Brief Interventions for Psychosis: Overview and Future Directions

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1.1 Introduction

Psychosis (etymology: Gk. *psyche* + *osis,* condition) as defined in the Merriam-Webster dictionary (http://www.merriam-webster.com/dictionary/psychosis) is a mental and behavioral disorder due to fundamental derangement of the mind (as in schizophrenia) and is characterized by defective or lost contact with reality especially as evidenced by delusions, hallucinations, and disorganized speech and behavior. This causes gross distortion or disorganization of a person's mental capacity, affective response, and capacity to recognize reality, communicate, and relate to others to the degree of interfering with that person's capacity to cope with the ordinary demands of everyday life. The word *psychosis* has become a part of the vocabulary of general population including the media and is extremely stigmatizing. For many in general public, psychosis is synonymous with schizophrenia and is associated with dangerousness and negative stereotypy, often leading to social distancing, discrimination, and even victimization (Diefenbach 1996; Wood et al. 2014). Societal stigma combined with self-stigma leads to diminished opportunities, demoralization, and impaired recovery process for individuals with schizophrenia and other psychotic illnesses (Corrigan and Wassel 2008; Horsfall et al. 2010). Also, mental health practice until very recently was guided by the belief that individuals with serious mental illnesses like psychosis do not recover. The course of

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their illness was either seen pessimistically, as deteriorative, or optimistically, as a maintenance course (Harding and Zahniser 1994). The pessimistic outlook goes hand in hand with biomedical conceptualization of psychosis that neglects environmental risk factors (Mizrahi 2015). While the biomedical hypothesis is a driver of pharmacological research and current practice, meta-analyses of first person accounts of mental illness show that there are a variety of opinions about the cause of psychosis. Different individuals view the cause of their condition as spiritual crisis, environmental cause, and political, biological, or specific trauma (Farkas 2007). Psychosis can be attributed to one or other medical illnesses (most importantly neurologic or endocrine), and determination of a cause-effect relationship between a medical illness and psychosis is not always easy. Importantly, the disconnect between the opinion of professionals and individuals extends to the focus of treatment. While professionals have been focused on symptom remission and reduction in hospitalization, people with psychosis are more focused on regaining life roles and improvement in quality of their life. In fact, a recent report of the state of mental health systems in the USA has concluded that mental health care in America fails a wide variety of individuals but particularly fails those with serious mental illnesses (IOM 2006) because it is "not oriented to the single most important goal of the people it serves, that of recovery" (The President's New Freedom Commission on Mental Health 2003). An objective look at the outcomes for psychosis shows that contrary to prevailing professional opinion, there is evidence from several studies that a sizable proportion of individuals with psychotic disorders have good outcomes. For example, in a 15–25-year follow-up of individuals with psychotic disorders in 18 different countries, it has been revealed that the majority (56 %) showed recovery. A sixth of them were completely recovered to the point of not requiring any treatment (Harrison et al. 2001). In addition, people with serious mental illnesses have themselves published accounts of their own recovery as well as advocated for the development of recovery promoting services (Farkas 2007). All the above point to an urgent need for us in the profession of behavioral health to rethink how we conceptualize, label, and treat psychotic disorders. We need to look at our existing services, how they are delivered, and their focus to make them align with the goals of individuals who are suffering with these disorders, their families and communities supporting them.

1.2 Epidemiology

Psychotic experiences are fairly common, with 15 % of normal subjects reporting them at some point in their life. In most individuals these experiences are either transient or do not cause functional impairment and require no treatment (Balaratnasingam and Janca 2015). The distinction between psychotic experience and psychotic symptom is not clear, and the two terms are used interchangeably. As a result all psychotic experiences are considered pathological and may lead to unnecessary use of antipsychotic medication. Even though schizophrenia is considered a prototype of psychotic disorder, psychotic symptoms are trans-diagnostic and seen in all serious mental

illnesses and also in some personality disorders. For example, in borderline personality disorder, psychotic symptoms that at times are persistent are seen in 25–50 % of individuals and may indicate the severity of the disorder. Traditionally psychotic symptoms are viewed in categorical terms and always considered to be pathological. This categorical view contributes to the stigma, discrimination, and isolation of individuals with psychotic disorders. However, a paradigm shift is necessary to have a more comprehensive and nuanced approach to psychotic symptoms. The shift should include a distinction between psychotic experiences that are transient and psychotic symptoms and a recognition that some psychotic experiences are described part of spiritual experiences and may be self-enhancing. Secondly, the psychotic symptoms should be viewed dimensionally on a continuum from normal to pathological instead of the current categorical approach (Balaratnasingam and Janca 2015). This is a key premise of cognitive models of psychosis wherein the presence of voices in isolation is not sufficient to determine the transition to clinical psychosis (i.e., "need for care"). Put simply the way in which individuals make sense of, and respond to, their hearing experiences can determine whether voices remain benign (even life enhancing) or alternatively result in distress, impairment, and a need for clinical care (Garety et al. 2001). Thirdly, there should be recognition that the long-held biomedical hypotheses of the cause of psychosis are inadequate as there is evidence for the role of environmental factors in causation and maintenance of psychotic symptoms (Bebbington et al. 1993; Mizrahi 2015).

