WELCOME TO THE FIRST ANNUAL WESTERN MASS EARLY PSYCHOSIS SYMPOSIUM 2025

We will be getting started shortly

Introduction to Early Psychosis and Clinical High Risk

Dr. Melissa D. Weise, PhD, LICSW

Today’s agenda

-Overview of psychosis

-Overview of early psychosis

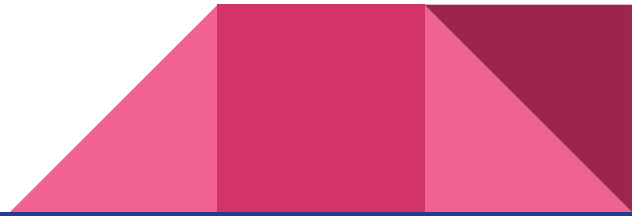
-Overview of Clinical High Risk

- Assessment overview

-Treatments overview

-CBT for psychosis overview

-Referral resources



WHAT IS PSYCHOSIS?

Symptoms

Positive: Hallucinations, delusions, disorganized speech

Negative: flat affect, amotivation, anergia, anhedonia

Psychotic disorders

Duration of symptoms →

Involvement of mood →

Schizophrenia
Need 1, 2, or 3 and >1 more of:
1. Delusions
2. Hallucinations
3. Disorganized speech
4. Disorganized / catatonic behavior
5. Negative symptoms (flat affect, anhedonia, flat speech, cognitive def)

For at least one month
Total disease length >6 months including prodromal/residual phases

Schizophreniform
Same criteria as schizophrenia but total disease length >1 month and <6 months
Upgrade from brief psychotic disorder, precursor to schizophrenia

Brief psychotic disorder
Same criteria as schizophrenia but total disease length >1 day and <1 month
Can be caused by major stressor; termed post-partum psychosis if following pregnancy

Schizoaffective
Meet criteria for schizophrenia PLUS criteria for mood disorder (depression or bipolar) for majority of illness
WITH
Delusions/hallucinations are present for at least two weeks without mood disorder
Psychosis in absence of mood disorder

Mood disorder with psychotic features
Meet criteria for mood disorder (SIGECAPS for major depressive disorder or DIGFAST for mania in bipolar I) with additional symptoms of psychoses.
BUT
Delusions/hallucinations are NOT present for two weeks without mood disorder.
Constant mood disorder with intermittent psychosis

MDD: Depressed mood + 4 of:
S = sleep changes
I = interest loss
G = guilt (worthless)
E = energy lack
C = cognition/concentration reduced
A = appetite change
P = psychomotor change
S = suicide ideation or thoughts

BPAD 1: for mania, 3 or more of:
D = Distractible
I = Irresponsibility / irritable / impulsive
G = Grandiose
F = Flight of ideas
A = Activity increase
S = Sleep decrease
T = Talkative

A spectrum of disorders

Diagnoses

- 301.22 Schizotypal Personality Disorder
- 297.1 Delusional Disorder
- 298.88 Brief Psychotic Disorder (1 day to 1 month)
- 295.40 Schizophreniform Disorder (1- 6 months)
- 295.90 Schizophrenia (6+ months)
- 295. 70 Schizoaffective Disorder

298.88 Brief Psychotic Disorder

- Delusions- strange beliefs and ideas which are resistant to rational/logical dispute or contradiction from others.
- Hallucinations- auditory, or visual.
- Disorganized Speech- incoherence, or irrational content.
- Disorganized or Catatonic behavior- repetitive, senseless movements, or adopting a pose which may be maintained for hours. The individual may be resistant to efforts to move them into a different posture, or will assume a new posture they are placed in (American Psychiatric Association, 2013).

To fulfill the diagnostic criteria for Brief Psychotic Disorder, **the symptoms must persist for at least one day, but resolve in less than one month.** The psychotic episode cannot be attributed to substance use (ethanol withdrawal, cocaine abuse) or a medical condition (fever and delirium) and the person does not fit the diagnostic criteria for Major Depressive disorder with psychotic features, Bipolar disorder with psychotic features, or Schizophrenia (American Psychiatric Association, 2013).

295.40 Schizophreniform Disorder

- The characteristic symptoms of schizophreniform disorder are identical to those of schizophrenia, but schizophreniform disorder is distinguished by its duration. An episode of the disorder (including prodromal, active, and residual phases) **lasts at least one month but less than 6 months.**
- Another way schizophreniform disorder differs from schizophrenia is that impaired social and occupational functioning are not required criteria. While such impairments may potentially be present, they are not necessary for a diagnosis of schizophreniform disorder.

297.1 Delusional Disorder

While the essential feature of this disorder is simply the existence of one or more delusions that occur for at least 1 month, the following are all used to make a correct diagnosis of delusional disorder:

- The individual has one or more delusions that persist for at least a month or more.
- Criterion A for schizophrenia is not and never has been met.
- Aside from the delusion(s) direct effects, functioning is not obviously impaired, and behavior is not noticeably strange.
- Any manic or major depressive episodes have been brief, compared to the length of the delusional period.
- The disturbance cannot be attributed to the physiological effects of a substance, another medical condition, or another mental disorder.
- The severity of the delusions should be noted and it should also be specified if delusions involve bizarre content, or are clearly implausible. Additionally, there are a few subtypes with specific delusional themes that should be specified:
- **Erotomanic type:** This involves delusions about another person being in love with the affected individual.
- **Grandiose type:** Individuals with the grandiose type of delusional disorder believe they have a great talent (which is unrecognized) or made a great, important discovery.
- **Jealous type:** This involves delusions about his or her lover being unfaithful.
- **Persecutory type:** This subtype pertains to individuals with delusions involving their beliefs that they are being conspired against, spied or cheated on, poisoned or drugged, harassed or followed, or generally obstructed in the pursuit of long-term goals.
- **Somatic type:** Individuals with the somatic type of delusional disorder have delusions involving bodily functions/and or sensations.
- **Mixed type:** There is not one delusional theme that persists over others.
- **Unspecified type:** The dominant delusional belief cannot be clearly determined or does not fall into the descriptions of the specific types.

