



Psychosis Screening in Primary Care

Informational tool produced by the Center for Early Detection, Assessment, and Response to Risk (CEDAR) in conjunction with the Prevention Collaborative, the Massachusetts Child Psychiatry Access Project (MCPAP), Boston Children's Hospital (BCH) Adolescent Medicine and BCH Psychiatry. This work was funded by the Sydney R. Baer, Jr. Foundation, the Massachusetts Department of Mental Health, MCPAP, and the Beth Israel Deaconess Medical Center and Harvard Medical School Departments of Psychiatry.

**KNOW
THE SIGNS**

**FIND
THE WORDS**

**MAKE THE
CONNECTION**



*Brain abnormalities emerge **EARLY**.*

***YOUR ACTIONS** may help prevent progression.*

CONTENTS

Summary Pages	4
A Place for Caution and Balance	8
<hr/>	
KNOW THE SIGNS	9
What is Psychosis?	9
Family History & Other Risk Factors	10
Signs of Psychosis	12
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FIND THE WORDS	15
Tips for Talking About Psychosis	15
Screening & Follow-Up Questions	15
Case Examples	18
Could This Be Depression? Anxiety? ADHD?	22
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MAKE THE CONNECTION	28
Medical Workup Considerations	29
PATH 1: Reassure & Redirect	32
PATH 2: Monitor & Educate	34
Monitoring Symptoms, Behavior, & Risk	35
Educational Resources	36
Treatment & Assessment Resources	37, 39
PATH 3: Specialized Assessment & Treatment	38
PATH 4: Same-Day Assessment	42
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APPENDIX	43
Tips for Talking with Parents & Caregivers	44
16-Item Prodromal Questionnaire (PQ-16)	46

EARLY INTERVENTION CAN SAVE LIVES

You would act immediately if a patient showed the early signs of a stroke. Responding quickly to the early signs of mental illness is just as critical for patients' health and wellbeing. Recovery can be a realistic goal with timely help.

The next few pages provide a QUICK REFERENCE GUIDE. More detailed information on each topic begins on page 9.

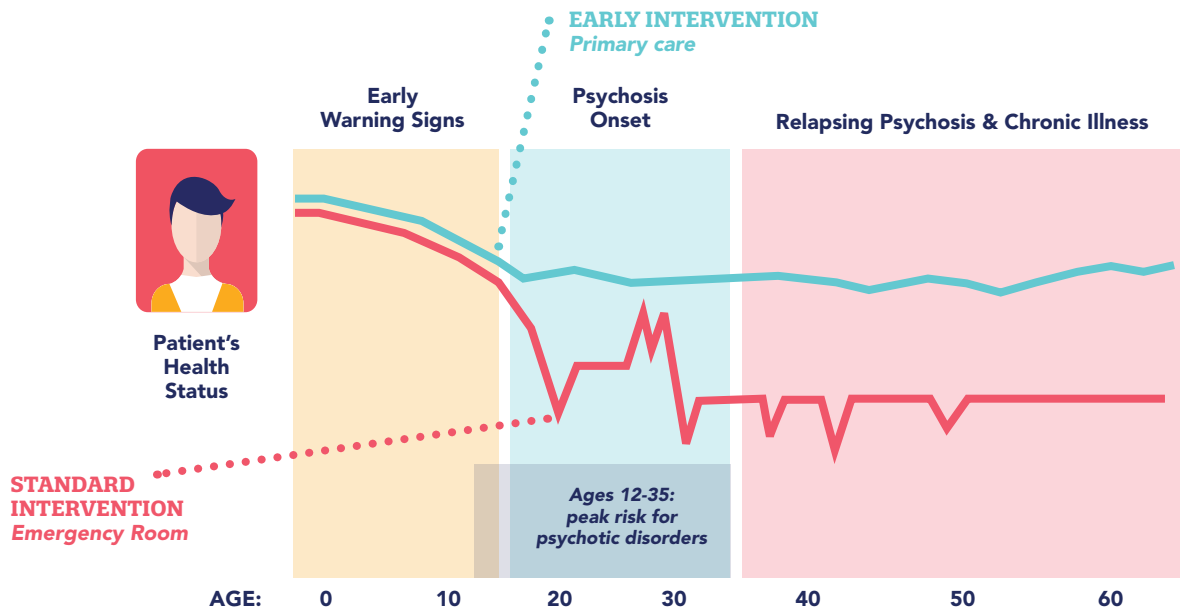
EARLY INTERVENTION CAN:

INCREASE

Quality of life
Functioning

DECREASE

Suicide risk
Care utilization
Medical costs



This booklet was designed to help providers working with adolescents and young adults:



KNOW THE SIGNS

FACTS will help you remember the most common early warning signs. Patients for whom any of these are new or worsening should be assessed further (see **FIND THE WORDS**):



FUNCTIONING: *Functional decline*

- Decline in performance at school/work
- Withdrawal from family, friends, and usual activities
- Changes in sleep patterns



ATYPICAL: *Atypical perceptual experiences*

- Seeing things not there: e.g., shadows, flashes, figures, people, or animals
- Hearing things others do not: e.g., clicking, banging, wind, mumbling, or voices
- Seeing or hearing everyday experiences as unfamiliar, distorted, or exaggerated



COGNITION: *Cognitive difficulties*

- Memory, attention, organization, processing speed
- Understanding abstract concepts, social cues, complex ideas



THOUGHTS: *Thought disturbance or unusual beliefs*

- Unwarranted suspiciousness about friends, family or strangers
- Unfounded concern something is wrong with their bodies
- Thinking that their body or mind has been altered by an external force
- Believing others can read their mind or control their thoughts



SPEECH: *Speech or behavior that is disorganized*

- Trouble putting thoughts into words
- Speaking in jumbled or hard to follow sentences
- Dressing inappropriately for the weather or behaving oddly

Familial Risk

Family history is the best known predictor of psychosis. Regular monitoring for changes in mental health and functioning in these patients is advised, as subtle warning signs are more concerning. That said, most patients with a family history of a major psychotic disorder will NOT develop a psychotic disorder.

FIND THE WORDS

When patients present with nonspecific signs of risk, such as general difficulties in **FUNCTIONING, COGNITION, or SPEECH**, the following Yes/No questions can help tease out if these are related to psychotic experiences:

- Have you started to wonder if your mind was trying to trick you or was not working right?
- Have you felt confused whether an experience was real or imaginary?
- Have you thought that some person, force, or creature was around you, even though you couldn't see anyone?
- Have your thoughts been so strong that you felt like you heard them or worried other people could hear them?
- Have you seen objects, people, or animals that no one else could see?
- Have you heard voices or sounds that no one else could hear?
- Have you thought that the world may not be real or that you may not be real?
- Have you thought that people were following or spying on you?

For spontaneous disclosures or positive responses to these or similar questions (**ATYPICAL** perceptual experiences, **THOUGHT** disturbance or unusual beliefs), follow up with some of these open-ended questions:

What is the EXPERIENCE like?

- *Tell me more about that experience.*
- *What do you make of that?*
- *Why do you think this is happening?*
- *How so?*

Is it IMPACTING them?

- *What do you do/how do you feel when that happens?*
- *Do you ever do anything differently (as a result of that thought/experience)?*
- *Does it ever bother you?*
- *Do you ever worry that (that's true, it's going to get worse, or that you're going to lose track of whether something is real or not)?*

Is it RECURRING or PROGRESSING?

- *How often is this happening?*
- *Does it seem to be happening more now than it used to?*
- *When did you first begin having this experience?*
- *Has this experience changed at all over time? (for instance, becoming more intense or harder to dismiss)*

MAKE THE CONNECTION

Use what you've observed and learned in **FIND THE WORDS** to consider one of the following paths. For rapid assistance choosing the appropriate path, call MCPAP (mcpap.com) or consult the resources on page 28.

PATH 1: REASSURE & REDIRECT

IF:
Symptoms are not psychotic-like or are better explained by:

- Cultural/familial norms
- Developmental stage
- Other mental/medical health diagnoses

THEN:

- Reassure the patient; help them put their experience in context and know they are not alone
- Connect them to relevant educational resources and/or redirect them to appropriate mental health treatment

Page 32

PATH 2: MONITOR & EDUCATE

IF:

- Mild or vague psychotic-like content is not **IMPACTING, RECURRING, or PROGRESSING**
- Family history of psychosis

THEN:

- Monitor the patient's symptoms and screen regularly for additional psychotic-like experiences
- Educate the patient and family on general mental health resources and direct them to call if symptoms increase in intensity, frequency, or impact

Page 34

PATH 3: SPECIALIZED ASSESSMENT & TREATMENT

IF:

- Psychotic-like content is **IMPACTING, RECURRING, or PROGRESSING**
- Suspicious/concerned psychosis may be emerging even without relevant self-disclosure

THEN:

- Refer the patient to specialized assessment of psychosis and/or psychosis risk
- Seek consultation/specialized treatment options

Page 38

PATH 4: SAME-DAY ASSESSMENT

IF:

