Preventing Psychotic Disorders by Early Detection and Intervention

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Tufts University School of Medicine
the CATCHER in the RYE

a novel by J. D. SALINGER
Early detection and prevention in another illness

“If you catch cancer at Stage 1 or 2, almost everybody lives. If you catch it at Stage 3 or 4, almost everybody dies.

We know from cervical cancer that by screening you can reduce cancer up to 70 percent. We’re just not spending enough of our resources working to find markers for early detection.”

---Lee Hartwell, MD
Nobel Laureate, Medicine
President and Director,
Hutchinson Center
New York Times Magazine
December 4, 2005, p. 56
Shortened productive lives

Cardiovascular disease
Mental illness
Cancer
Respiratory disease
Alcohol use
Infectious disease
Drug abuse

Productive years lost

Source: Mental Health Report of the Surgeon General
Figure 3. Model of psychosis onset from the clinical high-risk state. The higher the line on the y-axis, the higher the symptom severity.
Functioning as an effect of number of psychotic episodes
Mental health and substance use disorders account for 60% of the non-fatal burden of disease amongst young people aged 15-34 (Public Health Group 2005)

Developed by Patrick McGorry, MD
Age of onset of disabling mental illnesses

![Graph showing the age of onset of disabling mental illnesses]

- Affect
- Mood disorders
- Personality disorders
- Schizophrenia, pos. sxs.
- Schizophrenia, Neg. sxs.

Relative dominance

Years

0 0.1 0.2 0.3 0.4 0.5 0.6 0.7

6 8 10 12 14 16 18 20 22 24 26 28 30 32 34 36 38 40 42 44 46 48 50
Biosocial theory

Major psychiatric disorders are determined by the continual interaction of specific biological dysfunctions and specific social phenomena.

Psychological factors determine course at the case level by influencing biological and social forces.
Cognitive Deficits

Affective Sx: Depression

Social Isolation

School Failure

Biological Vulnerability: CASIS

Early Insults
- e.g. Disease
- Genes, Possibly Viral Infections,
- Environmental Toxins

Brain Abnormalities
- Structural
- Biochemical
- Functional

Social and Environmental Triggers

Increasing Positive symptoms

Disability

After Cornblatt, et al., 2005
Biologic risk factors

• Genetic risk
  – 80-85% heritability

• Non-genetic biologic risk
  – Prenatal infections (influenza)
  – Prenatal toxic exposure (lead)
  – Obstetrical complications
  – Traumatic (head trauma, perinatal period to adolescence)
  – Autoimmune (Rh incompatibility, increasing risk with multiple births)
  – Nutrition (starvation, vitamin D and omega-3 deficiency)
  – Heavy cannabis, other psychotogenic drug exposure

• Non-heritable genetic risk
  – Age of father >50; probably natural mutations in spermatogenesis
  – Spontaneous mutations in embryo after conception
Cortical volume reduction in childhood-onset schizophrenia, ages 14-19
Effects of genetic risk and family functioning on eventual schizophrenia-spectrum disorders

Biosocial causal interactions in schizophrenic prodrome

Early prodrome
- Social & performance deficits
- Social & performance deficits

Late prodrome
- Critical comments
  - CD, EOI
  - Anxiety
- Withdrawal
  - "Oddness"
  - Functional deterioration

Acute onset
- Panic
  - Misattribution
  - High EE

Structural
- Perceptual distortions
- Pervasive anxiety

Family/Social
- Illusions
  - Dread
  - Insomnia
  - Anorexia

Physiological
- Biological

Psychosis
Is early intervention indicated prevention of psychotic disorders?
Risk of psychosis over 10 years

% of at-risk subjects converting to psychosis

Trials of Indicated Prevention

- Buckingham, UK
- OPUS, Denmark
- PIER, Maine
- EDIPPP, USA
- GRN
- PACE I, II, Australia
- EDIE I, II, III, UK
- Addington, Canada
- PRIME, North America
- Omega-3 FAs, Austria