1.3 Spiritual and Psychotic Experiences

Religion, spirituality, and psychosis intersect and it is difficult to disentangle them. A model has been proposed to distinguish spiritual experiences from psychotic symptoms. Spiritual experience is described as a positively evaluated psychotic experience, which enables the subject to transcend their normal limitations and accomplish more than what he or she normally does, but these distinctions are not always clear. However, there is lack of quality studies that help us distinguish spiritual from psychotic experiences (Menezes and Moreira-Almeida 2010; Moreira-Almeida 2012). In clinical practice it is important to be aware of and understand the religious and spiritual background of individuals so that these resources are utilized for supporting hope, buffering stress, and possibly activating psychosomatic processes that promote health (Griffith 2012). In a normal community sample of individuals, the spiritual emergencies and psychotic symptoms are highly correlated, and some authors suggest that the two concepts are one and the same and all psychotic experiences should be treated as spiritual emergencies (Goretzki et al. 2009). There are individual case examples of psychotic symptoms conceptualized as spiritual emergencies and treated with psychological approaches particularly transpersonal psychotherapy (Lukoff 2005). However, there are no controlled studies to evaluate the effectiveness of transpersonal psychotherapy, and treating psychosis as a spiritual emergency can reduce the stigma associated with it but may lead to the unintended consequence of increasing the duration of untreated psychosis.

1.4 Continuum of Psychotic Process

It is helpful to keep the entire spectrum of psychotic process – from vulnerabilities at one end to recovery and reintegration at other end – in devising systems of care that facilitate phase appropriate interventions.

1.5 High Risk for Psychosis

The risk for psychosis is explained by the stress vulnerability model described by Zubin and Spring (1977) and further elaborated by Neucterlein et al. (2008). It emphasizes the interaction between life events, circumstances, and individual genetic, physiological, psychological, and social predispositions which lead to variation in vulnerability. Meta-analysis of risk factors identified age, sex, minority or migrant status, income, education, employment, marital status, alcohol use, cannabis or other drug use, stress, trauma, living in urban areas, and family history of mental illness as important predictors of psychotic experiences (PE). Of those who report PE, ~20 % go on to experience persistent PE, whereas for ~80 %, PE remit over time. Of those with baseline PE, 7.4 % develop a psychotic disorder outcome (Linscott and van Os 2013). An interesting recent finding is that the degree of psychotic symptoms at baseline does not distinguish individuals who go on to develop a psychotic disorder (Addington and Heinssen 2012). The factors that are likely to determine the long-term outcome of psychotic experiences are resilience, support systems available, individual and family perspective of the experiences, and the type of interventions that were utilized. Study of individuals who develop psychotic experiences but do not develop disorders is likely to provide clues for better treatment of psychotic disorders akin to study of individuals who are HIV infected but remain asymptomatic.

Psychosis has classically five dimensions (positive, negative, affective, cognitive, and disorganization).

The DSM-IV description of psychotic disorders had several limitations including a categorical approach to diagnosis that lent itself to enhancing stigma, questions about the validity of various diagnoses, and lack of clinical utility of some of the subtypes of illnesses. The work group on psychotic disorders for DSM-5 had to juggle multiple challenges of improving validity, reliability, and clinical utility. At the same time, they had to ensure simplicity and easy applicability. This was a huge challenge, and the expectation that there will be a paradigm shift in DSM-5 to a dimensional diagnostic system did not materialize. According to the work group on psychosis, the reason for the same was a lack of adequate research data to support this shift (Tandon 2013; Heckers et al. 2013). However, within the established categorical system, an effort was made to capture the underlying dimensional structure of psychosis. To that end, the terms domains, gradients, and dimensions are introduced. There are five domains of psychopathology that define psychotic disorders. The level of psychosis, the number of symptoms, and the duration of psychosis are the gradients that have been used to demarcate psychotic disorders

from each other and continue to be used for the same purpose in DSM-5 (Heckers et al. 2013).

