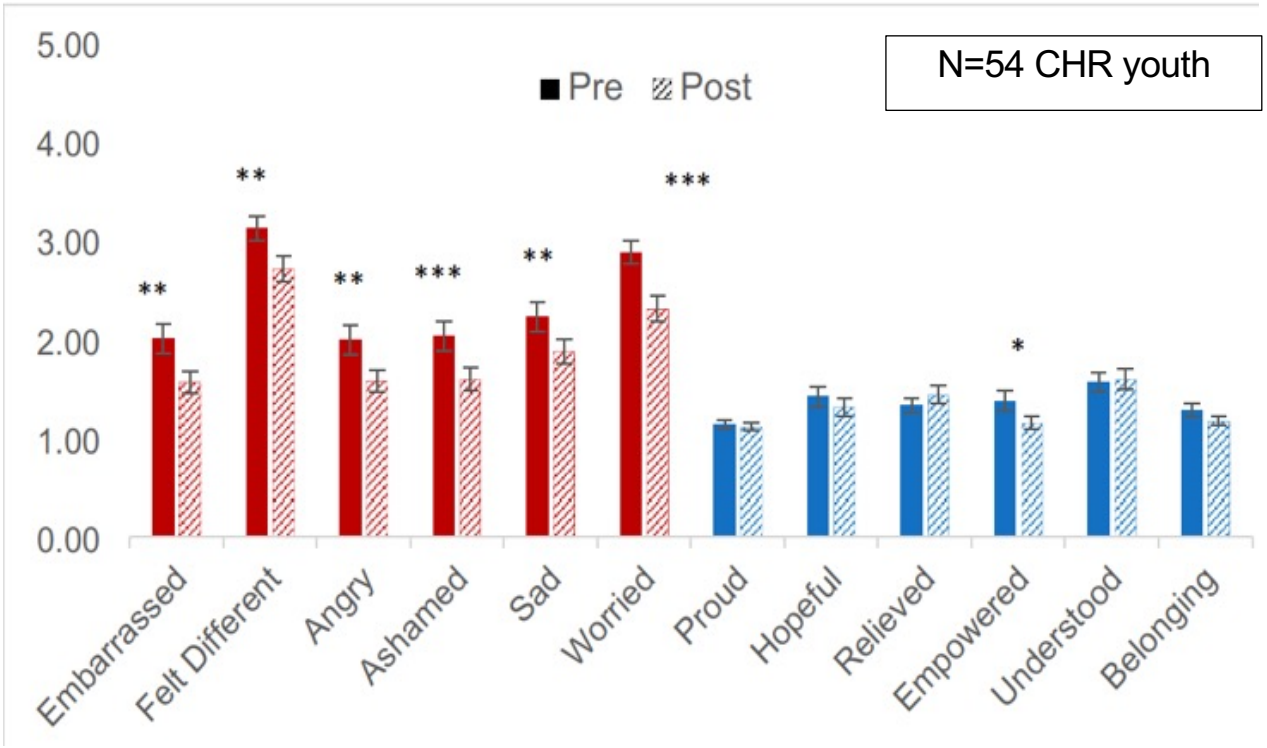



(Herrera et al., under review)

-Increases in positive emotions after receiving CHR psychoeducation

- No change in any other form of stigma measured (internalized stigma, stereotype awareness, stereotype agreement, discrimination, negative emotions)

# Is there CHR Label-Related Stigma?




(Woodberry et al., 2021)



-Reductions in negative emotions after being told about one's CHR status
- Stigma was present *before* being told

# Psychological Interventions for psychosis risk

**Goals of interventions**

- To prevent or delay transition to threshold psychosis
- To restore or maintain functioning
- To treat any underlying conditions contributing to psychosis risk
- To develop strategies for resilience

- **Adjunctive** to current treatment
- All offered via **telehealth**

**Recommended Interventions**

- Cognitive Behavioral Therapy
- Psycho-education
- Family work
- Medication as needed

RFMH Research Foundation for Mental Hygiene, Inc.
THE INSTITUTE FOR FAMILY HEALTH
The Mount Sinai


Welcome to
Our group!