295.90 Schizophrenia

a disorder in which a person will experience gross deficits in reality testing, manifested with at least two or more the following symptoms, which must be present for at least one month (unless treatment produces symptom remission):

- At least one symptom collectively referred to as positive symptoms: must be in categories 1, 2, or 3,
- 1.Delusions- strange beliefs and ideas which are resistant to rational/logical dispute or contradiction from others.
- 2.Hallucinations- typically auditory, or less frequently, visual.
- 3. Disorganized Speech- incoherence, irrational content.
- 4 Disorganized or Catatonic behavior- repetitive, senseless movements, or adopting a pose which may be maintained for hours. The individual may be resistant to efforts to move them into a different posture, or will assume a new posture they are placed in.
  5. Negative symptoms- flat affect, amotivation, anergia, failure to maintain hygiene (American Psychiatric Association, 2013).
- 1. Marked reduction in level of functioning in one or more areas, such as occupational, social, or personal care or hygiene . If symptom onset occurs during childhood or adolescence, there is inability to reach age-typical functioning in academic, social or interpersonal areas. 2. **Symptoms must persist at least six months, during which at least one month of symptoms (unless treatment produces symptom remission) meet the criteria for positive symptoms and may include periods of prodromal or residual symptoms.** During prodromal or residual periods, the signs of the disturbance may be manifested by negative symptoms or by two or more positive symptoms present in a less prominent form (e.g.,unusual beliefs or perceptions)

295. 70 Schizoaffective Disorder

- characterized by the presence of a generally continuous psychotic illness plus intermittent mood episodes. Mood episodes are present for the majority of the total duration of the illness, which can include either **one or both of the following**:
- Major depressive episode (must include depressed mood)
- Manic episode

301.22 Schizotypal Personality Disorder

Schizotypal personality disorder is characterized by a pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships. The disorder is also characterized by cognitive or perceptual distortions and eccentricities of behavior. These begin by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

- Ideas of reference (excluding delusions of reference)
- Odd beliefs or magical thinking that influences behavior and is inconsistent with subcultural norms (e.g., superstitiousness, belief in clairvoyance, telepathy, or "sixth sense"; in children and adolescents, bizarre fantasies or preoccupations)
- Unusual perceptual experiences, including bodily illusions
- Odd thinking and speech (e.g., vague, circumstantial, metaphorical, overelaborate, or stereotyped)
- Suspiciousness or paranoid ideation
- Inappropriate or constricted affect
- Behavior or appearance that is odd, eccentric, or peculiar
- Lack of close friends or confidants other than first-degree relatives
- Excessive social anxiety that does not diminish with familiarity and tends to be associated with paranoid fears rather than negative judgments about self

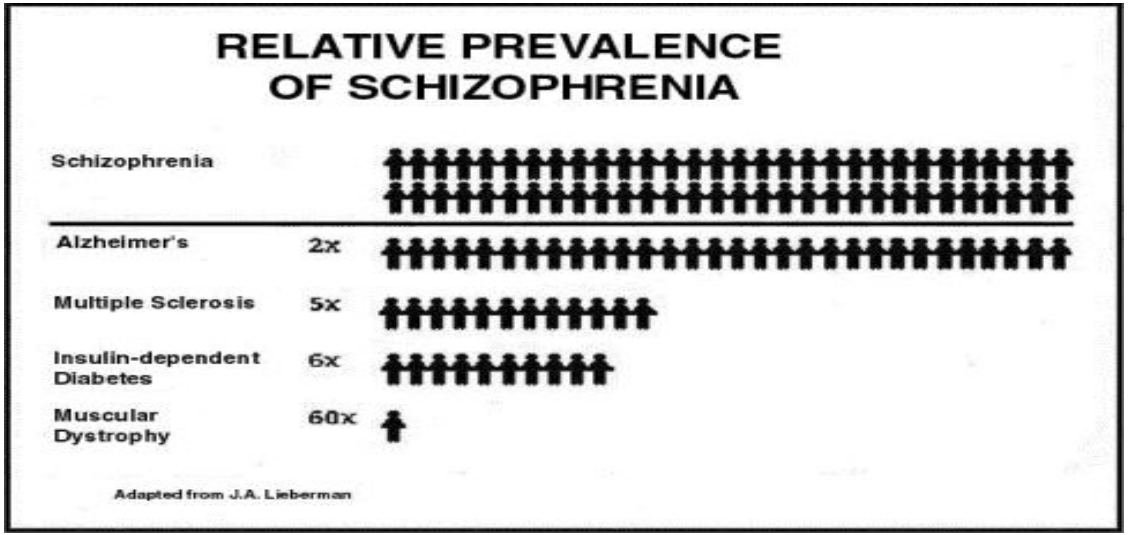
Prevalence

Worldwide prevalence estimates range between 0.5% and 1%.

Schizophrenia occurs in all societies regardless of class, color, religion, culture - however there are some variations in terms of incidence and outcomes for different groups of people.

At any one time as many as 51 million people worldwide suffer from schizophrenia.

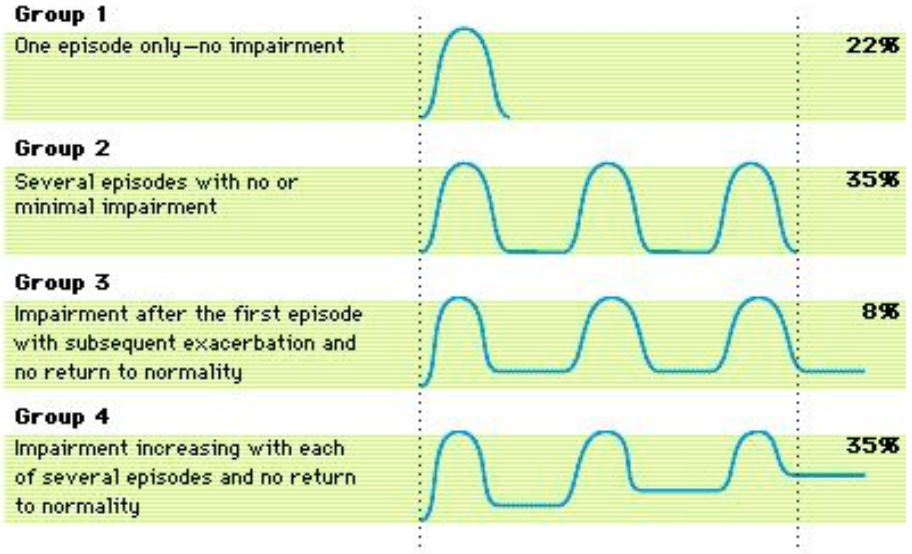
Schizophrenia Ranks among the top 10 causes of disability in developed countries worldwide