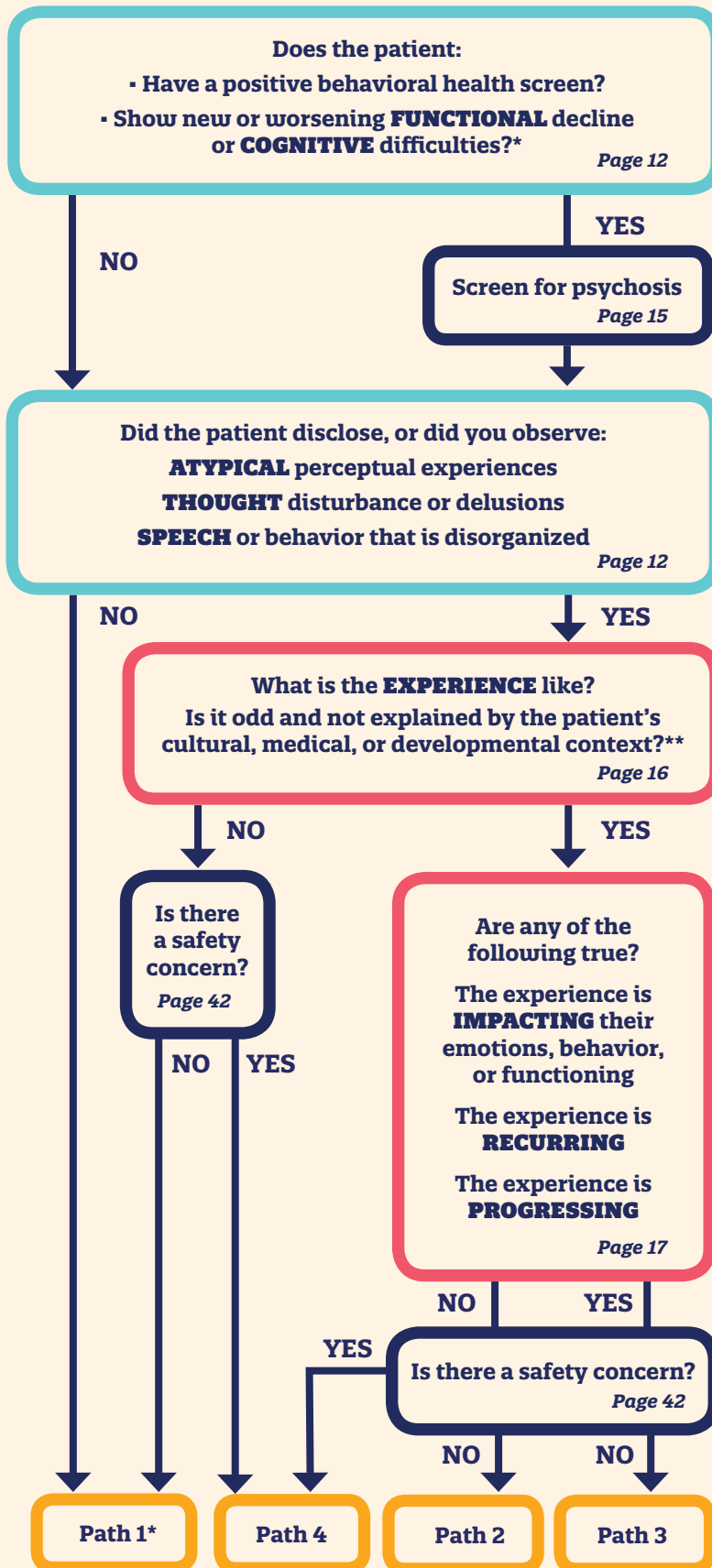
- Suicidal/violent thoughts or impulses
- Significantly out of touch with reality
- Behavior is severely disorganized or dangerous
- Questionable ability to manage command hallucinations to hurt themselves or someone else

THEN:
If these are not sufficiently managed by existing treatment:

- Seek consultation from MCPAP or mental health professional trained to address this level of need
- Respond to risk of harm using established protocols
- Consider calling a mobile crisis team or recommending that the family bring the child to a Psychiatric Emergency Room

Page 42

DECISION-MAKING FLOWCHART FOR ALL PATIENTS AGES 12-35



*FAMILY HISTORY

Patients who have a first- or second-degree relative with a psychotic disorder should receive **REGULAR SCREENING** for psychotic-like symptoms regardless of their mental health status.

These patients should fall under PATH 2 in the absence of other psychosis risk indicators.

**PERFORMING A MEDICAL WORKUP

See pages 29-31 for considerations on differential medical work-up prior to or in conjunction with selection of a Path.

A PLACE FOR CAUTION AND BALANCE

Active screening and risk management in primary care settings may make the difference between recovery and long-term disability for individuals at risk for or in the early stages of major psychotic disorder. However, as with all early intervention, it is important to minimize inappropriate or premature diagnoses. Roughly 17% of young people have psychotic-like experiences, and most will never develop a major psychotic disorder. This booklet is written to help you address the following complementary goals:

1. EARLY DETECTION: The primary goal of screening for psychosis is to allow those experiencing warning signs to get help as soon as possible. If health professionals are knowledgeable, comfortable, and willing to ask about psychosis, their patients may be more likely to disclose their internal experiences and to be guided to timely assessment and treatment.

2. MINIMAL HARM: A secondary goal is to minimize worry and stigma, which can be done by assuring that information provided is accurate and appropriate to each individual's experiences, context, and level of risk. Patients experiencing unusual thoughts and behaviors are often scared about what is happening and may worry that they are "going crazy." For a substantial subgroup, these symptoms may remit with minimal or no intervention.

BALANCING the potential benefits and risks of early intervention involves:

- An **ACTIVE** and **THOUGHTFUL** response to signs and disclosure of symptoms
- **CURIOSITY** and **HOPE** rather than fear, hopelessness, or premature labeling
- A **COLLABORATIVE** and **PRACTICAL PROBLEM-SOLVING** approach that **RESPECTS** each individual and family's perspective, language, values, and goals.

More comprehensive training and education on psychosis are available through resources such as:

<http://www.cedarclinic.org/index.php/understanding-early-psychosis/what-is-psychosis>



~60% of psychotic disorders are first diagnosed in crisis settings such as the ED or inpatient unit, after the patient has been psychotic for an average of 18 months. -Anderson et al., 2013



WHAT IS PSYCHOSIS?

Psychosis is a medical term referring to the loss of contact with reality or a difficulty telling what is real from what is not. It is not a diagnosis on its own, but rather references a set of symptoms that often combine to form the basis of a psychotic disorder. The person experiencing psychosis can feel like their mind is “playing tricks” on them. They may have difficulty telling the difference between their own thoughts and perceptions and those that come from the outside world. Although real to the person experiencing them, psychotic experiences are not experienced as real to others from the person’s own social groups.

Psychosis is more common than many people think. Symptoms may come and go, or be relatively constant. It is often associated with mental health disorders like depression, bipolar disorder, and schizophrenia. However, psychosis can also occur in the context of other conditions, including, but not limited to, substance use, brain injury, seizure disorders, or conditions of extreme sleep deprivation or isolation (see Medical Conditions on page 29).

Most importantly, psychosis is treatable, and in some cases, it may be preventable. It is one part of a person’s experience, and must be understood within the broader context of a person’s experiences and being.

DOESN’T PSYCHOSIS APPEAR “OUT OF THE BLUE”?

For people developing a “primary” psychotic disorder such as schizophrenia, psychosis rarely comes on suddenly. Onset is typically in the late teens to early 20s, but most people experience gradual changes over a period of months to years before experiencing pronounced or diagnosable syndromes.

We now know that the earlier a person gets help when they are experiencing warning signs or initial psychotic symptoms, the better the person’s outcome is likely to be. In fact, early treatment may be able to delay or prevent the development of pronounced or disabling psychotic symptoms, help someone stay in school or work, develop or maintain important social connections, and live meaningful and productive lives. Accurate recognition of these warning signs provides the best opportunity for early intervention and good outcomes.

THE LOOK, FEEL, AND IMPORTANCE OF EARLY SIGNS

The earliest changes in psychosis-spectrum illnesses can be subtle and nonspecific. Some people begin to have more difficulty screening out distracting information and sensations, or with focusing or understanding what they are hearing. Visual experiences may become brighter; sounds may become louder. They may feel overloaded or find it harder to keep track of what they are thinking and what others are saying. They may feel more and more disconnected from others and even from a sense of “self,” and just want to be alone.

Other people may notice that someone is withdrawing, acting oddly, or just does not seem like themselves. The person may begin struggling at school, work, or extracurricular activities. They may not be able to sleep, or begin sleeping during the day rather than the night. These early changes are often not specific to psychosis or psychotic disorders; the majority of young people with these symptoms will have mental health problems other than psychosis.

For those in the very early stages of a psychotic illness, however, these changes are important warning signs. When several signs or symptoms occur together, become more intense over time, cannot be clearly explained by other factors, or occur alongside a family history of psychosis, it is particularly important that the person be assessed by a skilled mental health provider who has some knowledge about early psychosis.

Other early warning signs are more obviously “psychotic-like,” albeit milder or more easily dismissed; for example, rather than hearing a clear voice they believe is real, a person may initially hear mumbling or whispers. We call these “attenuated” psychotic symptoms. When these symptoms are new or increasing in frequency or intensity, the risk for acute psychosis may be imminent. However, a surprising number of adolescents and even some young adults will report attenuated psychotic symptoms that are longstanding and stable. Depending on the nature of their symptoms, these individuals may not be at imminent risk for a psychotic disorder, but they are at higher long-term risk for psychosis and other serious mental health challenges. Early intervention is particularly warranted for youth with recurrent or impairing, even if attenuated, psychotic symptoms.

FAMILY HISTORY & OTHER RISK FACTORS

A number of risk factors have been identified for psychosis and, in particular, schizophrenia. These include complex genetic abnormalities and interactions, neurocognitive dysfunction, early social and motor abnormalities, and structural brain alterations (e.g. loss of gray matter). Environmental risk factors include those that impact neurodevelopment, such as perinatal complications, head injuries, malnutrition, hypoxia, and viruses. They also include factors such as urbanicity, migration, minority status, and familial conflict. Finally, substance use can pose a more proximal risk—in particular, stimulants, hallucinogens, psychedelics, MDMA, phencyclidine, and cannabis. However, distinguishing between substance-induced psychosis and a primary psychotic disorder can be challenging in young people. A careful review of the person’s symptoms along with a period of sustained abstinence is typically needed if symptoms do not quickly remit.

Family history of a major psychotic disorder (such as schizophrenia, schizoaffective disorder, bipolar disorder, or depression with psychotic features) remains the single best predictor that a person will develop a psychotic disorder. Individuals with multiple affected family members are at even higher risk. Young people with a known family history of psychosis **warrant careful monitoring** for changes in either functioning or mental health. Screening and early detection of symptoms can help to identify those in need of specialized treatment early enough to prevent the suffering and disability that a relative may have experienced. Youth with a family history of major mental illness are likely to benefit from education about mental health and treatment options, and from support from others who have been in their shoes (see page 34). That said, **the vast majority of these individuals will NOT develop a psychotic disorder.**

ASKING ABOUT FAMILY HISTORY OF PSYCHOSIS:

Many people may not know their family mental health history, but may have pieces of information that are relevant. To gather these pieces, we recommend asking several different questions. It is often helpful to create a list of all first and second degree relatives and have the patient think about all of them for each question.

Do you know of any family members who have:

- *Been diagnosed with a major mental illness such as schizophrenia, bipolar disorder, or major depression?*
- *Been hospitalized for mental health reasons?*
- *Been unable to go to work or school for more than a couple of weeks?*
- *Had very few friends or seemed like loners?*
- *Seemed odd or eccentric in behavior or appearance?*
- *Seen visions, heard voices, or had beliefs that seem strange or unreal?*
- *Had problems with their nerves or emotions? Seen a doctor or taken medication for this?*

For any positive responses, ask the patient to tell you what they know of the person’s symptoms and ask specifically about hallucinations and unusual beliefs (see page 15).

YOUNG CHILDREN WITH FAMILY HISTORY OF PSYCHOSIS

For young children with a positive family history of psychotic symptoms or disorder, it is important to help caregivers consider options for enhancing general protective factors to support mental health (e.g., structure, warmth, open communication). The challenge is to help caregivers understand that the child is at higher risk for serious mental health issues without triggering unproductive anxiety or a sense that psychosis is inevitable. Families might take advantage of local chapter activities or resources of the National Alliance on Mental Illness (NAMI), or establish a relationship with a mental health clinician knowledgeable about both child development and serious mental illness who can provide education, support, and relevant intervention for mental health challenges if and as they emerge. Establishing a relationship in which the monitoring and addressing of mental health issues is a priority for the child’s healthcare is perhaps the most important task.