Family psychoeducation

Cognitive therapy

Biological treatment
Early intervention is prevention
One year rates for conversion to psychosis

Risk reduction = 66%

Fusar-Poli, et al, JAMA Psychiatry, 2013
Meta-analyses of RCTs
Conversion to psychosis

Study
- Stafford, et al, 2013

Risk ratio (risk reduction)
- 0.34 (-66%; n=554)
- 0.46 (-54%)
- 0.54 (-46%; n=1246)
- 0.19 (-81%)
Portland Identification and Early Referral (PIER)

Reducing the incidence of major psychotic disorders in a defined population, by early detection and treatment:

Indicated prevention
Assessing Risk for Psychosis
Signs of prodromal psychosis
Schedule of Prodromal Syndrome (SOPS), McGlashan, et al

A clustering of the following:
Changes in behavior, thoughts and emotions, with preservation of insight, such as:

- **Heightened perceptual sensitivity**
  - To light, noise, touch, interpersonal distance
- **Magical thinking**
  - Derealization, depersonalization, grandiose ideas, child-like logic
- **Unusual perceptual experiences**
  - "Presence", imaginary friends, fleeting apparitions, odd sounds
- **Unusual fears**
  - Avoidance of bodily harm, fear of assault (cf. social phobia)
- **Disorganized or digressive speech**
  - Receptive and expressive aphasia
- **Uncharacteristic, peculiar behavior**
  - Satanic preoccupations, unpredictability, bizarre appearance
- **Reduced emotional or social responsiveness**
  - "Depression", alogia, anergia, mild dementia
Signs of prodromal psychosis

Changes in behavior, thoughts and emotions, with preservation of insight, such as:

Unusual perceptual experiences

“Presence”, shadows, visual trails, ghosts
Imaginary friends
Fleeting apparitions
Odd sounds
Somatic illusions or hallucinations
Heightened or dulled perceptions
Vivid sensory experiences
Sensations and thoughts located outside the body
Frequent distortions or illusions
Brief but frank hallucinations, minimal effect on behavior or thinking
Signs of prodromal psychosis

Changes in behavior, thoughts and emotions, with preservation of insight, such as:

Unusual fears

- Marked guardedness, distrustful
- Fear of assault (not social phobia)
- Avoidance of bodily harm
- Somatic delusions
- Severe nihilism
- Persistent persecutory self-referential thoughts
- Paranoia
- Extreme guilt, fear of harming others
- Bizarre obsessional preoccupations
- Fears of mind-reading
- Frank delusions, without full conviction
Signs of prodromal psychosis

2. Significant deterioration in functioning
   - Unexplained decrease in work or school performance
   - Decreased concentration and motivation
   - Decrease in personal hygiene
   - Decrease in the ability to cope with life events and stressors

3. Social withdrawal
   - Loss of interest in friends, extracurricular sports/hobbies
   - Increasing sense of disconnection, alienation
   - Family alienation, resentment, increasing hostility, paranoia
Intervening to Prevent Onset
Family-aided Assertive Community Treatment (FACT):
Clinical and functional intervention

- Rapid, crisis-oriented initiation of treatment
- Psychoeducational multifamily groups
- Case management using key Assertive Community Treatment methods
  - Integrated, multidisciplinary team; outreach PRN; rapid response; continuous case review
- Supported employment and education
  - Collaboration with schools, colleges and employers
Family-aided Assertive Community Treatment (FACT):
Clinical and functional intervention

• Cognitive assessments used in school or job

• Low-dose atypical antipsychotic medication
  – aripiprazole 2-20 mg, quetiapine 300-600 mg, risperidone 0.25-3 mg

• Mood stabilizers, as indicated by symptoms:
  – Mood stabilizing drugs: lamotrigine 50-150 mg, valproate 500-1500 mg, low-dose lithium by blood level

• SSRIs, with caution, especially with aripiprazole and/or a family history of manic episodes
Key clinical strategies in family intervention specific to prodromal psychosis