Course of the illness

Wide variations

Some people have psychotic episodes of illness lasting weeks or months with full remission of their symptoms between each episode; others have a fluctuating course in which symptoms are continuous but rise and fall in intensity; others have relatively little variation in the symptoms of their illness over time.



Where individuals with schizophrenia live in the US

- 6% are homeless or live in shelters
- 6% live in jails or prisons
- 5% to 6% live in Hospitals
- 10% live in Nursing homes
- 25% live with a family member
- **28% are living independently**
- 20% live in Supervised Housing (group homes, etc.)

People with the condition have a much higher risk of attempting suicide than the general population

Suicide is the number one cause of premature death among people with schizophrenia, with an estimated 10 percent to 13 percent completing suicide and approximately 40% attempting at least once.

The general population suicide rate is somewhere around 0.01%.

Prognosis

- After 10 years, of the people diagnosed with schizophrenia:
- 25% Completely Recover
- 25% Much Improved, relatively independent
- 25% Improved, but require extensive support network
- 15% Hospitalized, unimproved
- 10% Dead (Mostly Suicide)

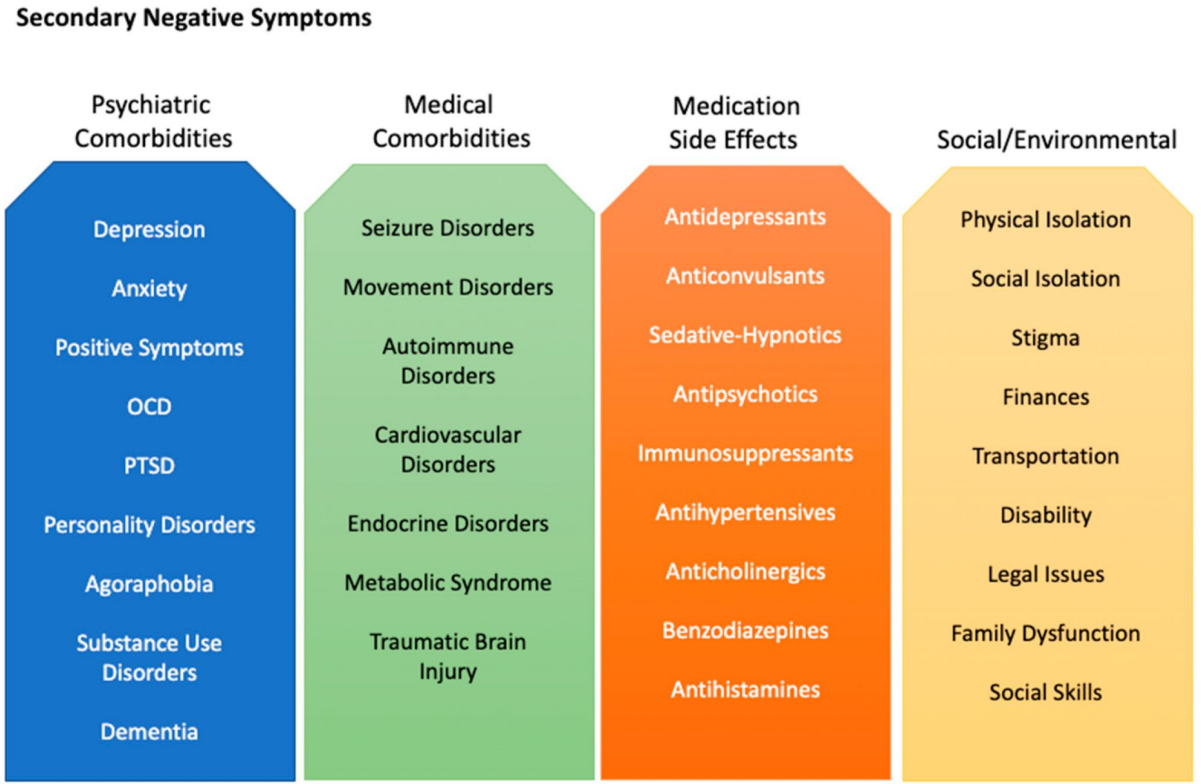
- After 30 years:
- 25% Completely Recover
- 35% Much Improved, relatively independent
- 15% Improved, but require extensive support network
- 10% Hospitalized, unimproved
- 15% Dead (Mostly Suicide)

Lifetime quality

Individuals with schizophrenia are more likely to have reduced lifespans and poorer quality of life due to

- Metabolic syndromes from medications
- Social oppressions, stigmas, isolation and violence toward them
- Difficulty maintaining general health due to lower incomes, less access to care, and difficulty with cognitions and executive function

Quality of life



Schizophrenia and oppression

RACIAL

In the 1970s, the DSM changed the overall tone of psychosis to better encompass behaviors that would pathologize civil rights and social justice work, starting a trend of overdiagnosis of global majority races.