# ProSPECT:

## Prevention of Symptoms and Psychosis through Education and Cognitive Therapy

Comprehensive evidence-based clinical services for youth and young adults ages 12-30 who are at Clinical High Risk for Psychosis (CHR-P)

RFMH
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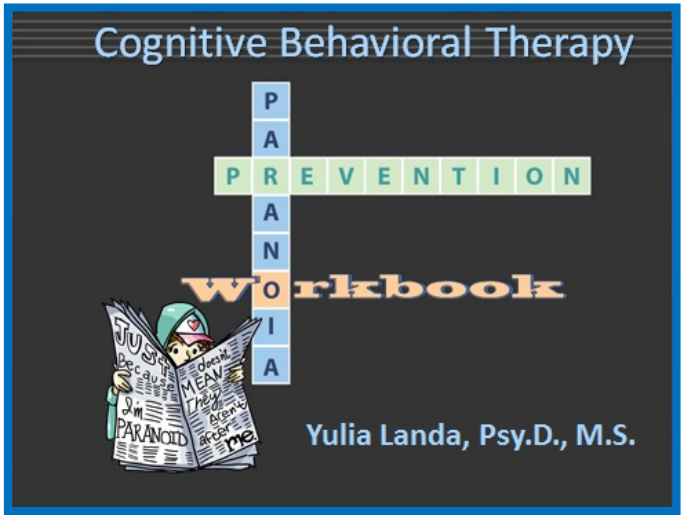
# Manualized Interventions Used in ProSPECT



Illustrations by Lisa Lavoie

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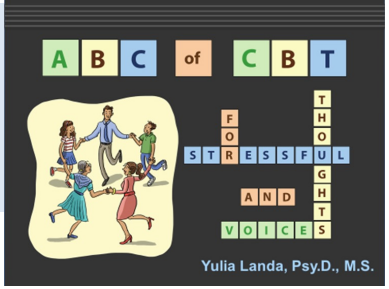
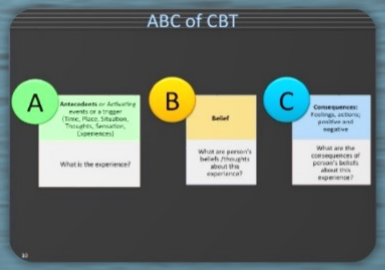
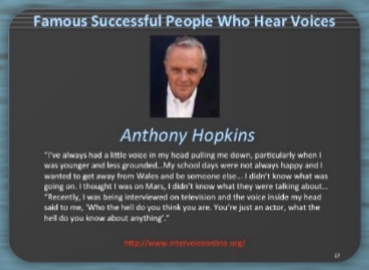
# Step 1 Introductory CBT for Youth at CHR and their Families



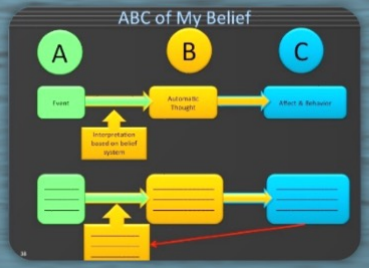




Understand CBT and Learn ABC Model




Participants learn how to use ABC model for stressful thoughts, delusions, and voices

- Coping with voices through Anthony Hopkins
- Characters as examples




Apply it to their own goals and beliefs

# Step 2

## Group and Family-Based Cognitive Behavioral Therapy (GF-CBT)

**GF-CBT has 3 distinct parts:**
**15 CBT skills group sessions and 15 individual sessions for youth, and 15 CBT skills group sessions for families.**


In **group sessions,** youth learn CBT skills to develop effective strategies for dealing with stressful thoughts and experiences. They also receive support from other young people who have experiences similar to their own.

In **family group sessions,** parents learn to better understand youth's experiences and how to talk about them in a helpful way. Parents also learn the same CBT skills as their children so that they can help support, encourage, and reinforce skill-use at home.