FAMILIAL RISK FOR SCHIZOPHRENIA

Relative with Schizophrenia	Risk of Schizophrenia
Identical Twin	48%
Fraternal Twin, especially if same sex	17%
2 Parents	35%
1 Parent	13%
Full Sibling	9%
1/2 Sibling	6%
Cousin, Uncle, Aunt, Grandparent	2%
General Population	1%

Remember the **FACTS**

Any of the following new or worsening signs in an adolescent or young adult should trigger assessment for psychosis:



FUNCTIONING:

Functional decline

Because psychotic experiences are not observable by others, the following observable changes should prompt careful inquiry into a young person's internal experience:

- Decline in self-care
- Decline in attendance or performance at school/work
- Withdrawal from family, friends, and usual activities
- Reduced emotional expression
- Reduced interest in activities previously enjoyed
- Decreased ability to handle everyday stress
- Insomnia or altered sleep
- Decline in the amount or content of speech

Often the initial signs of a psychotic disorder include **shifts in a person's emotions or behavior:**

- Increased dysphoria, irritability, agitation, hopelessness, anxiety
- Preoccupation with new ideas or causes (e.g., religion, politics, philosophy)
- Pacing, staring, talking to self, seeming disconnected or disengaged



ATYPICAL:

Atypical perceptual experiences

These include false perceptions or misperceptions involving one or more of the five senses: hearing, sight, touch, taste, or smell. The most common are auditory (hearing noises or voices). Visual disturbances can include distortions in color, lines, or perspective, as well as seeing things no one else can see. People with psychosis experience these as real, although many may realize that even vivid experiences are the product of their own minds. Individuals with psychotic disorders describe feeling more sensitive to or overwhelmed by stimulation. Examples include:

- Sounds seeming louder than usual
- Seeing movement, shadows, or vague figures out of the corner of the eye
- Finding that everyday noises sound like words
- Hearing voices talking, giving commands, or narrating a person's day
- Seeing people or animals
- Feeling an unexplained presence or touch

C

COGNITION:

Cognitive difficulties

Basic neurocognitive disabilities are typically among the earliest signs of an emerging psychotic disorder. Difficulties in the following may begin years before psychotic symptoms appear, and make a significant contribution to functional difficulties:

- Learning, memory, attention, mental speed, planning and organization
- Abstract reasoning and social perception
- Motivation or initiative
- Basic receptive and expressive language
- Following conversations, or capturing the “gist,” particularly in social situations

T

THOUGHTS:

Thought disturbance or unusual beliefs

The content of one’s thoughts can also be altered in psychosis. Delusions are false beliefs that do not fit within a person’s cultural, familial, or religious context. Even though delusions may seem odd or obviously irrational to others, they are captivating or compelling to the young person. In the early stages of psychosis, an individual may recognize these beliefs as illogical. Take note when your patients:

- Feel suspicious of friends or family without clear reasons
- Have persistent or bizarre concerns that something is wrong with their bodies or brains without medical findings
- Have unusual beliefs about their capacity to eat, physical sensations, or pain
- Feel that their body or mind has been altered by an external force

S

SPEECH:

Speech or behavior that is disorganized

A person experiencing psychosis may have trouble thinking clearly, speak in jumbled or hard to follow sentences, lose their train of thought, or be unable to put their thoughts into words. They may make meaningful connections between ideas and events that have no logical connection, leading them to say or do things that confuse others.

Psychotic individuals may dress inappropriately for the weather, wander aimlessly, shout at strangers, or otherwise behave in ways that appear bizarre or even dangerous. This behavior is often more obviously recognized as psychotic, but also can be mistaken for substance use or erratic youthful behavior.

FIND THE WORDS

If a patient presents with any of these indicators, further assessment is warranted to guide which of the following responses might be indicated.



MAKE THE CONNECTION

- Path 1: Reassure & Redirect**
- Path 2: Monitor & Educate**
- Path 3: Specialized Assessment & Treatment**
- Path 4: Same-Day Assessment**

A detailed description of each response (pages 32-42) and a flowchart of the steps leading to each response (page 7) are included in this booklet.

TYPES OF DELUSIONS

SOMATIC DELUSIONS

A person may develop a belief that something is abnormal or has changed about the way their body looks or functions; this can include belief that something is wrong with their physical health.

Example: Tim believes that his internal organs have turned black and cancerous as a result of toxins in the environment.

IDEAS OF REFERENCE

A person may believe they are receiving special messages from the TV, radio, or music. Alternatively, they may believe that colors, words, or other things in the environment have special meaning just for them.

Example: Whenever Jenny sees blue print, she believes that the government is sending her a message about an upcoming event.

PARANOIA

A person may believe that friends, family, government agencies, or others are trying to bother or harm them when there is no evidence this is true.

Example: Andre is convinced that his roommate is trying to poison his food and refuses to eat anything that he does not prepare himself.

THOUGHT BROADCASTING

A person may believe that other people can hear or read their thoughts.

Example: Tamika has been avoiding her friends because she believes they can hear her thoughts, especially when she is angry or thinking about something embarrassing.

THOUGHT INSERTION

A person may have thoughts that feel foreign to them and seem as if they have been inserted by an outside force or person.

Example: John has been finding himself thinking highly offensive comments about women that he would never say out loud. He is convinced that his cell phone is somehow implanting these thoughts in his mind.

GRANDIOSE/ RELIGIOUS DELUSIONS

A person may develop a belief that they have a supernatural power, are the messiah, or have been chosen for a special mission.

Example: Julietta believes that she controls the internet, and has been chosen by God to save the world by deciphering codes on web pages.

TIPS FOR TALKING ABOUT PSYCHOSIS

Young people are unlikely to spontaneously share their early experiences of psychosis. As such, it is important to be ready and willing to ask about these experiences.

- **Be curious and matter of fact.** Clearly convey that you're there to help. You don't have to know a lot about psychosis, but it's important that you convey with your actions and words that you are not afraid and won't be overwhelmed to hear what the patient is experiencing. If it seems appropriate, the following can be helpful:
 - *"You might be surprised how common your experiences are. I'm here to figure this out with you. Do your best to explain what's going on."*
- **If inquiring about initial concerns or observable behavior changes, start with simple open-ended questions.**
 - *"You seem distracted. Can you describe what's going on in your mind right now?" (or "when you're staring off," "pacing like that," etc.)*
 - *"Can you help me understand what you are experiencing?"*
- **Be ready to follow-up with additional questions as outlined in the next pages.**
 - *"Can you give me an example?"*
- **Move to more specific questions as it makes sense (see below or the PQ-16 on page 46 for examples).** Include these as part of your overall interview without special emphasis, hesitation, or implication that they carry more significance than other experiences being queried (e.g., insomnia, anxiety, headache).
- **If you notice odd behaviors that the patient denies, consider gathering more information from a parent or caregiver.**
- **Clearly convey that you view these experiences as only a part of their life experience; the experiences do not define or change who they are as a person.**

PSYCHOSIS SCREENING QUESTIONS

The following questions cover a range of symptoms and are written at a fifth grade reading level:

- *Have you started to wonder if your mind was trying to trick you or was not working right?*
- *Have you felt confused whether an experience was real or imaginary?*
- *Have you felt that some person, force, or creature was around you, even though you couldn't see anyone?*
- *Have your thoughts been so strong that you felt like you heard them or worried other people could hear them?*
- *Have you seen objects, people, or animals that no one else could see?*
- *Have you heard voices or sounds that no one else could hear?*
- *Have you thought that the world may not be real or that you may not be real?*
- *Have you thought that people were following or spying on you?*

We recommend using these questions or a self-report psychosis screening tool (see Appendix on page 43) to help elicit the disclosure of experiences for further experiences. Please note that none of the available screens have established thresholds for screening in general medical settings, especially for children and adolescents. Visit psychosisscreening.org for updates on screening tools as they become available.

When a patient discloses a potential psychotic-like experience, follow-up questions may help to determine the appropriate next step:

WHAT IS THE EXPERIENCE LIKE?

People experiencing psychosis or psychosis risk symptoms have difficulty determining what is real and what is not. To understand these symptoms, it is important to understand the nature of their experiences and **how they are interpreting their experiences**. Does the experience or behavior fall outside the range of what would be considered typical for the young person's developmental, social/cultural, or diagnostic/medical context? Limitations in cognitive and expressive capacities can often confound our understanding of a young person's experience. Young people may struggle to adequately convey subtle or abstract changes in thought process or content, or say something that sounds psychotic when it is not. Use gentle questioning and refer to specialized mental health assessment (page 28) as needed.

Questions you might ask:

- *Tell me more about that experience.*
- *What do you make of that?*
- *Why do you think this is happening?*
- *How so?*

IS IT IMPACTING THEM?

As a person's reality testing falters, their psychotic-like experiences may begin to impact their functioning. An experience may catch their attention in a way that is hard to dismiss, or a thought may become "sticky" or difficult to ignore. Impact can be **behavioral**, such as wearing headphones to block out auditory hallucinations or avoiding situations that frighten them, or **emotional**, including feeling confused, irritated, or otherwise distressed. Both behavioral and emotional impacts suggest that the experience is becoming more convincing or difficult to control. In many cases, young people may deny or downplay the fact that an experience is impacting them. Observed behavioral and/or emotional responses must be considered in assessing whether this is indeed true.

Questions you might ask:

- *What do you do when that happens?*
- *Do you ever do anything differently because of it?*
- *How do you feel when that happens?*
- *Does it ever bother you? How so?*
- *Do you ever worry that [that's true/it's going to get worse/you're going to lose track of whether it is real or not]?*

IS IT RECURRING OR PROGRESSING?

In considering whether an experience is part of an emerging disorder, we look for patterns. Experiences that occur repeatedly, or are “ramping up,” are more concerning than a single, fleeting experience.

Questions you might ask:

- *How often is this happening?*
- *Do you have any other experiences like this?*
- *Does it seem to be happening more now than it used to?*

Recurring, even long-standing, symptoms that indicate a person is having trouble with reality testing warrant attention by a trained mental health clinician. Onset of new symptoms suggest a shift in a young person’s mental state and a change from their mental health/functional baseline. Similarly, symptoms that have gotten worse over time suggest a more pressing clinical concern. Symptoms are considered worsening when: 1) they have increased in frequency, intensity, or duration, 2) they have begun to cause the young person more distress, 3) they have begun to impact the young person’s behavior/functioning, and/or 4) it has gotten harder for the young person to determine that the symptom is ultimately not real.