• Strengthening relationships and creating an optimal, protective home environment:
  – Reducing intensity, anxiety and over-involvement
  – Preventing onset of negativity and criticism
  – Adjusting expectations and performance demands
  – Minimizing internal family stressors
    • Marital stress
    • Sibling hostility
    • Confusion and disagreement
  – Buffering external stressors
    • Academic and employment stress
    • Social rejection at school or work
    • Cultural taboos
    • Entertainment stress
    • Romantic and sexual complications
Outcomes
# Efficiency of identification:
Diagnosis for those eligible by geography and age

\[ n = 780 \]

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referred for another disorder</td>
<td>314</td>
<td>40.2%</td>
</tr>
<tr>
<td>Prodromal</td>
<td>148</td>
<td>19.0%</td>
</tr>
<tr>
<td>Psychosis</td>
<td>79</td>
<td>10.1%</td>
</tr>
<tr>
<td>Any psychiatric illness</td>
<td>589</td>
<td>69.4%</td>
</tr>
</tbody>
</table>
Treated cases converting to psychosis within 24 months (n = 148)

- Cases not converted 121 81.8%
- Cases converted, 1-30 days 14 9.4%
- SOPS psychosis conversions 13 8.8%
First hospitalizations for psychosis

Greater Portland vs. Maine Urban controls areas

Net difference = 34%*

*p < 0.0001

Ratio of PIER area to Urban Control area
First hospitalizations for psychosis/100,000
PIER long-term outcome
4-12 years after identification of risk

**During 2-year treatment, 2001-2009**

- Received any treatment: 139 (100%)
- Severe episode: 14 (10%)

**Post-2-year treatment, 2-10 years**

- Followed-up: 72 (52%)
- Severe psychosis or hospitalization: 9 (13%)
- In school or working: 55 (76%)
Early Detection and Intervention for the Prevention of Psychosis (EDIPPP)

A national multisite effectiveness trial of indicated prevention

Reducing the incidence of major psychotic disorders in a defined population, by early detection and treatment:

Indicated prevention
Early Detection and Intervention for the Prevention of Psychosis

- Effectiveness Trial at six sites:
  - Portland, Maine / Maine Medical Center
  - Glen Oaks, New York / Albert Einstein College of Medicine
  - Ann Arbor, Michigan / University of Michigan
  - Salem, Oregon / Oregon Health Sciences University
  - Sacramento, California / University of California at Davis
  - Albuquerque, New Mexico / University of New Mexico
- Sponsored by RWJF
- Risk-based allocation and incidence reduction
- Regression discontinuity and time series analyses
- Large and diverse nationally representative sample
- PIER community outreach and identification systems
- For further information:
  - www.ChangeMyMind.org
Entry and assignment criteria

- Ages 12-25
- Living in the experimental catchment area
- Positive symptom score by SIPS criteria:
  - Clinical Low Risk (CLR) Control
    - Sum <7; OR
  - Clinical High-Risk (CHR) Treatment
    - Sum = 7 or more; OR
  - Early First Episode Psychosis (EFEP) Treatment
    - Any 6 for < 1 month
- IQ 70 or higher
- No previous psychosis
- Not toxic or medical psychosis
Outcomes
## Early identification across sites

<table>
<thead>
<tr>
<th>SITE</th>
<th>Population</th>
<th>Age-corrected rate**, at 25/100,000*</th>
<th>Years of community outreach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maine</td>
<td>323,105</td>
<td>63%</td>
<td>8</td>
</tr>
<tr>
<td>Michigan</td>
<td>344,791</td>
<td>37%</td>
<td></td>
</tr>
<tr>
<td>Oregon</td>
<td>631,853</td>
<td>29%</td>
<td>2.5</td>
</tr>
<tr>
<td>California</td>
<td>466,488</td>
<td>26%</td>
<td></td>
</tr>
<tr>
<td>New York</td>
<td>557,725</td>
<td>17%</td>
<td>1.5</td>
</tr>
<tr>
<td>New Mexico</td>
<td>662,564</td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,986,526</strong></td>
<td><strong>27%</strong></td>
<td></td>
</tr>
</tbody>
</table>