In **individual sessions,** young people apply the CBT skills they have learned to their own situations and work towards personal goals.



Landa,Y., Mueser KT, Wyka KE, Shreck E, Jespersen R, Jacobs MA, Griffin KW, van der Gaag M, Reyna VF, Beck AT, Silbersweig DA, Walkup JT. (2016) Early Intervention in Psychiatry. 10(6):511-521.

# Step 2

# CBT Skills Groups for Youth at CHR and their Family Members

## Initial Phase: **Learning + Safe, Supportive Environment** (Sessions 1-10):

- Getting to know each other. How do we make our group enjoyable?
- Personal goals and group goals.
- Learning about CBT, ABC of CBT.
- Leaning to identify and correct cognitive biases.
- Utility of Beliefs. Core beliefs. Can we change our beliefs?
- Putting it all together: Learning how to evaluate beliefs step by step.

## Middle Phase: **Practice** (Sessions 11-14):

- Collaboratively helping each group member achieve their goals & reality test suspicious or stressful beliefs.

## Closing : **Feedback** (Session15):

- How can I continue to do well? What did we learn in this group? What is my contribution to the group? Saying Good-bye.

# Individual CBT in Support of CBT Skills Group

Facilitate learning

Address group process

Apply concepts learned in group to personal goals

# Integration of GF-CBT into Community Behavioral Health Care- Missouri Department of Mental Health

## System of Care Community Enhancement for Early Signs and Symptoms (SOC-CESS)

## SAMHSA: SM063402-01

**Professionals Trained:**

<u>COMPASS Health in Jefferson City</u>

-5 clinicians

<u>Ozark Center in Joplin</u>

-6 clinicians

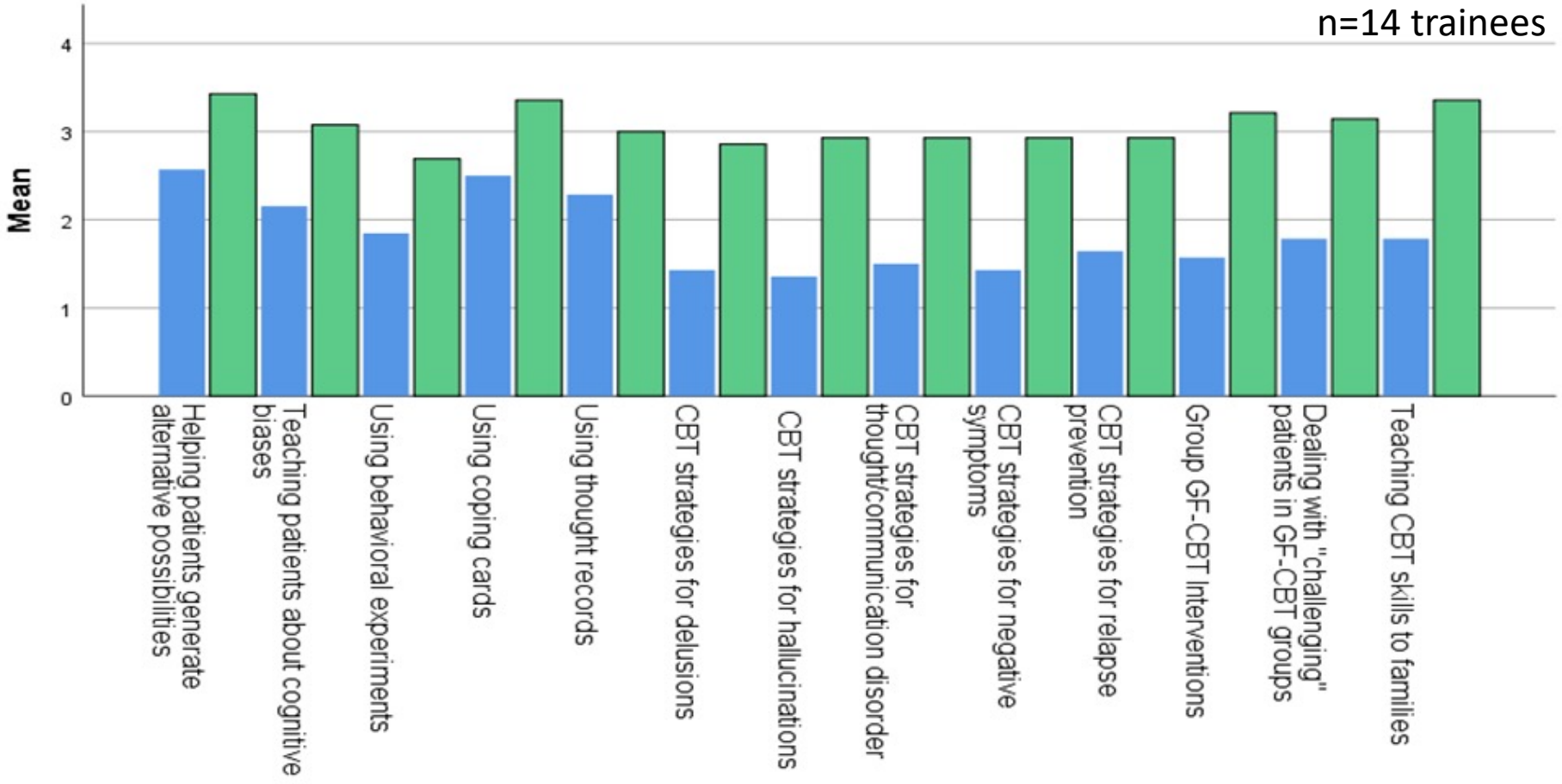
<u>Burrell Behavioral Health in Springfield</u>