Questions you might ask:

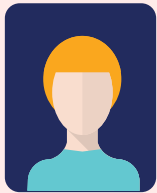
- *Is this experience new for you?*
- *When did you first begin having this experience?*
- *Has this experience changed at all over time? (for instance, becoming more intense or harder to dismiss)*
- *Has this experience been happening more frequently or bothering you more than it used to?*

DID YOU KNOW?

Psychotic disorders are almost always preceded by early warning signs, often in adolescence.



CASE EXAMPLES THAT WOULD WARRANT SPECIALIZED ASSESSMENT & TREATMENT (PATH 3, PAGE 38)



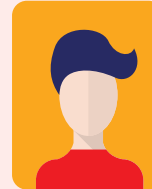
SOMETHING IS WRONG WITH MY BODY

Fifteen-year-old Sasha just hasn't seemed like herself lately. Her dad brought her in for an appointment. He says she stopped going to track practice a couple of months ago, and now he's noticed she's only showering about once per week. Sasha denies that anything is wrong, saying she just doesn't like doing those things anymore, and doesn't have the energy to do them. You ask her why she doesn't like showering or going to track anymore, and she says, "I don't know, sometimes I just think my body can't. Or shouldn't, because it'll be bad for me." You encourage Sasha to tell you more, and she explains, "I've been having thoughts that my legs aren't working right. Sometimes I think they're detached from my body, like there's a gap where they used to connect at my hips. Running will make it worse, and showering might let water in."

EXPERIENCE: *Thinking that one's body is no longer working correctly or in the same way is a somatic delusion (THOUGHTS) – in Sasha's case, this is the thought that her legs are no longer connected directly to her body.*

IMPACTING: *Sasha has stopped participating in activities she normally does and enjoys, including a social, extracurricular activity and hygiene routines (FUNCTIONING).*

PROGRESSING: *This experience is recurring, and has begun to impact Sasha's functioning; her thought that running will worsen the gap between her legs and body, and that water may get into the gap during a shower, indicate that it may be becoming increasingly difficult for her to maintain insight into the fact that this experience is ultimately not real.*



SOMETHING IS WRONG WITH MY BRAIN

Justin's aunt brought him in this afternoon for a checkup. He (age 12) is healthy with no evidence of a visual disturbance or neurological abnormality. During his appointment, however, Justin told you he's been seeing shadows around him, especially in a particular hallway at school. He thinks something is wrong with one of his eyes or that maybe he has a brain tumor that is pressing on his eye. When you ask why he thinks that, he says he knows what's happening is not normal, that no one else sees what he sees, and it's beginning to freak him out. Last week, he skipped a few classes because they're in that part of the building and he didn't want to go over there.

EXPERIENCE: *Justin appears to be developing an attenuated somatic delusion (THOUGHTS) based on ATYPICAL perceptual experiences. He knows that his visual experience is not shared by others and is interpreting this as a sign that something is seriously wrong.*

IMPACTING: *Justin is distressed and has skipped class just to avoid the experience.*

PROGRESSING: *Justin says this is "beginning to freak [him] out."*



DISTRACTED

When you're seeing 13-year-old Lamar for his physical, his mom tipped you off that he's not doing well at school. You ask him what's going on and he says he just doesn't care about school. "What's changed?" He tells you he's having a harder time paying attention. You ask, "How so?" and he says, "I'm just thinking about a lot of stuff and feeling distracted." You ask, "What's distracting you?" Lamar says, "It's like random things seem meaningful, like somebody's chosen a certain color combination in their clothes to try to tell me something, or if a particular song comes on before I'm about to do something, it's a sign I shouldn't do it. It's all little stuff, but it's like it's bombarding my mind."

EXPERIENCE: *Lamar is having difficulty filtering environmental stimuli and is beginning to make meaning of little things, interpreting inconsequential details as messages intended to communicate something to him (THOUGHTS).*

IMPACTING: *Lamar is distracted by this experience and feels "bombarded."*

PROGRESSING: *He is having a harder time in school because of this.*



AFRAID TO EAT

Fourteen-year-old Sam came in for her physical for the basketball team last week. In looking at her records, you notice she's lost a notable amount of weight since her last appointment; Sam says she hadn't thought much about the weight loss, but has had little interest in eating over the past several weeks. She doesn't expand further, but you ask her to tell you more about when that started. Sam then says, "My parents are messing with my food and I think they may be trying to poison me. A few weeks ago I noticed people at school were looking at me so I knew it was true. Now I only eat stuff that's sealed in packages I open, which doesn't end up being much."

EXPERIENCE: *Sam's thoughts that her parents are trying to hurt her via poisoning her food suggest paranoia (THOUGHTS).*

IMPACTING: *As a result of these thoughts, Sam has limited what she eats to the point that she has lost a significant amount of weight (FUNCTIONING).*

PROGRESSING: *This experience is recurring, and Sam's level of conviction increased after an incident at school a few weeks ago when she "knew it was true."*



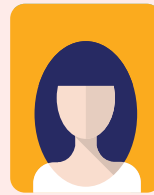
WEIRD THINGS ARE HAPPENING

Last week, 16-year-old Cory told you he's been feeling off the last several months. You say, "How so?" and he explains that it feels like weird things are happening and he feels distant from himself. "Can you give me an example of the weird things?" He says he's heard whispering/talking that others don't seem to hear. You ask him to tell you more, and he says, "Sometimes, mostly when I'm in class or at home in my room, I think I hear somebody talking even when it's quiet. Most of the time I can't make out what the person is saying, but it usually sounds like it's coming from a corner of the room." You ask, "What do you do when that happens?" Cory says, "I turn to check where it's coming from, but nobody's there."

EXPERIENCE: *Cory is aware that something "weird" is happening to him and he's "feeling off," and "distant from himself" (THOUGHTS – a subjective change in the sense of self may be particularly concerning). He is interpreting internal stimuli as external to himself (ATYPICAL perceptual experiences). In particular, he hears the sound of the voice as coming from outside his head (from a corner of the room).*

IMPACTING: *The voice catches Cory's attention and he checks his surroundings for a source of the sound.*

RECURRING: *He's having this experience regularly.*



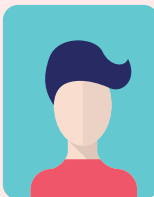
WITHDRAWN

While in your office to get her flu shot, 18-year-old Breanna mentions that she's been spending more time alone than she did last semester. When you ask her why that is, she says she's been feeling really nervous and uncomfortable around people. You ask, "How so?" and Breanna says, "I don't know where this is coming from, but I just feel really uneasy when I'm around people, especially in public, like people are watching me or have it in for me somehow." "Enough to feel you need to be on guard?" "I feel like I really have to pay close attention to everything around me. I'm constantly checking over my shoulder and looking at everyone around me."

EXPERIENCE: *Breanna is feeling suspicious that others intend her harm (THOUGHTS). Her own comment, "I don't know where this is coming from," suggests that she knows there is no actual threat.*

IMPACTING: *She is uneasy, hypervigilant, and spending time alone because of this experience.*

PROGRESSING: *She reports spending more time alone now than she did last semester.*



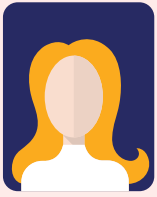
DREADING SCHOOL

During a check-up, 17-year-old Avery mentions that they're beginning to dread going to school. You check in about a variety of potential mental health concerns. They seem disconnected, like something's just "off," so you have them fill out the PQ-16, a self-report psychosis risk screen. Avery indicates feeling like they're not always in control of their own ideas and thoughts, so you ask them to tell you more about this experience. Avery says, "I know this probably sounds weird, but I think other people may be able to read my mind, especially if I'm thinking about something violent or embarrassing." When you ask them if they do anything differently because of this, they say, "I look around to see if anybody's looking at me weirdly, and I try to make my mind blank."

EXPERIENCE: *Avery thinks that others may be able to know/access the content of their thoughts telepathically, not just based on their facial expressions or body language (THOUGHTS).*

IMPACTING: *Avery is checking whether people around them seem to be reacting to their thoughts, and is trying to change their thoughts to prevent their being read.*

PROGRESSING: *It's clear this is RECURRENT but they're also beginning to dread going to school, signaling a growing impact on functioning.*



THOUGHTS CIRCLE OUTSIDE MY REACH

While seeing 15-year-old Lee, you noticed she kept asking you to repeat your questions. You commented that this seemed unusual for her, and asked her to tell you more about what was going on for her that she was having trouble taking in or holding onto your questions. Lee said, "I know, I'm sorry. It seems like I'm thinking and then I'm not. Words float around insensibly. Clouds float too. Minds are not what they used to be. I feel like I can't explain myself well anymore. After 10 seconds no trace ideas of where I was going. Thoughts circle outside my reach." You ask if anyone else has noticed. "My English teacher. My last paper, she couldn't follow. I have to rewrite it."

EXPERIENCE: *Lee is demonstrating disorganization in her SPEECH that suggests an underlying thought disorder. Importantly, this is new, not part of a longstanding attentional or language disorder. Difficulty following conversations, losing her train of thought and putting words together in an unusual way that is hard to follow, are all examples of this. English teachers may be the first to pick up on this, and asking to see someone's writing can be very helpful in grasping the extent of this difficulty.*

IMPACTING: *Lee's trouble following conversations and expressing herself is clearly affecting her ability to interact with you. The disorganization in her thinking and writing is impacting her schoolwork.*

PROGRESSING: *This is new since you last saw her.*



THINGS FEEL UNREAL

During his annual physical, 15-year-old Tariq mentioned that he's worried about his mind. His dreams sometimes seem really vivid, to the point that he's unsure if something actually happened. You encourage him to tell you more about this experience, and Tariq says, "It's really weird; it's like I don't always know what's real anymore. I've mentioned things to friends a couple of times and they have no idea what I'm talking about. It must just be something that happened in a dream." As part of gathering more information, you also ask, "Has this been getting worse?" Tariq says, "Yeah, even though it started when I was little, it seems more real over the past few months. I just keep getting confused whether something really happened or not."

EXPERIENCE: *Tariq is experiencing difficulty knowing the difference between what is real and what is not, a hallmark of psychosis risk/early psychosis (THOUGHTS).*

IMPACTING: *At times, he needs input from other people in order to determine whether a thought/experience is reality-based.*

PROGRESSING: *Tariq is finding this increasingly difficult.*

COULD THIS BE DEPRESSION? ANXIETY? ADHD?

Keep psychosis in the differential – seek consultation if there is any doubt. Early detection of psychosis and serious mental illness, more broadly, is complicated by a number of factors.

First, psychotic and psychotic-like symptoms are much more common than psychotic disorders, particularly in children and adolescents. They often require specialized assessment and time to judge their significance as indicators of risk for a future disorder.