*Rate for Nottingham, U.K., in Kirkbride, et al., Arch Gen Psychiatry. 2006;63:250-258

** Proportion (69.2%) of ages 12-35 population represented by ages 12-25 population
## Demographic and Psychosocial Characteristics

<table>
<thead>
<tr>
<th></th>
<th>Total (n = 337)</th>
<th>Clinical Low Risk (n = 87)</th>
<th>Treatment High-Risk (n = 250)</th>
<th>Early 1st Episode (n = 45)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (mean)</strong></td>
<td>16.6</td>
<td>16.2</td>
<td><strong>16.4</strong></td>
<td>17.9</td>
</tr>
<tr>
<td><strong>Female, n (%)</strong></td>
<td>134 (40%)</td>
<td>26 (30%)</td>
<td><strong>89 (43%)</strong></td>
<td>19 (42%)</td>
</tr>
<tr>
<td><strong>Caucasian, %</strong></td>
<td>62%</td>
<td><strong>71%</strong></td>
<td>61%</td>
<td>47%</td>
</tr>
<tr>
<td><strong>African-American, (%)</strong></td>
<td>9%</td>
<td>6%</td>
<td><strong>8%</strong></td>
<td>22%</td>
</tr>
<tr>
<td><strong>Asian-American, n (%)</strong></td>
<td>13 (4%)</td>
<td>4 (5%)</td>
<td>9 (4%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td><strong>Hispanic</strong></td>
<td><strong>15%</strong></td>
<td>8 (9%)</td>
<td>33 (17%)</td>
<td>6 (16%)</td>
</tr>
<tr>
<td><strong>In School/Working, %</strong></td>
<td>83%</td>
<td><strong>84%</strong></td>
<td>84%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Income (dollars)</strong></td>
<td>40K – 50K</td>
<td>50K – 60K</td>
<td>40K – 50K</td>
<td>30K – 40K</td>
</tr>
</tbody>
</table>
### Clinical Characteristics

<table>
<thead>
<tr>
<th>Current SCID-IV Axis-I Diagnoses</th>
<th>Total (n = 337)</th>
<th>Clinical Low-Risk (CLR) (n = 87)</th>
<th>Treatment (High-Risk) (n = 250)</th>
<th>Clinical High Risk (CHR) (n = 205)</th>
<th>Early First Episode (EFEP) (n = 45)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Diagnosis</td>
<td>14%</td>
<td>22%</td>
<td>14%</td>
<td>0%</td>
<td>.01</td>
<td></td>
</tr>
<tr>
<td>Mood Disorder</td>
<td>42%</td>
<td>37%</td>
<td>49%</td>
<td>18%</td>
<td>.01</td>
<td></td>
</tr>
<tr>
<td>(1) Bipolar</td>
<td>16 (5%)</td>
<td>2 (2%)</td>
<td>12 (6%)</td>
<td>3 (7%)</td>
<td>.38</td>
<td></td>
</tr>
<tr>
<td>(2) Major Depression</td>
<td>114 (34%)</td>
<td>27 (31%)</td>
<td>83 (41%)</td>
<td>3 (7%)</td>
<td>.01</td>
<td></td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>28 (8%)</td>
<td>8 (9%)</td>
<td>7%</td>
<td>5 (11%)</td>
<td>.66</td>
<td></td>
</tr>
</tbody>
</table>
Rates of Conversion or Relapse
Over 24 months

<table>
<thead>
<tr>
<th></th>
<th>CLR</th>
<th>CHR</th>
<th>EFEP</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>87</td>
<td>205</td>
<td>45</td>
</tr>
<tr>
<td>Severe Psychosis</td>
<td>2.3%</td>
<td>6.3%</td>
<td></td>
</tr>
<tr>
<td>Relapse</td>
<td></td>
<td></td>
<td>11%</td>
</tr>
<tr>
<td>Negative Events*</td>
<td>22%</td>
<td>25%</td>
<td>40%</td>
</tr>
</tbody>
</table>