GENDER

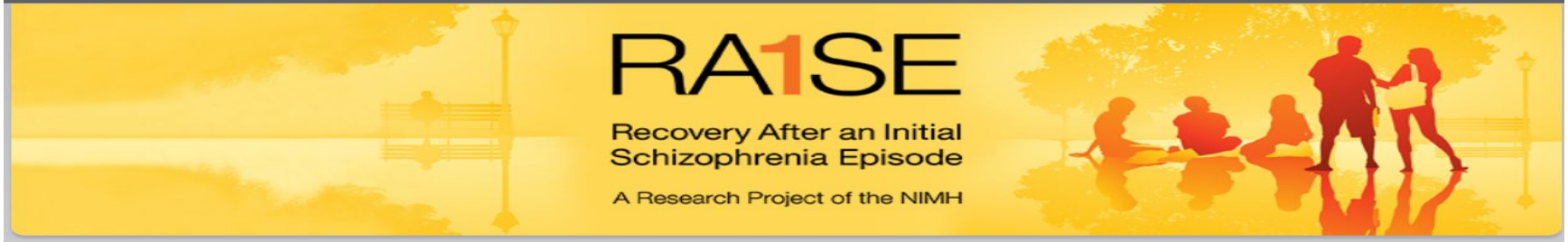
Since this change, psychotic disorder diagnosis is found more often in male identified people than female, although the Borderline Personality Disorder gender disparity may impact this.

Overview of Early Psychosis clinical indications

"All we ever saw in the '80s was the equivalent of stage 4 schizophrenia," says Ken Duckworth, a psychiatrist and medical director of the National Alliance on Mental Illness. "It would be as if you were an oncologist, and all you saw were people with metastatic breast cancer. (Cohn, 2014, "The Psychosis Prodrome")

Early Psychosis

Early psychosis is a concept that began developing as a clinical concept in earnest in the late 1990s, first in Australia (Cohn, 2014) and then expanding worldwide. It postulated that there were many stages of the development of schizophrenia, starting with a prodrome stage and that if caught earlier and given treatment could prevent or allow for complete recovery from a historically devastating illness (Larsen, McGlashan, & Moe, 1996; McGlashan & Johannessen, 1996; "RAISE Recover after initial schizophrenia episode," 2016).



Recovery After an Initial Schizophrenia Episode (RAISE)

Home
Patients and Families
State Health Administrators/Clinics
RAISE Questions and Answers
Published Articles
RAISE In The News
Contact Us / Press
Glossary

What is RAISE?

In 2008, the National Institute of Mental Health (NIMH) launched the *Recovery After an Initial Schizophrenia Episode (RAISE)* project. RAISE is a large-scale research initiative that began with two studies examining different aspects of coordinated specialty care (CSC) treatments for people who were experiencing first episode psychosis. One study focused on whether or not the treatment worked. The other project studied the best way for clinics to start using the treatment program. Read more.

What is Psychosis?

The word psychosis is used to describe conditions that affect the

Science News About Schizophrenia

- Disorders Share Same Gene Pathways
  January 29, 2015
- Medications May Not Meet Guidelines
  December 12, 2014
- Medical Risks Rise Early in Psychosis
  October 8, 2014

+ MORE

Results from the NIMH RAISE (Recovery After an Initial Schizophrenia Episode) Early Treatment Program study, conducted in 34 sites across 21 states, provide some disturbing insights into the quality of care provided in the community. **The duration of untreated psychosis for the 404 subjects in this study was 74 weeks.**[11] At the time of enrollment into the RAISE trial, 39 percent were not receiving medication consistent with guidelines in terms of agent or dose.[12](Insel, 2015)

What delayed treatment means

"The majority of individuals with serious mental illness experience their first symptoms during adolescence or early adulthood, and there are often long delays between the initial onset of symptoms and a person receiving treatment," said SAMHSA Administrator Kana Enomoto during her testimony to Congress last October. ***"The consequences of delayed treatment can include loss of family and social supports, reduced educational achievement, disruption of employment, substance use, increased hospitalizations, and reduced prospects for long-term recovery.***("National Effort Addresses Early Psychosis," 2016)

Population at risk

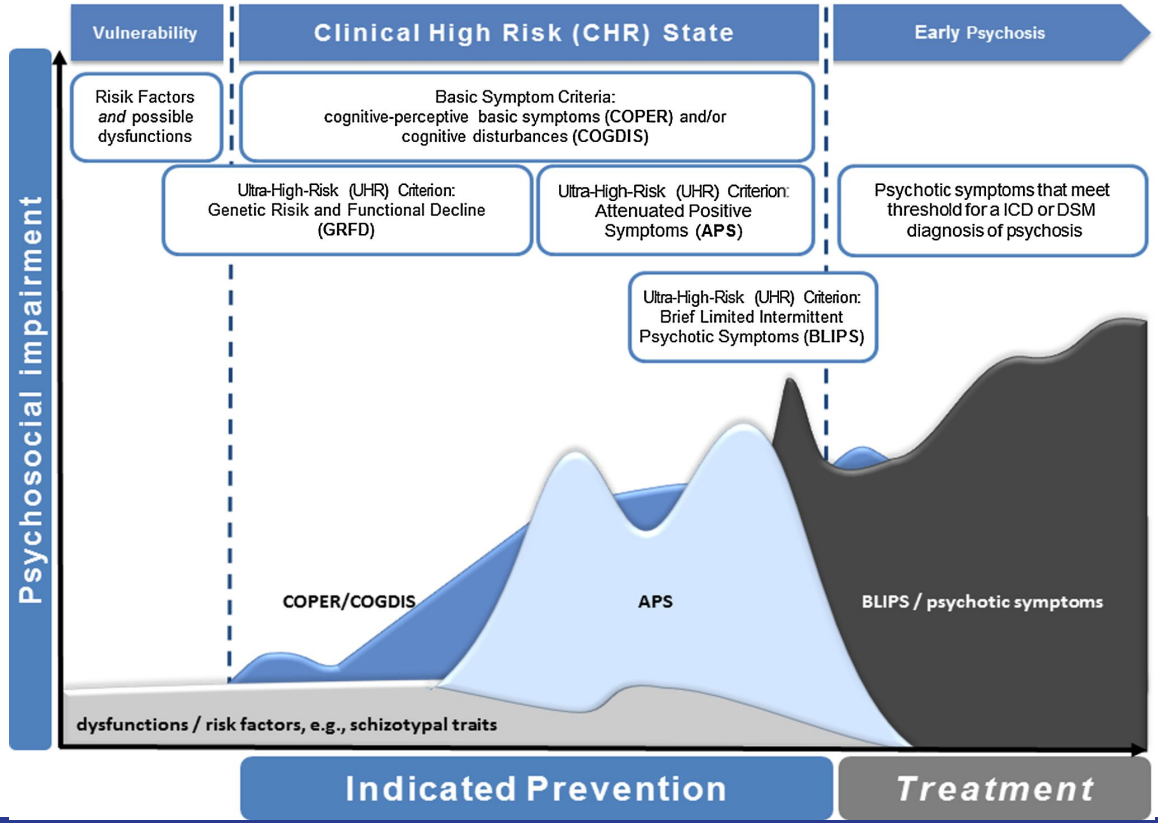
Research shows that young people experiencing first episode psychosis have a much higher death rate than previously thought. Researchers analyzed data on approximately 5,000 individuals aged 16-30 with commercial health insurance who had received a new psychosis diagnosis, and followed them for the next 12 months. **They found that the group had a mortality rate at least 24 times greater than the same age group in the general population, in the 12 months after the initial psychosis diagnosis.**