Second, symptom presentations evolve over time, such that what may at first appear to be an anxiety disorder may eventually emerge as schizophrenia. Similarly, psychotic and psychotic-like experiences may be brief and remitting or intermittent, initially suggesting an imminent acute psychosis or psychotic disorder but with time being better understood as, for instance, panic, OCD, or substance-induced psychosis.

Third, although there are some very common early symptoms of major psychotic disorders, the early course of schizophrenia and related disorders is quite varied. In most young people, acute psychotic symptoms are preceded by “negative” or “non-specific” symptoms such as amotivation, challenges with attention and learning, and social withdrawal. Only a subset of youth who develop major mental illness experience psychotic symptoms in the absence of negative or non-specific symptoms.

Fourth, comorbidity should be expected. In addition to assessing “either/or” differentials, clinicians should consider “both/and” possibilities. Young people can have both PTSD and schizophrenia, both OCD and Delusional Disorder, both Cannabis Use Disorder and Bipolar I Disorder. In many cases, one disorder may increase the risk of a subsequent or comorbid disorder.

Despite some of these challenges, clinicians should remember that psychotic and psychotic-like symptoms are associated with higher risk for poor functional outcomes, including suicide. Diagnostic ambiguity and uncertainty about future clinical course are part of early detection and are not cause for inaction.

WHEN CONSIDERING DIFFERENTIAL DIAGNOSES, THE FOLLOWING QUESTIONS MAY BE HELPFUL:

- *How consistent is the person’s experience with the range of experiences considered typical for a particular disorder?*
- *Does the individual describe their experiences in ways that suggest some break from a longstanding disorder?*
- *What is the temporal relationship between different symptom clusters? For instance, do symptoms emerge only in the context of a significant stressor or substance use? Are there inconsistencies over time? Are there any examples of one in the absence of the other?*

Research into early trajectories is ongoing, and as our level of understanding deepens, so will our diagnostic acuity. The following cases highlight some common diagnostic challenges and features relevant to differential diagnosis. Importantly, they serve as examples, not an exhaustive guide; please seek consultation around challenging diagnostic questions.

CASE EXAMPLES

CHALLENGING DIFFERENTIAL DIAGNOSES

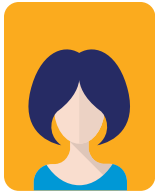


INATTENTION/HYPERACTIVITY

Aaron's step-father brings him in for an appointment at the request of staff at his school, who have reported that 12-year-old Aaron's behavior is increasingly erratic and disorganized. School staff report that Aaron struggles to stay on topic while talking, jumping around between ideas in ways that do not make sense to others and make it difficult to follow him. Aaron's school also reports that frequently, his behavior and affect are silly, inappropriate for a given situation, and disruptive to the class. When you ask about any other difficulties, Aaron's step-father explains that when he tries to help Aaron with his homework, it's as if he's not taking in or remembering written material. You've known Aaron for several years, and although he's always been a bit of a spacey kid, he liked to read and had done okay in school. You wonder if he has ADHD that's only evident now in the context of increasing academic demands. You ask him if he thinks he'd have a harder time this year doing last year's work and he says yes. He denies substance use or feeling depressed and he is not distracted by a specific stressor, but he feels like his mind isn't working quite right.

Challenges with attention and executive functioning such as those seen in Attention Deficit/Hyperactivity Disorder (ADHD) are very common in psychotic spectrum illnesses. In fact, many individuals who later develop psychotic disorders were diagnosed with ADHD as children. Emerging psychosis should be considered in the differential diagnosis for new or worsening attentional or executive functioning challenges, particularly when a child is presenting for the first time in early or late adolescence or has a family history of psychotic illness. This is particularly important because stimulant prescription in these youth can trigger psychosis. Consultation with a neuropsychologist familiar with the early course of psychotic disorders is recommended for any atypical presentation, new adolescent referral, or child with a family history of psychosis.

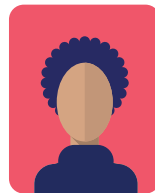




SOCIAL ANXIETY

While in your office to get her flu shot, 13-year-old Davina mentions that she's been spending more time alone than she did last semester. When you ask her why that is, she says she's been feeling really nervous and uncomfortable around people. You encourage her to tell you more about this experience, and Davina says, "I just keep wondering what people are thinking about me, if they think I look stupid or am saying something lame. I'm always worried that I'm going to embarrass myself. I've sort of worried like this for a couple of years, but it seems like it's just getting worse."

When a young person's discomfort in social situations is related to concerns that they will be judged, negatively evaluated, or feel ashamed/humiliated, it is most likely best explained by social phobia; here, Davina is nervous around others because she is worried that she will look bad or embarrass herself. If she was feeling unsafe (without an actual threat or source of danger), or felt that others were harboring ill will or intending to harm her, this would raise concern about psychosis or psychosis risk.



TRAUMATIC STRESS RESPONSE

Last week, Courtney told you she's been feeling off the last several months, like weird things are happening and she feels distant from herself. When you give her the PQ-16, she checks off that she's seen things that other people apparently can't see. You encourage Courtney to tell you more about that experience and she says, "Sometimes I think I see figures that look like people, always men, out of the corner of my eye and wonder if they're following me. I get really nervous and have to turn and check; I have to make sure I'm alert so no one messes with me." You ask Courtney to tell you more about when the experience first began, and she says, "It's been happening ever since a guy took advantage of me after a party last year. But it seems weird that it keeps happening."

Courtney's experiences are pretty consistent with hypervigilance and detachment following a traumatic event. Coupled with the fact that this experience began after she was assaulted, Courtney's presentation is probably best explained as a possible traumatic stress response rather than psychosis risk. However, due to the level of comorbidity between PTSD and psychosis, and the fact that Courtney thinks her own response is "weird," continued psychosis risk monitoring is indicated.

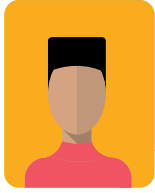


SUBSTANCE USE

Becca, age 17, is brought in by her mother after several incidents of behaving oddly. Her mom describes her laughing inappropriately, talking about seeing dancing shapes in the air in front of her, and asking whether family members were real or imposters. The last time this happened, she ran from the home and her family was unable to locate her for hours. They almost called the police. Although they thought she must have been on some type of drug, Becca denied any drug use, telling them that a kid acting weird doesn't have to mean she is on drugs. When you meet with Becca alone, you ask her to tell you more about these experiences.

She says they're "weird," and that she gets really confused, but that she's always back to herself after a few hours. You ask Becca what she makes of these experiences, and she says she's not sure. You know that Becca's family strictly prohibits any substance use, so you explain to Becca that there are special laws to protect her privacy around substance use and treatment, and that you will not tell her parents if she is using substances unless her use is extremely dangerous. She discloses that she is smoking marijuana with friends and confirms that every incident her mother reported occurred after smoking for several hours. Further questioning reveals no psychotic-like experiences outside the context of cannabis.

Considering the temporal relationship between her marijuana use and these experiences, Becca's behavior is consistent with the effects of cannabis. A detailed timeline of use and symptom onset/occurrence is often necessary to differentiate a psychotic disorder from the effects of substances (such as cannabis) known to elicit psychotic-like symptoms. If psychotic-like symptoms preceded substance use, occur during sufficient periods of abstinence, or linger after the effects of the substance would be expected to remit, a psychotic disorder is more likely. Whenever possible, the young person should be urged and helped to maintain a period of abstinence to see if symptoms remit. Recent research suggests that psychotic-like experiences in the context of cannabis use may be associated with a higher risk for developing a psychotic disorder. Becca should be counseled that cannabis may be a particularly risky substance for her to use and that her "weird" experiences could progress into something less temporary and more debilitating.



DEVELOPMENTAL CONCERNS

At a recent appointment, Eddie's grandmother mentioned that he's been struggling since transitioning to fifth grade last fall. You know he has a history of being socially awkward, making little eye contact, misreading nonverbal cues, talking endlessly about rockets and space, and often ending conversations abruptly if others tried to change the topic. Eddie has been easily overwhelmed by loud noises, bright lights, and sudden change since he was a toddler. He has meltdowns at school when he becomes overstimulated, including yelling and flapping his hands. Since he was an avid reader and did fairly well in classes, he never received special services. According to Eddie's grandmother, his teachers have reported lately that he's struggling even more than usual, and that he often talks to himself when upset. When you speak with Eddie about school, he says he doesn't like people at school because they don't like rockets. You note, "Your grandmother told me that you seem to be talking to yourself a lot." He says, "I talk to myself because it makes me feel better." When you ask, "Do you ever talk to someone or something that no one else knows is there?" He looks at you with a puzzled expression, "No, I just talk to myself."

Eddie is not actually responding to internal stimuli, but is talking to himself to help with affect regulation. The differential of psychosis and autism spectrum disorder (ASD) and other developmental disorders can be challenging because schizophrenia and related disorders are also neurodevelopmental disorders. Early childhood delays or deficits in the development of social, motor, cognitive, and language skills are not uncommon. However, Eddie's challenges are very consistent with ASD, exacerbated by age and increased social demands. Whereas new anxiety in social situations and difficulty filtering and tolerating environmental stimuli can be signs of an emerging psychotic disorder, they are also common in ASD. It is important to inquire about psychotic-like experiences when there are marked changes such as those Eddie is experiencing, but in the absence of more specific psychotic thought content or trouble with reality testing, referral to or consultation with a developmental disorder clinic is the best next step.



OBSESSIVE THOUGHTS/COMPULSIONS

After observing an unexplained decline in sleep, mood, and ability to get up for work over your last couple of appointments, you decide to ask Ramon, age 16, to fill out the PQ-16. He endorses feeling like he's sometimes not in control of his own ideas or thoughts. You ask, "How so?" and Ramon elaborates, "Sometimes I have these bad thoughts and I don't know why; I know they are just in my own head, but I don't want to have them and they make me feel a little crazy." You explain that unwanted thoughts, especially embarrassing ones, are quite common, and ask him if he can be more specific. "These thoughts that I like child porn and am going to become a pedophile and end up making child porn keep popping into my head from nowhere. I keep thinking they are true. It's horrible. I have to say five prayers in a row before I feel better."

Ramon has intrusive thoughts that he cannot control, but these types of thoughts are consistent with OCD, particularly given that he tries (and is able to) neutralize his anxiety with a repetitive behavior. Importantly, however foreign the thoughts, he knows that they are his own. If Ramon thought that these thoughts were coming from outside himself or his head, or that an external person or force was interfering with his thinking, this would be more consistent with a delusional thought and psychosis. The differential between OCD and psychosis is particularly tricky as people may have no insight in OCD, and having obsessions or OCD is associated with higher risk for psychosis. Obtaining a consultation from an OCD and/or psychosis specialist is advised if there is any concern that a person's experience is not fully accounted for by OCD.