*Hospitalizations, incarcerations, suicide attempts, assaults, rape
Psychotic Symptoms

Baseline 6 Months 12 months 24 months

Controls APS EFEP

CHR vs. CLR = 0.0034
EFEP vs. CLR <0.0001
Negative Symptoms

Controls
APS
EFEP

CHR vs. CLR = 0.099
EFEP vs. CLR <0.012
In school or working:
Baseline and 24 months

<table>
<thead>
<tr>
<th></th>
<th>CLR</th>
<th>CHR&amp;EFEP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>84%</td>
<td>83%</td>
</tr>
<tr>
<td>24 months</td>
<td>79%</td>
<td>83%</td>
</tr>
</tbody>
</table>

- In School or Working at baseline
- In School or Working at 24 months
Global Test: Treatment vs. Control

*Overall outcomes over 24 months across ten clinical and functional variables*

**Clinical High Risk Subsample**

<table>
<thead>
<tr>
<th>Estimate</th>
<th>S.E.</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.38</td>
<td>0.17</td>
<td>2.26</td>
<td>0.0244</td>
</tr>
</tbody>
</table>

**EFEP Subsample**

<table>
<thead>
<tr>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.77</td>
<td>0.0002</td>
</tr>
</tbody>
</table>

**Both Treatment Subsamples**

<table>
<thead>
<tr>
<th>f</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.50</td>
<td>0.0007</td>
</tr>
</tbody>
</table>
## Outcomes in Four California PIER Programs*

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Baseline</th>
<th>12 Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>N = 125</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working</td>
<td>15%</td>
<td>49%</td>
</tr>
<tr>
<td>In school</td>
<td>57%</td>
<td>56%</td>
</tr>
<tr>
<td>Onset of Psychosis:</td>
<td>21%</td>
<td>3%</td>
</tr>
<tr>
<td>Hospitalizations:</td>
<td>13%</td>
<td>7%</td>
</tr>
<tr>
<td>Suicide attempts:</td>
<td>8%</td>
<td>2%</td>
</tr>
</tbody>
</table>

*San Diego, Santa Clara (San Jose), Ventura Counties*
## Contra Costa County

### Outreach Summary

<table>
<thead>
<tr>
<th>Category</th>
<th>Events</th>
<th>Audience #</th>
<th>% of target</th>
</tr>
</thead>
<tbody>
<tr>
<td>School Professionals</td>
<td>31</td>
<td>602</td>
<td>83% 15/18 districts</td>
</tr>
<tr>
<td>Healthcare Professionals</td>
<td>11</td>
<td>156</td>
<td>67% 2/3 colleges</td>
</tr>
<tr>
<td>Mental Health Professionals</td>
<td>21</td>
<td>397</td>
<td>70%***</td>
</tr>
<tr>
<td>Social Services Providers</td>
<td>13</td>
<td>205</td>
<td>50%***</td>
</tr>
<tr>
<td>Clergy</td>
<td>3</td>
<td>38</td>
<td></td>
</tr>
</tbody>
</table>
## Contra Costa County
### Outcomes Summary

<table>
<thead>
<tr>
<th>Educational/Vocational Outcomes</th>
<th>Baseline</th>
<th>6 Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Working</td>
<td>2/36 5%</td>
<td>6/21 29%</td>
</tr>
<tr>
<td>% In School</td>
<td>21/36 58%</td>
<td>19/21 90%</td>
</tr>
<tr>
<td>% Volunteering</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>% Graduated High School</td>
<td>6/36 17%</td>
<td>7/21 33%</td>
</tr>
<tr>
<td>Avg. GAF Score</td>
<td>41</td>
<td>58</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Conversions/ Incidents</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>% Converted to Psychosis</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>% Hospitalizations</td>
<td>9/36 25%</td>
<td>1/21 5%</td>
</tr>
<tr>
<td>% Suicide attempts</td>
<td>13/36 36%</td>
<td>0/21 0%</td>
</tr>
<tr>
<td>% Suicides</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>% Incarcerated</td>
<td>3%</td>
<td>0%</td>
</tr>
</tbody>
</table>
Current PIER programs