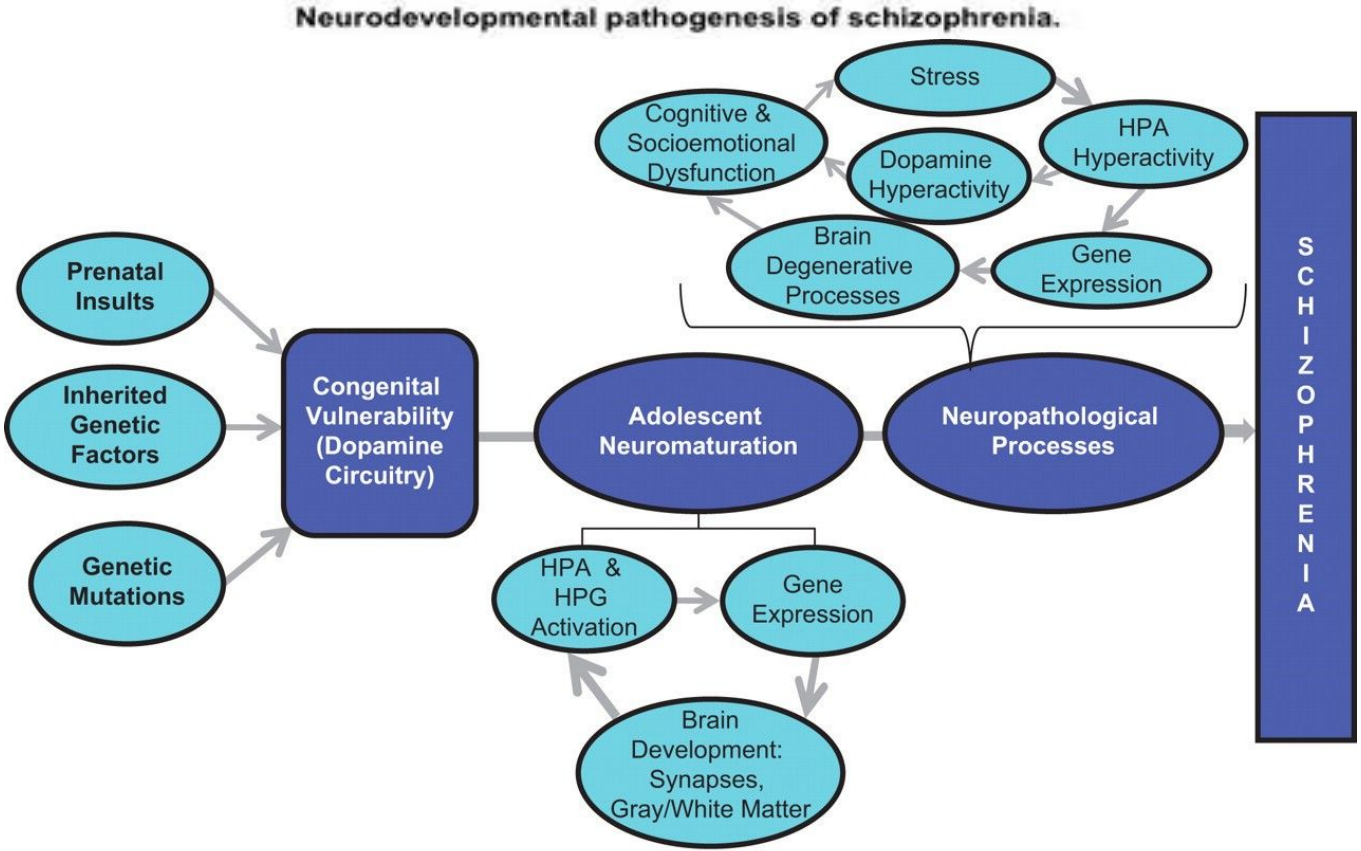
("Higher Death Rate Among Youth with First Episode Psychosis," 2016)