**DID
YOU
KNOW?**

Roughly 80% of those with a psychotic disorder have another comorbid, mental illness. –Kessler et al., 2005

TO CHOOSE THE APPROPRIATE PATH, CONSIDER:

1. CONSULTING WITH AN EXPERIENCED MENTAL HEALTH CLINICIAN WHO HAS:

- Knowledge of the age group and any other relevant features (cultural, special populations, such as developmentally-disordered adolescents)
- Knowledge and experience with psychosis, particularly the early signs
- Good skills in differential diagnosis

2. CONSULTING ONE OF THE FOLLOWING SPECIALIZED RESOURCES:

***Massachusetts Child Psychiatry Access Project
(MCPAP)***

**Ages: All pediatrics
mcpap.com**

***Center for Early Detection, Assessment, and Response to Risk
(CEDAR)***

**Ages: 12-35
cedarclinic.org**

***Massachusetts Psychosis Network for Early Treatment
(MAPNET)***

**Ages: 14 and older
mapnet.online/program-directory**

3. REFERRING THE PATIENT FOR A COMPREHENSIVE PSYCHOLOGICAL, MEDICAL, NEUROPSYCHOLOGICAL, AND/OR NEUROLOGICAL EVALUATION as indicated by complexity, timing, family history, or symptom combination, details, or atypicality.

For specific medical considerations, see pages 29-31.

For updated materials and additional resources, please visit psychosisscreening.org

MEDICAL WORKUP CONSIDERATIONS

MEDICAL CONDITIONS ASSOCIATED WITH PSYCHOSIS:

Many medical conditions can lead to psychotic symptoms – too many to include a detailed review here. A consultation with MCPAP or other psychiatric service provider is recommended to consider which tests or assessments may be indicated. See also the list of resources at the end of this section.

Importantly, medical conditions or drugs may not only directly lead to the onset of psychotic-spectrum symptoms but can also trigger the onset of symptoms in individuals already vulnerable to psychosis (e.g., genetics, early central nervous system [CNS] insults, etc.). CNS insults associated with higher risk for psychosis include obstetrical complications, in utero toxic exposures, and traumatic brain injury.

Condition	Examples
Delirium	Sleep deprivation, Serum electrolyte abnormalities, Sepsis
Seizure Disorders	Particularly temporal lobe
Central Nervous System Lesions	Brain tumors, Head trauma, Congenital malformations
Infections	Encephalitis, Meningitis
Nutritional	B1, B3, or B12 deficiency, Hypocalcemia, Hypomagnesemia
Metabolic Disorders	Hypoglycemia, Uremia, Acute intermittent porphyria
Endocrine Disorders	Cushing Disease, Diabetes mellitus, Thyroid disease
Genetic Syndromes	Wilson's, Huntington's
Autoimmune Disorders	Lupus, Multiple sclerosis, Anti-NMDA receptor or other encephalitis
Toxic Exposures	Carbon monoxide, Organophosphates, Heavy metals
Pharmacologic	Stimulants, Cannabis, Dextromethorphan, Lysergic acid, Diethylamide, Hallucinogenic mushrooms, Psilocybin, Peyote, Solvents and inhalants, Serotonin syndrome

TIPS FOR DIFFERENTIAL DIAGNOSIS:

- 1) Symptoms due to intoxication typically have an abrupt onset in the context of substance use and resolve within days to weeks of drug discontinuation.
- 2) Isolated symptoms (e.g., hearing voices), in the absence of depression, anxiety, decline in function, or of familial psychiatric illness are less likely to indicate a serious illness.
- 3) Visual hallucinations in conjunction with neurologic signs, headache or seizures are more consistent with a neurologic disorder.
- 4) Consciousness and awareness are usually, if not always, intact in major psychotic disorders such as schizophrenia, bipolar disorder, schizoaffective disorder, etc.
- 5) Consider the pattern of onset:
 - a. Acute onset (days or weeks) may be more likely to be associated with drug effects, infection, or other specific medical states. It may also be associated with psychiatric states resulting from discrete stressors. More rapid onset is also more typical of major depressive disorder or bipolar disorder (versus schizophrenia), particularly as mood symptoms intensify.
 - b. Subacute onset (less than 12 weeks) may also be associated with neurological or medical illnesses (e.g., autoimmune encephalitis, which is uncommon but requires immediate assessment and treatment).
 - c. Insidious or more gradual onset is more frequently seen in schizophrenia and more characteristic of child or adolescent onset. This is considered one of the reasons that accurate diagnosis is often delayed years in this age group, with unfortunate long-term consequences.

RECOMMENDED MEDICAL WORKUP FOR FIRST PRESENTATION OF PSYCHOTIC SYMPTOMS:

1

CAREFUL HISTORY

- Temporal pattern of onset of psychiatric symptoms
- Recent drug ingestion, infectious disease, head injury, or seizure
- New or worsening headaches
- Family history of psychiatric disorders (Review of specific symptoms and treatment may be needed to identify history of psychosis; see questions on page 11)
- Collateral history from family to clarify behavioral changes and timeline
- Suicidal or violent thoughts and actions

2

PHYSICAL EXAMINATION

- Mental status, including cognitive functioning
- Neurological examination; note emergence of new signs or symptoms, subtle involuntary movements
- Signs of fever, endocrinopathies, metabolic illness
- Tachycardia or severe hypertension

3

LABORATORY STUDIES

- CBC with differential to consider possible infectious illness
- Comprehensive metabolic panel, including:
 - Electrolytes – Na, K, CO₂, Chloride
 - Glucose
 - BUN
 - Creatinine
 - Albumin, Total Protein
 - Ca, Mg
 - Alkaline phosphatase (ALP)
 - Alanine amino transaminase (ALT or SGOT)
 - Aspartate amino transaminase (AST or SGOT)
 - Bilirubin
 - Parathyroid hormone
 - Vitamin B12, Folate, Niacin
- Urine toxicology
- Imaging and EEG are not indicated in the absence of specific indicators (new, severe, unremitting headache, focal neurological deficits, or history of recent head trauma)
- Further assessment if initial observations and studies suggest pathology

BASELINE STUDIES PRIOR TO INITIATING ANTIPSYCHOTIC MEDICATIONS:

- Lipid profile, fasting
- Glucose, fasting
- Height, weight, body mass index, waist circumference
- Comprehensive metabolic panel

PATH 1

REASSURE & REDIRECT

Patients may present with symptoms that, while initially appearing to indicate concern for psychosis risk, are ultimately determined to not be psychotic-like or to be better explained by something else. Such cases may include:

1. A patient whose **EXPERIENCE** is consistent with cultural/familial norms
2. A patient whose **EXPERIENCE** is consistent with their developmental stage (e.g., daydreaming, imaginative play/friends)
3. A patient whose **EXPERIENCE** is consistent with other mental/medical health diagnoses (e.g., social anxiety, obsessive compulsive disorder, acute stress, a substance use disorder, brain injury)

When any of the above are true, consider the following steps:

- **REASSURE THE PATIENT, AS APPROPRIATE.**

Help them put their experience in context, and let them know that they are not alone. Provide education to the patient and family about relevant mental health concerns contributing to their experience; instruct them to reach back out if the experience becomes distressing or affects their behavior (**IMPACTING**), happens repeatedly (**RECURRING**), or seems to be getting worse in any other way (**PROGRESSING**).

- **REDIRECT THE PATIENT TO RELEVANT EDUCATIONAL OR MENTAL HEALTH RESOURCES**

appropriate to any clinically meaningful symptoms and experiences. These may include specialized care (e.g., an anxiety specialist, trauma informed care, neurology). See page 37 for a list of specialized mental health resources available in Massachusetts.



CULTURAL/FAMILIAL NORMS

During her annual physical, Marie tells you she sometimes speaks to people who are not physically there. When you ask her more about this, Marie shares that her church teaches that the spirits of deceased relatives provide protection and guidance to those still living. Marie's mother confirms that this belief is shared by the rest of the family.

You might respond to Marie: "I'm glad that you can get comfort from your relatives. Are things feeling overwhelming right now?" If yes, or there is reason for concern that she may not be coping well, "Would it help to maybe talk with a counselor who is trained to teach people skills to get through tough times?" Consider culturally acceptable and sensitive options for additional education, support, or therapy.

**DID
YOU
KNOW?**

7.5% of teenagers and 17% of children have psychotic-like experiences. -Kelleher, 2012



PATH 2

MONITOR & EDUCATE

Young people may present with notable risk factors or warning signs that don't (yet) reach a threshold for a psychosis-specific assessment or intervention. Since this is a tricky call, do not hesitate to seek consultation on this. Primary examples include:

1. A patient whose **EXPERIENCE** appears to have mild, vague, or questionably psychotic-like content, but is not **IMPACTING, RECURRING, or PROGRESSING**.
2. A patient with a **close biological relative** (typically first- or second-degree) who has been diagnosed with a psychotic-spectrum illness (e.g., schizophrenia, schizoaffective disorder, bipolar or major depressive disorders with psychotic features).

Consider the following steps:

MONITOR THE PATIENT'S SYMPTOMS AND SCREEN FOR ADDITIONAL PSYCHOTIC-LIKE EXPERIENCES

If a patient has mild or vague psychotic-like experiences with no other risk indicators, make a note to check in about these symptoms at your follow-up appointments and actively screen for other psychotic-like experiences (see monitoring options outlined below). For those with familial risk, regular monitoring of mental health and functioning may help detect any early warning signs. Even mild warning signs are more concerning in these patients. The monitoring options outlined below may help to identify undisclosed internal experiences or track changes in functioning.

EDUCATE THE PATIENT AND FAMILY ON WHEN TO SEEK FURTHER HELP

Although these patients may not be at imminent risk for psychosis, they are at increased long-term risk compared to the general population. In many cases, these patients are quietly worried that they may develop a major mental illness; talking about their worries may provide opportunity to reassure them that it is much more likely that they will not develop a serious disorder than that they will, and that caught early, symptoms are much more treatable than they used to be. This can also be an opportunity to let them know you will check in regularly so that any early symptoms can be treated quickly and they will have a good chance of recovery. Educate the patient and family on general mental health resources, and direct them to call if an experience becomes distressing or affects their behavior (**IMPACTING**), happens repeatedly (**RECURRING**), or gets worse in any other way (**PROGRESSING**).

MONITORING SYMPTOMS, BEHAVIOR, & RISK

When monitoring patients presenting with mild symptoms and/or asymptomatic familial risk, it's important to be thoughtful and thorough without raising alarm or rushing to conclusions. Here are some general guidelines for how often to assess this population for psychosis risk concerns:

Mild, vague, or questionable symptoms occurring less than once a month

Asymptomatic relatives of individuals with suspected psychotic disorders

Reassess and screen for psychotic-spectrum symptoms **every 12 months**, and sooner if they increase in intensity or frequency.