- San Diego County, CA
- Ventura County, CA
- Santa Clara County (San Jose), CA
- San Francisco, CA
- Contra Costa County, CA
- Sacramento, CA
- Imperial County, CA
- Weber County, UT
- State of Delaware
- City of Philadelphia, PA
- Several Counties, OR
- Albuquerque, NM
- Ann Arbor, MI
- Queens, NY
- Portland, ME
- Boston, MA

Total Population >15 million
Prediction of Psychosis Onset

Diagonal segments are produced by ties.

C = .79
History of CBTp

First described by Beck (1952)

However ...

Largely overlooked as an intervention for psychosis
  › Prominence of biological/medical models
  › Studies in the 80’s that reported talking therapies as damaging to people with psychosis
  › Long held assumption psychosis lies outside of realm of ‘normal psychological functioning’
CBT for psychosis

• Focus is on reducing the distress caused by positive symptoms including hallucinations and unusual thoughts and increasing functioning by addressing negative symptoms

Thoughts

• Interpretation of the event that causes distress rather than the event itself
• Need to check the accuracy of the interpretation

Behaviors

• How are current behaviors maintaining the problem?
• Need to check the helpfulness of current behaviors
CBT for psychosis

Other target areas:
- Symptoms of depression and anxiety
- Past traumatic events
- Social skills
- Negative symptoms including lack of motivation
- Problem solving and decision making
- Developing coping skills
- Relapse prevention planning
Evidence Base for CBTp

- Highly acceptable to consumers (Morrison et al, 2004; Byrne et al, 2013)
- Reductions in positive, negative, and general symptoms (Burns et al, 2014; Turner et al, 2014)
- Reduction in transition to psychosis at 12-month follow-up (Stafford et al, 2013)
- Generalization of skills following therapy (Sarin et al, 2011)
- Long term brain changes following CBTp? (Kumari et al, 2011)
CBTp: a word of caution

• Complaints of publication bias and ‘overselling’ (Jauhar et al 2014)

• CBTp only effective if delivered in full (Dunn et al, 2012)

• Poor therapeutic alliance predictive of poor outcomes (Dunn et al, 2015)
  • CBTp should only be delivered when good therapeutic alliance is possible

• Emerging evidence for brief interventions but further research needed (Turkington et al., 2014, Chang et al., 2014)
Rationale for training CBTp in EI

• CBTp should be offered adjunctive to medication management (Dixon et al., 2010; NICE, 2013; NICE, 2014; British Psychological Society, 2014)

• Evidence to suggest CBTp most effective in UHR, early phase psychosis, and stable chronic symptoms (Birchwood et al., 2014)
Why provide CBTp for early psychosis?

<table>
<thead>
<tr>
<th>Early Intervention Principles *</th>
<th>CBTp</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide interventions with demonstrated efficacy</td>
<td>Evidence Based</td>
</tr>
</tbody>
</table>
| Provide services that actively partner with young people (Shared Decision Making) | Client generated problem list  
Collaborative approach (the “collaborative fence”)  
Development of shared understanding (formulation) |
| Challenge stigmatizing and discriminatory attitudes | Normalization |
| Generate optimism and expectation of positive outcomes and recovery | Problem list and goals  
Focus on functional recovery (not symptom reduction)  
Development of skills and tools to support and maintain recovery  
Wellness Planning |
| Respect the right to recovery and social inclusion | |
| Culturally Sensitive Services | Individualized formulation |
| Respect the right for family & friends to participate in treatment | Include family and important support people in wellness planning |

*based on values and vision described in Bertolote and McGorry (2006)
Positive Practices for Working with Psychosis
Positive Practices for working with Psychosis