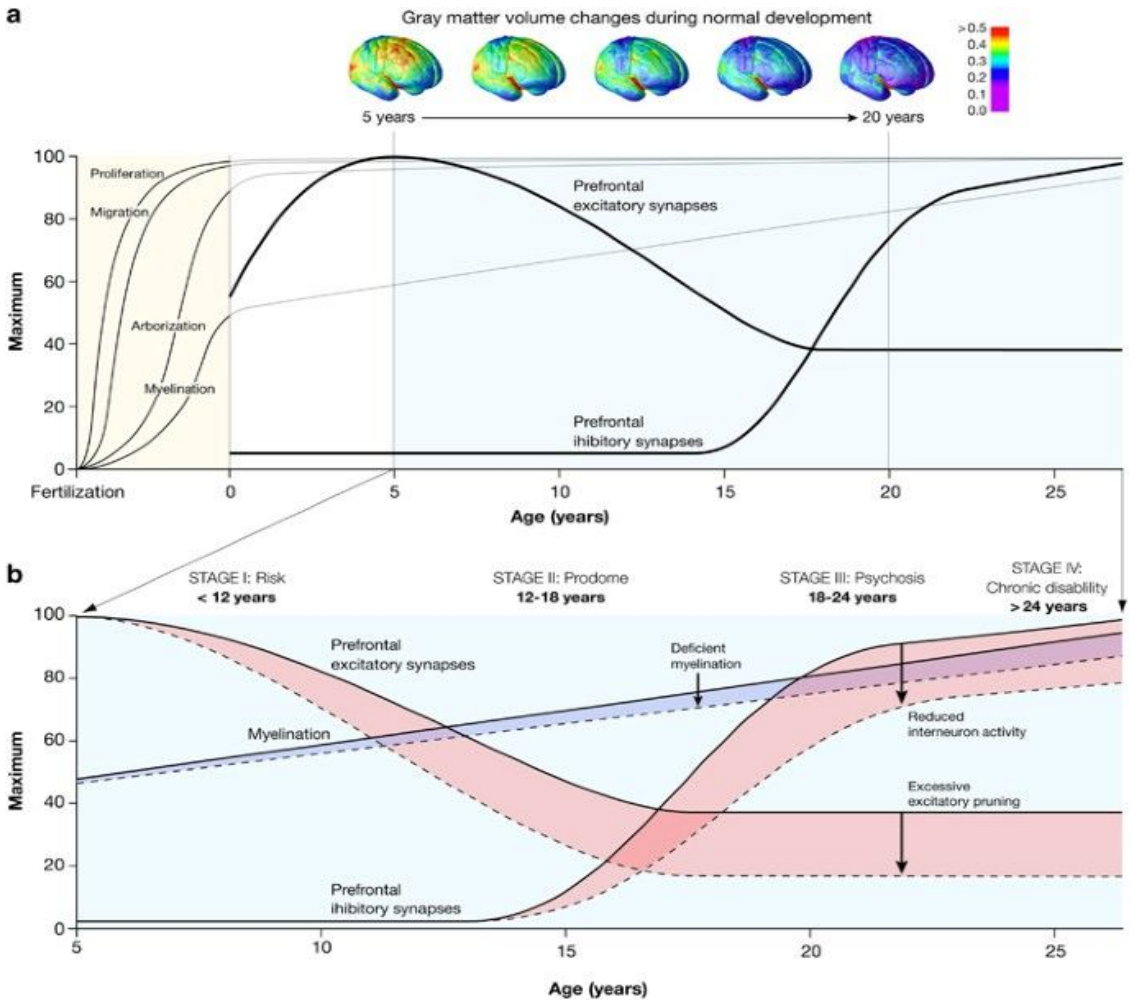
Prevalence of early psychosis

There is no precise figure for the number of first episodes of psychosis each year in the U.S., but incidence data from other countries suggest that around 100,000 people per year have a first onset of psychosis in the U.S.[10]

Early psychosis as a stage model




Neurodevelopmental pathogenesis of schizophrenia.
Stress
Cognitive & Socioemotional Dysfunction
HPA Hyperactivity
Dopamine Hyperactivity
Brain Degenerative Processes
Gene Expression
Prenatal Insults
Inherited Genetic Factors
Genetic Mutations
Congenital Vulnerability (Dopamine Circuitry)
Adolescent Neuromaturation
Neuropathological Processes
SCHIZOPHRENIA
HPA & HPG Activation
Gene Expression
Brain Development: Synapses, Gray/White Matter
Prenatal
Neonatal
Childhood
Adolescence
Young Adulthood


a
Gray matter volume changes during normal development
>0.5
0.4
0.3
0.2
0.1
0.0
5 years
20 years
Proliferation
Migration
Arborization
Myelination
Prefrontal
excitatory synapses
Prefrontal
ihibitory synapses
Maximum
Fertilization
Age (years)
b
STAGE I: Risk
< 12 years
STAGE II: Prodome
12-18 years
STAGE III: Psychosis
18-24 years
STAGE IV:
Chronic disability
> 24 years
Prefrontal
excitatory synapses
Deficient
myelination
Myelination
Reduced
interneuron activity
Excessive
excitatory pruning
Prefrontal
ihibitory synapses
Maximum
Age (years)

ASSESSMENT OF EARLY PSYCHOSIS

Negative symptoms as primary early clinical indicator

+Subclinical positive symptoms

- **Avolition**: A lack of motivation or initiative to complete tasks. This can be so severe that it prevents a person from keeping a job or caring for themselves.
- **Asociality**: A lack of interest in social relationships or an increased desire to be alone.
- **Blunted affect**: A flat or diminished emotional state, where a person may appear to have no emotions. This can include decreased vocal and facial expressions, and expressive gestures.
- **Anhedonia**: A decreased ability to experience pleasure.
- **Poverty of speech**: Decreased speech output.
- **Limited emotional expression**: Difficulty showing emotions.
- **Defects in attention control**: Problems with attention, concentration, and memory.

CHR ASSESSMENT

STRUCTURED INTERVIEW FOR
PSYCHOSIS-RISK SYNDROMES
ENGLISH LANGUAGE

Thomas H. McGlashan, M.D.
Barbara C. Walsh, Ph.D.
Scott W. Woods, M.D.

PRIME Research Clinic
Yale School of Medicine
New Haven, Connecticut
USA

CONTRIBUTORS

Jean Addington, PhD, Kristin Cadenhead, MD, Tyrone Cannon, PhD,
Barbara Cornblatt, PhD, Larry Davidson, PhD,
Robert Heinssen, PhD, Ralph Hoffman, MD, TK Larson, MD,
Tandy Miller, PhD, Diana Perkins, MD, Larry Seidman, PhD,
Jeanne Reyes, PsyD, Ming Tsuang, MD, PhD, Elaine Walker, PhD

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Rev. 3, 2017
Version 5 of 5

Patient ID: _____ Date: _____

Interviewer: _____ Rater: _____ Other Raters Present: _____

Anchors in each scale are intended to provide guidelines and examples of signs for every symptom observed. It is not necessary to meet every criterion in any one anchor to assign a particular rating. Basis for ratings includes both interviewer observations and patient reports.