Mild to moderate but non-impactful symptoms occurring more than once per month

Familial risk plus a marked change in cognitive, social, or academic functioning

Consider reassessment and/or additional screening **every 6 months**.

Instruct patients and families to be in touch if they experience or observe a meaningful change. As appropriate, educate about what changes (**IMPACTING, RECURRING, or PROGRESSING**) might warrant attention before the next scheduled appointment.

Complex or diagnostically ambiguous presentations that trigger clinical concern but might easily resolve with time (e.g., concurrent substance misuse in someone willing to try abstinence)

Moderate to severe symptoms in someone awaiting mental health assessment or treatment

Consult with MCPAP, CEDAR, or other mental health provider.

Reassess and screen in **1-3 months**, depending on significance of symptoms and availability of mental health providers.



FAMILY HISTORY

Destiny is a sophomore in high school whose grades have been in the B-range since she was in elementary school. She isn't highly social, but plays in her school's marching band and has a small, close group of friends she sees outside of school about once per week. Three years ago, Destiny's older brother was diagnosed with schizoaffective disorder.

She would be appropriate to Monitor and Educate.

EDUCATIONAL RESOURCES

GENERAL MENTAL HEALTH WEBSITES SPECIFICALLY FOR YOUNG PEOPLE:

Voices4Hope.net OK2Talk.org
Headspace.org.au ULifeline.org

NATIONAL ALLIANCE ON MENTAL ILLNESS (NAMI) HAS A NUMBER OF EDUCATIONAL MATERIALS, INCLUDING SLIDESHOWS, VIDEOS, AND FACT SHEETS:

Programs & Support Groups:
NAMI.org/Find-support/NAMI-Programs

For Teens & Young Adults:
NAMI.org/Find-Support/Teens-Young-Adults

How to Talk to Youth about Mental Health:
NAMI.org/Extranet/Say-It-Out-Loud

NAMI In Our Own Voice: For the general public to promote awareness of mental illness and the possibility of recovery:
NAMI.org/Find-Support/NAMI-Programs/NAMI-In-Our-Own-Voice

NAMI Competent Caring: Presentation for people who work directly with individuals living with mental illness in a hospital or health care setting:
NAMI.org/Find-Support/NAMI-Programs/NAMI-Provider-Education/Competent-Caring-When-Mental-Illness-Becomes-a-Tr

Anti-stigma:

BringChange2Mind.org

Websites for Recovery in Serious Mental Illness:

ChoicesInRecovery.com



Almost half of adults will experience a mental illness in their lifetime.
-Kessler et al., 2003



ANCILLARY TREATMENT & ASSESSMENT RESOURCES

DEVELOPMENTAL CONCERNS

Lurie Center for Autism

All ages

(781) 860-1700

massgeneral.org/children/services/treatmentprograms.aspx?id=1614&display=overview

Autism Spectrum Center

Infant to young adult

(617) 355-7493

childrenshospital.org/centers-and-services/programs/a_-_e/autism-spectrum-center-program

INATTENTION/HYPERACTIVITY

College Learning Disorders/ADHD Clinic at Tufts Medical Center

All ages

(617) 636-0219

tuftsmedicalcenter.org/patient-care-services/Departments-and-Services/Psychiatry/Clinical-Care-Services/College-Learning-Disorders-ADHD-Clinic

Learning & Emotional Assessment Program (LEAP) at Mass General Hospital

Ages 2 – 22

(617) 643-6010

massgeneral.org/neuroscience/services/treatmentprograms.aspx?id=1972&display=overview

ANXIETY & OCD

Center for Anxiety and Related Disorders (CARD) at Boston University

Ages 3+

(617) 353-9610

bu.edu/card

McLean Anxiety Mastery Program

Ages 7 – 19

(800) 333-0338

mcleanhospital.org/programs/mclean-anxiety-mastery-program

OCD Institute Jr.

Ages 10 – 18

(877) 241-7670

mcleanhospital.org/programs/ocd-institute

Pediatric OCD and Tic Disorders Program at Mass General Hospital

Up to age 18

(617) 726-6766

massgeneral.org/psychiatry/services/treatmentprograms.aspx?id=2022&display=pediatric

SUBSTANCE USE

Adolescent Substance Use & Addiction Program (ASAP) at Boston Children's Hospital

Up to age 24

(617) 355-2727

childrenshospital.org/centers-and-services/programs/a_-_e/adolescent-substance-abuse-program

Addiction Recovery Management Service at Mass General Hospital

Ages 14 – 26

(617) 643-4699

massgeneral.org/psychiatry/services/treatmentprograms.aspx?id=2090&display=overview

TRAUMA

The Trauma Center at Justice Resource Institute

All ages

(617) 232-0687

traumacenter.org

Children's Charter

All ages

(781) 894-4307

key.org/programs/childrens-charter

GENERAL MENTAL HEALTH RESOURCES

Massachusetts Child Psychiatry Access Project (MCPAP)
Ages: All pediatrics
mcpap.org

Massachusetts Behavioral Health Partnership (MBHP) Emergency Services Program
All ages
1-877-382-1609
masspartnership.com/esp

PATH 3

SPECIALIZED ASSESSMENT & TREATMENT

Any concern about a possible underlying psychotic process should trigger a referral for psychosis-specific assessment and treatment. We specifically recommend this for patients who have the following, particularly in combination:

1. The patient discloses, or you observe:
 - a. **ATYPICAL** perceptual experiences or hallucinations
 - b. **THOUGHT** disturbance or delusions
 - c. **SPEECH** or behavior that is disorganized
2. The patient's psychotic-like **EXPERIENCE** is either **IMPACTING, RECURRING,** or **PROGRESSING**

Because evidence supports the use of specialized interventions with youth at imminent risk, we recommend referral to a specialized service that can conduct appropriate assessment and consult on treatment options. Information about area services is available on page 39. Additional services may be helpful for addressing a young person's life goals; many specialized programs offer comprehensive services.

CONSULT WITH AN EARLY PSYCHOSIS SPECIALTY SERVICE TO IDENTIFY BEST OPTIONS

Early consultation with a specialized service can provide guidance on managing a patient's mental health care while waiting for an assessment.

REFER THE PATIENT TO SPECIALIZED ASSESSMENT

A structured interview conducted by a highly trained clinician is essential to careful assessment of psychotic symptoms and psychosis risk, including imminent risk for developing a psychotic disorder.

REFER THE PATIENT TO SPECIALIZED TREATMENT

Individuals with acute psychosis or at imminent risk should be offered specialized treatment, as available. Specialized treatment programs typically serve either acutely psychotic or at-risk individuals, but not often both. However, distinguishing between those at very high risk and those newly psychotic is not easy. Let CEDAR or a similar resource help (e.g., mapnet.online/program-directory).

Generally speaking, the key difference between psychosis risk and fully psychotic symptoms is insight—patients who maintain insight into the fact that their experiences are not real are not considered "fully psychotic." Depending on their exact symptom picture, however, they may be at "imminent risk." Patients who completely believe that their experiences are real, or who have displayed dangerous or grossly disorganized behavior specifically related to their psychotic-spectrum symptoms, are typically considered fully psychotic.

MANAGE PSYCHOSIS OR PSYCHOTIC-LIKE SYMPTOMS WITHIN YOUR INTEGRATED PRACTICE

In some cases, it may be appropriate or necessary to assess and treat patients with psychotic symptoms internally; this may be because you/your practice are equipped to do so, or because a patient is unwilling or unable to utilize specialized treatment. Some considerations and best practice guidelines are outlined on page 40.

PSYCHOSIS-SPECTRUM ASSESSMENT & TREATMENT OPTIONS

BOSTON CHILDREN'S HOSPITAL DEVELOPMENTAL NEUROPSYCHIATRY CLINIC

**Ages: <18 and signs of possible
risk or clearly psychotic**

childrenshospital.org

**Contact: Eugene D'Angelo, PhD
(617) 355-7650**

The Developmental Neuropsychiatry Clinic (DNP) within the Outpatient Psychiatry Service at Boston Children's Hospital provides diagnostic evaluation, treatment, and consultation for children and adolescents who are presenting with symptoms such as disordered thinking, hallucinations, unusual suspiciousness about the intentions of others, and/or questions of possible psychosis. The clinic will accept referrals of children (generally 4-17 years old) and their families.

CENTER FOR EARLY DETECTION, ASSESSMENT, AND RESPONSE TO RISK (CEDAR)

**Ages: 12-35 and signs of
possible risk**

cedarclinic.org

**Contact: Megan Graham, LMHC
(617) 754-1223**

CEDAR provides assessment through both an outpatient clinic and research studies. Assessment and treatment are available through the CEDAR clinic for individuals identified as at clinical high risk for psychosis through either a research or clinic evaluation and found appropriate for CEDAR services and level of care. Through CEDAR's research studies, young people receive diagnostic interviews, are reimbursed for their time, and families can be reimbursed for parking and some travel expenses.

For patients who have severe and/or sustained psychotic symptoms, please contact:

MASSACHUSETTS PSYCHOSIS NETWORK FOR EARLY TREATMENT (MAPNET)

Ages: > 14 and clearly psychotic

Contact: mapnet.online/program-directory

MAPNET is dedicated to the early detection and treatment of mental illness. It is a Technical Assistance Center with the goal of connecting and supporting First Episode Psychosis service providers in Massachusetts. Here, you can find a list of first episode/early psychosis programs in the state, including information on location, contacts, accepted insurance, and eligibility.

MANAGING EARLY PSYCHOSIS WITHIN INTEGRATED PRACTICES

Responding to symptoms of psychosis and psychosis risk in an effective, balanced way, one that neither under- nor over-reacts to a patient's experiences, typically requires specialized training. To assess your practice's capacity to provide appropriate care, we recommend you consider the degree to which you have staff who:

- Are knowledgeable about psychotic/psychosis risk symptoms and best practices
- Are able to provide thorough, targeted assessment of psychotic/psychosis risk symptoms and common comorbid or differential diagnoses
- Have access to consultation/supervision with colleagues knowledgeable about psychotic/psychosis risk symptoms and best practices

CURRENT EVIDENCE AND PROFESSIONAL GUIDELINES SUPPORT:

- Specialized, comprehensive assessment of symptoms and potential differential diagnoses using a validated structured interview such as the Structured Interview for Psychosis-Risk Syndromes (SIPS) or the Structured Clinical Interview of DSM-5 Disorders (SCID-5)
- Psychoeducation about psychotic and psychosis risk symptoms, expectation of recovery with treatment, biosocial model for understanding risk and protective factors, both pharmacological and psychosocial treatment options, including options for families and peer, educational, and occupational support
- Having direct conversations about patients' and families' concerns, acknowledging and addressing stigma around psychosis spectrum illnesses, addressing familial and cultural beliefs about mental health and illness, and providing hope and a recovery perspective
- Targeting both psychotic and non-psychotic symptoms and life goals with therapeutic treatment modalities such as Cognitive Behavioral Therapy, Family Focused Therapy or Multifamily Psychoeducation, Social Skills Training, Cognitive Enhancement Therapy, Supported Employment or Education, and Acceptance and Commitment Therapy
- Psychopharmacological evaluation and monitoring as needed and acceptable to the youth and family
- Psychoeducation and support around pertinent lifestyle factors, including stress management, substance use, sleep hygiene, and nutrition/physical activity
- Regular assessment and monitoring of risk for violence toward self or others

With the proper training and resources, the integrated care setting may be ideal for reducing stigma and addressing psychotic spectrum experiences within the context of an individual's overall health and wellbeing.