• **F**orming a relationship
  – Develop shared goals
  – Normalize experiences

• **I**nquire Curiously
  – Asking questions and dropping assumptions

• **R**eview the information and put it together
  – Making sense of experiences through shared understanding

• **S**kill development
  – Developing skills and tools to support goal attainment

• **T**ry out the skill and elicit feedback
  – Encourage the patient to practice the skill independently and provide feedback on how it worked
Step 1: Form a relationship
Engagement and befriending

• Essential to developing therapeutic relationship
• Ongoing process throughout therapy
• May require increased amounts of befriending depending on symptoms
  – Paranoia
  – Hallucinations
  – Severe Negative Symptoms
Step 2: Inquire Curiously

Normalizing and questioning
Normalization

CBT is inherently normalizing
– We all experience negative thoughts
– We all engage in unhelpful thinking
– We all use coping strategies that aren’t always the most healthy choices

Allows for normalizing of psychotic symptoms as well
Psychosis exists on a continuum

• Stress
• Drugs
• Trauma
• Life experiences
• Sleep deprivation

No psychosis
Psychosis
Step 3: Review the information and put it together
Formulation

- Stress Bucket
- Mini Formulation
- Morrison’s Interpretation of Intrusions
Stress Bucket

- Hearing Voices
- Parents arguing
- Exams coming up
- Applying for college

- Talk to voices
- Stay up all night playing video games

- Play video game for one hour

- Go for a walk

Buffer Zone

Stress Level

Adapted from UNSW Counseling Services & Carver et al., 1989
Step 4: Skill Building
“People are talking about me and intend to harm me”

<table>
<thead>
<tr>
<th>Believe people are talking about me and they are talking about me</th>
<th>Believe people are talking about me and they are not talking about me</th>
</tr>
</thead>
<tbody>
<tr>
<td>= Not Safe</td>
<td>= “crazy”</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Don’t believe people are talking about me and they are talking about me</th>
<th>Don’t believe people are talking about me and they aren’t talking about me</th>
</tr>
</thead>
<tbody>
<tr>
<td>= Really not Safe</td>
<td>= “that would be great!”</td>
</tr>
</tbody>
</table>
Cognitive Intervention: Exploring the evidence

<table>
<thead>
<tr>
<th>Thought: the people across the hall are talking about me (90%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence For</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>They said my name</td>
</tr>
<tr>
<td>I feel afraid when I am around them</td>
</tr>
<tr>
<td>I’ve heard shouting from that room before</td>
</tr>
</tbody>
</table>

Belief: the people across the hall are talking about me (40%)

Alternative possibility: I am hearing an auditory hallucination (60%)
Step 5: Test out the skill and elicit feedback
Homework (but don’t call it homework!)

• Collaboratively develop a way in which the client can try out the skill over the next week
• Possibilities are endless:
  • Application of coping skills
    • Did this help?
    • What was helpful?
    • Does it need to be modified?
• Gathering evidence
  • What did the client discover?
  • How does it fit with their experience?
• Alternative thought
  • What did the client do differently because of the alternative thought?

• Ensure you follow up with them in the next session for feedback
Conclusions

- Community-wide education is feasible in 10 US cities.
- Referrals were 30% up to 60% of the at-risk population.
- Global outcome in FACT was better than regular treatment.
- The 2-year conversion rate for CHR is 1/5 of expected.
- The 2-year relapse rate for FEP is 1/4 of expected.
- Average functioning was in the normal range by 24 months.
- >80% were in school or working at 2 years.
- ¾ were in school or working up to 10 years later.
- Five cities show a declining incidence.
- Five county-wide California programs are replicating.
Conclusions

Most mental health services in most communities in the United States can now begin to prevent onset of the initial psychosis in youth and young adults. We have the tools. The health, social and economic benefits are very substantial.
Disclosure:
I am the owner of the PIER Training Institute, which provides training on request to public and not-for-profit mental health services.
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