UNUSUAL THOUGHT CONTENT/DELUSIONAL IDEAS **Severity Scale (circle one)**

0 Absent	1 Questionably Present	2 Mild	3 Moderate	4 Moderately Severe	5 Severe but Not Psychotic	6 Severe and Psychotic
	"Mind tricks" that are puzzling. Sense that something is different.	Overly interested in fantasy life. Unusually valued ideas/beliefs. Some superstitions beyond what might be expected by the average person but within cultural norms.	Unanticipated mental events that are puzzling, unwilled, but not easily ignored. Experiences seem meaningful because they recur and will not go away. Functions mostly as usual.	Sense that ideas/experiences/ beliefs may be coming from outside oneself or that they may be real, but doubt remains intact. Distracting, bothersome. May affect functioning.	Experiences familiar, anticipated. Doubt can be induced by contrary evidence and others' opinions. Distressingly real. Affects daily functioning.	Delusional conviction (with no doubt) at least intermittently. Interferes persistently with thinking, feeling, social relations, and/or behavior.

Rating based on: _____

_____

_____

For Symptoms Rated at Level 3 or Higher			
Symptom Onset	**Symptom Worsening**	**Symptom Frequency**	**Better Explained**
Record date when a positive symptom first reached at least a 3: ☐ "Ever since I can recall" ☐ Date of onset ___/___ Month/Year	Record most recent date when a positive symptom currently rated 3-6 experienced an increase by at least one rating point: Date of worsening ___/___ Month/Year	Check all that apply: ☐ ≥ 1h/d, ≥ 4d/wk ☐ ≥ several minutes/d, ≥ 1x/mo ☐ ≥ 1x/wk ☐ none of above	Symptoms are better explained by another DSM disorder. Check one: ☐ Likely ☐ Not likely

Prodrome diagnoses

Attenuated psychosis syndrome (APS; also referred to as clinical high-risk state, at-risk mental state, or ultra-high-risk state) refers to symptoms that are psychotic in nature but below the threshold for consideration as counting towards the diagnosis of a psychotic disorder. Typically, they are less severe and more transient. Individuals with APS may later meet diagnostic criteria for schizophrenia, bipolar disorder, or another disorder with psychosis [1]. Premorbid signs may also be present in childhood.

APS operationalizes the symptoms typically described as having been present during the prodromal phase of psychiatric illness. Individuals who meet the APS criteria have an increased risk of developing a psychotic disorder and those who do not later convert to psychosis may continue to have poor psychosocial functioning and develop other nonpsychotic Axis I disorders or personality disorders [2]. APS is included in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM 5-TR) Section III as one of the conditions for further study [3].

Genetic risk and deterioration (GRD) syndrome is one of the clinical features that can indicate an individual is ultra-high risk (UHR) for a psychotic disorder.

Conclusion

- Psychosis is a spectrum is disorders that fall on a stage model with a variety of variables that contribute to the development of these disorders
- Early assessment and intervention increases the likelihood of a more positive prognosis
- Treatment should match the level of distress and providers should be mindful of their own reactivity and internalized cultural biases which can lead to acute levels of stigma and oppression for individuals experiencing psychosis

Clinical High Risk Diagnosis

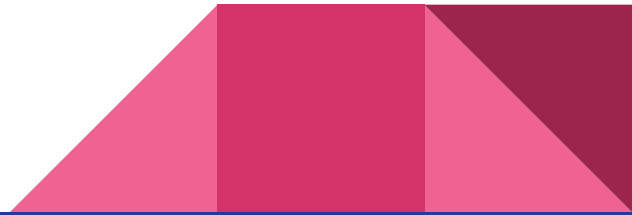
Term Defined		APSS Syndrome	BIPS Syndrome	GRD Syndrome
Syndromal Diagnosis		Attenuated pos sx ever met criteria for: -severity (rated 3-5 at some time), -frequency (≥ 1x/week the same month), -attribution (not due to other disorder).	Positive sx ever met criteria for: -severity (rated 6 in some month), -frequency (≥ 1x/mo), -attribution (not due to other disorder).	FHx psychosis, or ever SPD. Hx of current or past progression.
Current Status Specifiers	**Progression**	≥1 positive sx meets severity, frequency, attribution, and progression (≥1 point more than 12 mos ago) criteria.	≥1 positive sx meets severity, frequency, attribution, and progression (≥1 point more than 3 mos ago) criteria.	GAF meets current progression criteria (≥30% lower than 12 mos ago).
	Persistence	≥1 positive sx meets severity, frequency, and attribution but not progression criteria.	≥1 positive sx meets severity, frequency, and attribution but not progression criteria.	GAF <90% of 12 months prior to first progression.
	Partial Remission	No positive sx have met severity and attribution criteria ≤6 months, OR ≥1 positive sx meet severity and attribution, but not frequency criteria.	No positive sx have met severity and attribution criteria ≤6 months, OR ≥1 positive sx meet severity and attribution, but not frequency criteria.	GAF ≥90% of 12 months prior to first progression, for ≤6 months.
	Full Remission	No positive sx have met severity and attribution criteria >6 months.	No positive sx have met severity and attribution criteria >6 months.	GAF ≥90% of 12 mos prior to first progression, for >6 months.