RESOURCES FOR PATIENTS AND FAMILIES

Information about psychosis and its early warning signs is often absent from mental health educational resources, in spite of the fact that the earliest signs of severe mental illnesses typically emerge during childhood or adolescence. Increasing awareness, challenging stigma, and motivating early help-seeking with dialogue and hope are important to prevention and early intervention.

A FEW WEB-BASED RESOURCES ON PSYCHOSIS, SCHIZOPHRENIA, EARLY INTERVENTION, ETC.:

strongmindsproject.chantelgarrett.com – Support for young people by young people.

CEDARclinic.org – Basic definitions of psychosis, sample symptoms, signs of risk, and resources for clinicians, individuals, and families, including clinical and research opportunities. CEDAR clinicians are available to come to speak with primary care and behavioral health staff to enhance education about psychosis.

CEDARclinic.org/index.php/more-information/resources-and-links

Schizophrenia.com – Fairly comprehensive source of information on schizophrenia, early intervention, risk factors, treatments, and resources, including videos.

Schizophrenia.com/video/videofam.htm#szfamily

NASMHPD.org – Webinars and online trainings, links to research programs, and psychoeducational materials for clinicians, patients, and families.

NASMHPD.org/content/early-intervention-psychosis-eip

HANDOUTS FOR PATIENTS & FAMILIES:

Psychosis Fact Sheets (English & Spanish): NAMI.org/learn-more/fact-sheet-library

Psychosis Fact Sheet for Young Adults: store.samhsa.gov/system/files/sma16-5006.pdf

Psychosis Fact Sheet for Caregivers: store.samhsa.gov/system/files/sma16-5005.pdf

Caregiver & Family Guidelines: CEDARclinic.org/index.php/more-information/resources-and-links/for-families/handouts-for-understanding-and-managing-psychosis

MANAGING SYMPTOMS AND RECOVERY:

ChoicesInRecovery.com/about/documentary

BringChange2Mind.org

mentalhealthrecovery.com

bu.edu/cpr

StrengthofUs.org

PATH 4

SAME-DAY ASSESSMENT

Psychotic and psychotic-like symptoms, by themselves, do not necessarily indicate a safety concern. However, the following should prompt a careful safety assessment, and possible **call to a mobile crisis team** or recommendation that the family **bring the child to a Psychiatric Emergency Room:**

1. The patient has active or difficult-to-manage suicidal/violent thoughts or impulses.
2. The patient reports current or recent **command hallucinations** telling them to hurt themselves or someone else. The degree of risk will depend on:
 - What the commands are
 - How compelling they are
 - How specific they are
 - Whether the patient has acted on them before
 - The patient’s ability to dismiss or reliably manage them
3. The patient is significantly out of touch with reality for more than several minutes at a time and not actively engaged with mental health provider(s) helping them manage this.
4. The patient’s behavior is severely disorganized or dangerous.

For those who experience psychosis symptoms with violent content, helpful initial interventions may include:

- Reinforcing the client for sharing these experiences with you
- Noting they are more common than often believed
- Emphasizing that this is a temporary experience for most people
- Gathering details with existing violence/ suicide assessment tools and models
 - **Suicidality:** SAFE-T, CSSRS, MCPAP Screening Resources
 - **Violence:** V-RISK 10, Structured Assessment of Violence Risk in Youth (SAVRY)
- Asking follow-up questions to explore the client’s:
 - Emotional reactions
 - Interpretations (particularly beliefs involving the need to act)
 - Details about previous actions in response to these symptoms
 - Coping strategies
 - Access to relevant means
 - Available supports

If you have concerns about immediate safety contact:

EMERGENCY SERVICES TEAM (EST)

Ages: All

Contact: 1-800-981-4357, available 24/7

Mobile psychiatric crisis evaluation and intervention, including referral to all levels of care. Evaluations available at a variety of community-based locations—i.e., schools, homes, outpatient clinics—as well as onsite at BEST Urgent Care Centers. Patients can be screened for a range of presenting issues including possible symptoms of psychosis, other mood/behavioral disturbances, and substance abuse.

PSYCHOSIS SCREENING TOOLS

- Prodrome Questionnaire (PQ-16)
- Yale PRIME Screen–Revised (PS-R)
- Youth Psychosis At-Risk Questionnaire-Brief (YPARQ-B)
- Prodrome Questionnaire: Brief Child Version (PQ-BC) (ages <10)

NOTE REGARDING CHILDREN <10

The prevalence of psychotic disorders in children is significantly less than in adolescents and young adults. However, awareness and assessment tools remain an important aspect of care for children with and at risk for severe mental illness. In a recent study by Kelleher and colleagues (2012), data suggest that 17% of children ages 9-12 experience psychotic-like symptoms. At this time, the screening of non-specific risk factors and symptoms, as well as more specific psychotic-like experiences, remains similar for children and adolescents, with important caveats. When evaluating children, we are careful to consider what is developmentally appropriate for the child; for example, having imaginary friends may be a typical and developmentally appropriate phenomenon for a child. Additionally, the evaluation process necessarily involves parent report and observation, more so than may be seen with adolescents or young adults.

When screening children for the possible presence of severe mental illness, we strongly encourage non-mental health professionals to refrain from offering a diagnostic statement, but rather emphasize that there is a question or concern that needs to be clarified for the child.

For additional tips on talking with a young person about whom you have concerns, see: www.cedarclinic.org/index.php/understanding-early-psychosis/dos-and-donts

REFERENCES & RELEVANT RESOURCE LITERATURE

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TIPS FOR TALKING WITH PARENTS & CAREGIVERS

LISTEN

Don't get so caught up in what you are going to say that you forget to listen carefully to what the parent is feeling, what they've noticed and are worried about, their cultural or familial context, and their understanding of and language about mental health.

Use a STRENGTHS-BASED approach

Many parents will feel responsible, guilty, afraid, or powerless; in order to help them tolerate and manage their vulnerability more productively:

- Affirm their strengths and authority
- Highlight strengths and resilience in their child

CHALLENGE STIGMA

- Have a genuine conversation about concerns
- Don't emphasize labels
- Make sure that they know that what they see on TV or in movies is not the norm
- Convey hope



EDUCATE them about Psychosis or Psychosis Risk, as appropriate

- Psychosis is a medical term for difficulty discerning what is not real from what is real
- Psychosis is treatable
- Psychosis does not define their child
- Be specific and check their understanding
- Repeat major points, if needed
- Don't overwhelm them. Focus just on what they need to know to take the next step
- Family Friendly Handouts:
<http://www.cedarclinic.org/index.php/more-information/resources-and-links/families/handouts-for-understanding-and-managing-psychosis>

BE DESCRIPTIVE about your concerns

- When adolescents/young adults have disclosed details to you, discuss ahead of time what to tell their parents, and how
- In talking to parents, be as specific as you can about what behaviors or symptoms are concerning
- Don't provide a big lead-up as if you are giving dreadful news
- Use a calm, straight-forward, "I want to look out for and do right by your child" tone: "I think it would be good to have someone who knows more about these types of experiences in children/adolescents/young adults conduct an assessment. I know a resource that has been really helpful to other young people and families. I think we should call them."

Help them EMBRACE UNCERTAINTY

- Uncertainty is an opportunity to gather additional information and provide early treatment for best outcomes
- Support getting information, but prepare them for not getting all of the answers
- Let them know that they will not be alone

THE 16-ITEM VERSION OF THE PRODROMAL QUESTIONNAIRE (PQ-16)

*If TRUE: how much distress
did you experience?*

None Mild Moderate Severe

1. I feel uninterested in the things I used to enjoy.	<input type="checkbox"/> True <input type="checkbox"/> False	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
2. I often seem to live through events exactly as they happened before (déjà vu).	<input type="checkbox"/> True <input type="checkbox"/> False	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
3. I sometimes smell or taste things that other people can't smell or taste.	<input type="checkbox"/> True <input type="checkbox"/> False	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
4. I often hear unusual sounds like banging, clicking, hissing, clapping or ringing in my ears.	<input type="checkbox"/> True <input type="checkbox"/> False	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
5. I have been confused at times whether something I experienced was real or imaginary.	<input type="checkbox"/> True <input type="checkbox"/> False	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
6. When I look at a person, or look at myself in a mirror, I have seen the face change right before my eyes.	<input type="checkbox"/> True <input type="checkbox"/> False	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
7. I get extremely anxious when meeting people for the first time.	<input type="checkbox"/> True <input type="checkbox"/> False	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
8. I have seen things that other people apparently can't see.	<input type="checkbox"/> True <input type="checkbox"/> False	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
9. My thoughts are sometimes so strong that I can almost hear them.	<input type="checkbox"/> True <input type="checkbox"/> False	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
10. I sometimes see special meanings in advertisements, shop windows, or in the way things are arranged around me.	<input type="checkbox"/> True <input type="checkbox"/> False	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
11. Sometimes I have felt that I'm not in control of my own ideas or thoughts.	<input type="checkbox"/> True <input type="checkbox"/> False	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
12. Sometimes I feel suddenly distracted by distant sounds that I am not normally aware of.	<input type="checkbox"/> True <input type="checkbox"/> False	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
13. I have heard things other people can't hear like voices of people whispering or talking.	<input type="checkbox"/> True <input type="checkbox"/> False	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
14. I often feel that others have it in for me.	<input type="checkbox"/> True <input type="checkbox"/> False	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
15. I have had the sense that some person or force is around me, even though I could not see anyone.	<input type="checkbox"/> True <input type="checkbox"/> False	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
16. I feel that parts of my body have changed in some way, or that parts of my body are working differently than before.	<input type="checkbox"/> True <input type="checkbox"/> False	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

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KNOW
THE SIGNS

FIND
THE WORDS

MAKE THE
CONNECTION

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