-3 clinicians

| | Ozark | Compass | Burrell | Total |
|---|---|---|---|---|
| Already in Services at CBHC | 842 | 1,057 | 2,923 | 4,822 |
| 9-11 yrs old | 225 | 263 | 805 | 1,293 |
| 12-17 years old | 617 | 795 | 2,118 | 3,530 |
| | | | | |
| Enrolled as part of SOC-CESS | 170 | 640 | 811 | 1,622 |
| 9-11 yrs old | 47 | 144 | 225 | 416 |
| 12-17 years old | 123 | 496 | 586 | 1,205 |

# Integration of GF-CBT into Community Behavioral Health Care-Missouri Department of Mental Health

How confident were you in your ability to use each of the following skills and techniques before and after this training?




All p<.05

# GF-CBT training: JJ Gossrau (with Yulia Landa)

2017 collaboration with Missouri Department of Mental Health
SOC-CESS (System of Care Community Enhancement for Early Signs and Symptoms

2023 Training to DMH providers
Train-the-trainer model – Aubrey Doss – to train future staff
Recorded training

# GF-CBT Adaptations for Telehealth

Fillable versions of workbooks so that patients and therapists could easily type directly into the workbook during telehealth session

Manuals, workbooks and forms/worksheets are accessible via google drive so that therapists could send patients links via email or the EHR

Telehealth instructions are incorporated into training for clinicians (e.g. how to introduce telehealth, address connectivity issues, make role-plays Zoom compatible, discuss group rules, etc.)

Telehealth-specific instructions for patients, e.g.

- "People can tell if you are not looking at them, try your best to look into the camera – can position video of self below camera;"
- "Use a 'virtual background' to address any concerns of others being able to see their home"

# Clinician Training

SIPS training and certification (now PSYCHS)

- Mini-SIPS (Yale)
- PSYCHS (AMP-SCZ)

GF-CBT for Psychosis

- Introductory
  - 1-2 day of didactics
- Intermediate
  - 4 days of didactics
- To Competency
  - 5 days of didactics + 4 days of practica

Ongoing supervision and consultation

# Resources for screening/assessment/consults psychoeducation/ psychological treatments, clinical training and opportunities for research

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Project Director,
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CBT for the Treatment and Prevention of Psychosis

Cuemountsinai.org; ampscz.org; ssbcbio.org

# THANK YOU!!!

Questions? Comments?


Coping with Unique Experiences