Treatment models

-Coordinated speciality care

-Match level of care to level of distress

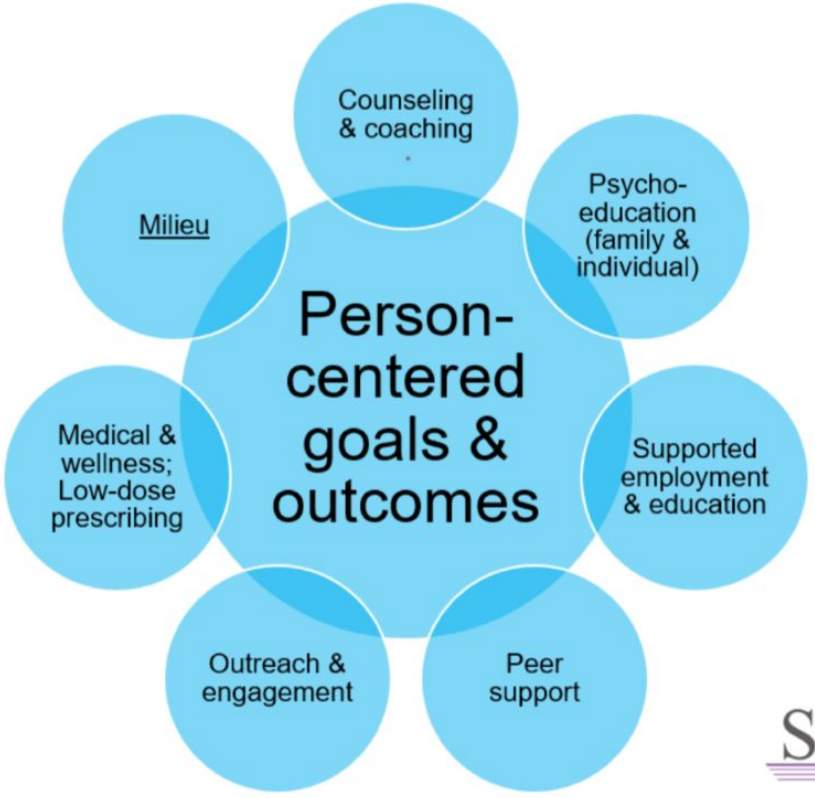
-CBT for psychosis



Historical Treatments

- Classic “talk therapy” struggles to achieve significant positive outcomes
- Biggest positive changes are in medications which are powerful and have difficult side effects.
- Community-based treatments and supports along with a general attitude of total disability prevail

PREP CSC Model

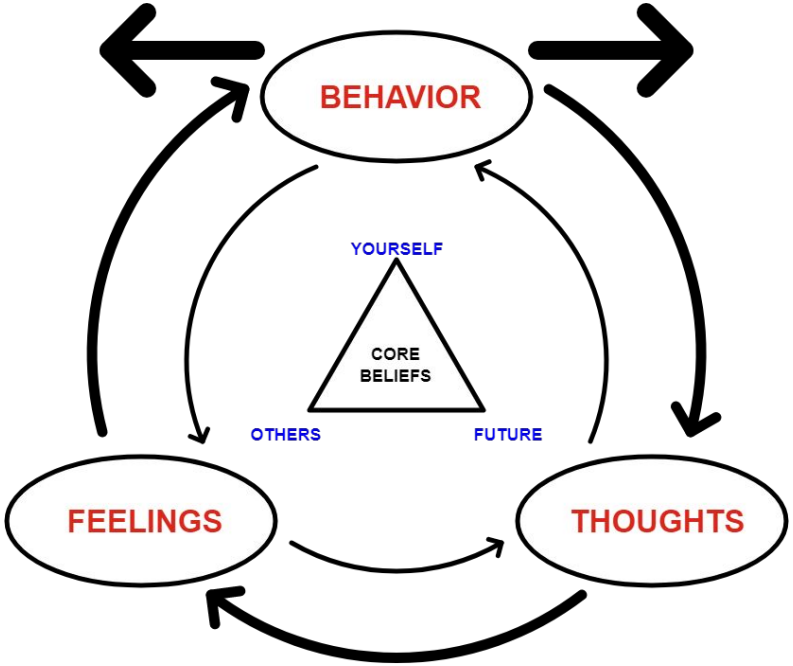


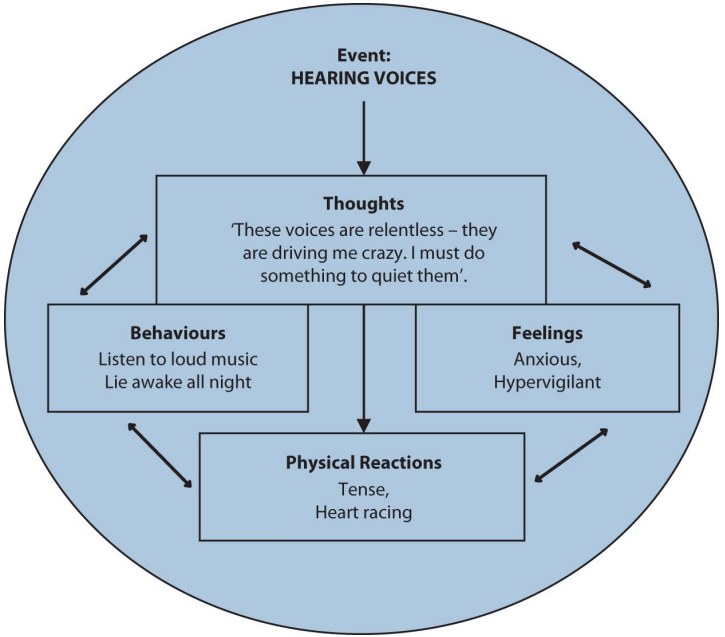
ServiceNet
Integrated Human Services

Clinical High Risk Treatments

Distress / Severity	Psychotherapy Track	Pharmacology Track	Family Track	Peer Support Track	Vocational & Educational Track
Lower Distress / Severity ↕ **Higher Distress / Severity**	• Psychoeducation • Substance Use Reduction		Clinic Orientation	Activity Group	Support offered at all levels of Distress / Severity
	• Unified Protocol		Joining Sessions	PEERS	
	• CBT_{CHR} • MCR	Consider SSRI	Multi-family Group		
		Consider Antipsychotic Medication			

CBT FOR PSYCHOSIS





Resources

MAPNET: https://www.mapnet.online/

M-PATH: https://www.brooklinecenter.org/centers/mpath/

PEPNET: https://med.stanford.edu/peppnet.html

Prime: https://www.prime.research.yale.edu/services

WCC: www.mentalhealthbythespoons

First Annual Western Mass Early Psychosis Symposium Jan 21-24

Referral Resources

Massachusetts Psychosis Network for Early Treatment

MAPNET: https://www.mapnet.online/

Educational and research resources

Provider directory

SIPS referrals:

- You can refer to me: melissadweise@gmail.com
- Cedar Clinic in Brookline