In the dimensional approach in the nosological system, schizophrenia, the prototype of all psychotic disorders, has been conceptualized to consist of five clusters of symptoms, and these are *positive symptoms* (delusions, hallucinations, and disorganization in thoughts, speech, and behavior), *negative symptoms* (social withdrawal, lack of motivations), *cognitive symptoms* (sustained attention, memory, and language), h*ostility and excitement symptoms* (includes impulse dys-control and violent behavior), and *affective symptoms* (includes depression or anxiety symptoms) (DSM-5, 2013). The *International Classification of Diseases* 10th edition (ICD-10) and the *Diagnostic and Statistical Manual of Mental Disorders* 4th edition (DSM-IV) both describe paranoid, hebephrenic, undifferentiated, catatonic, and residual group of schizophrenia. The problems with the subgroups are the instability of diagnosis over time and lack of predictive validity (Deister and Marneros 1994), and hence the subgroups have not been widely used clinically nor in research. The DSM-5 dispenses with these categories and catatonia becomes a different group. Efforts to find more homogenous subgroup of schizophrenia are ongoing. One such effort comes from two researchers working on the effectiveness of CBT for schizophrenia and other severe mental illnesses. Kingdon and Turkington (2005) propose that schizophrenia is a group of disorders and can be distinguished into four categories: (a) stress sensitivity psychosis (20 %), (b) drug-induced psychosis (20 %), (c) traumatic psychosis (49 %), and (d) anxiety psychosis (10 %) (Kingdon and Turkington 2005). A diagnostic instrument developed to distinguish these subtypes is shown to have good psychometric properties (Kinoshita et al. 2012). The categorization of schizophrenia into the above categories has implications for choice of psychosocial interventions based on the particular category. For example, as described in Chap. 5, the *Yoga and Mindfulness-Based Cognitive Therapy for Psychosis* (Y-MBCTp) shows efficacy in traumatic psychosis, in addition to its other benefits.

1.6 Expectation from the Interventions Done for Psychotic Disorders

Interventions for psychotic disorders should look at the entire spectrum from high-risk individuals to those who are in recovery and devise services that are based on their (a) phase of illness, (b) view of illness and receptivity to available interventions, (c) available mental health systems, and (d) mobilizing existing support systems. Services should ideally be provided for an indefinite period of time to reduce the fragmentation and help the individual smoothly transition through the various phases of their illness. Interventions are broadly biological and psychosocial, and the choices of interventions are based on our understanding of the etiology of psychotic disorders. These interventions should match the psychotic spectrum. As Fig. 1.1 illustrates, the first step in the spectrum is to identify individuals who are vulnerable and provide them with educational services to help them mitigate

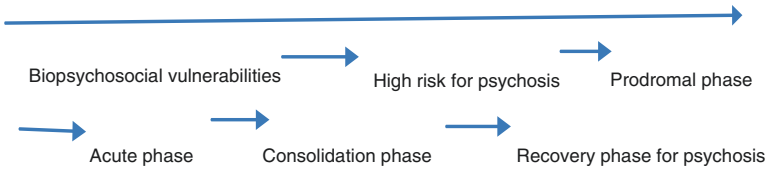

Fig. 1.1 Psychosis Spectrum

vulnerabilities. Next are ultra-high-risk (UHR) individuals for psychosis, and interventions are needed to address this group. Childhood trauma is prevalent in 86.6 % of individuals with UHR and is related to UHR status (Kraan et al. 2015). Interventions for those at UHR are to educate communities about risk for psychosis, identify individuals at risk for psychosis, and provide supportive and therapeutic services to prevent conversion to full-blown psychosis. These services are currently being evaluated on experimental basis and not integrated into the service provision model in most countries. Individuals with prodromal symptoms are usually not detected during this stage, and a diagnosis of prodrome is made in retrospective. Even when individuals develop psychotic symptoms, there is a significant delay in accessing treatment. At the back end of psychosis, rehabilitation and vocational services such as supported employment are not available for most individuals in maintenance phase of treatment. Currently our services are focused on the acute middle (narrow) end of spectrum, and a redesign of services that spans entire spectrum is necessary.

1.7 The Need for Evidence-Based Models Which Are Pragmatic and Client Centered as Well

Individuals who are functioning at a high level despite a diagnosis of psychotic disorder, describe the importance of a trusting relationship with a professional as critical in providing connection and containment during crises. In addition such relationship provides high degree of autonomy in personal decisions during periods of stability and thereby promote recovery and personal growth (Saks 2007). However, a long-term relationship over a period of years is a rare exception due to fragmented nature of the mental health-care provision. Fragmentation is such that an individual may see five different psychiatrists during the course of one acute episode. The closest one that comes to providing a long-term treatment team is the assertive community treatment (ACT) model. An ACT team in the USA is a multidisciplinary team (including psychiatrist, nursing staff, and individuals with lived experience of illness) available 24 h a day 7 days a week providing integrated coordinated care on a long-term basis (Schmidt et al. 2013). However, there are a limited number of ACT teams in the USA, and they focus on the most serious of the mentally ill and transfer individuals when more stable to a less-intensive treatment setting. This is a far cry from a system that is comprehensive enough to

address the entire spectrum from identifying and dealing UHR individuals to those that are in recovery. The Affordable Care Act is shifting the focus of care provision from acute treatment to more broad prevention, from individual care to population health and systems of are called Accountable Care Organizations are being developed to help provide this degree of care.

More recently another integrated approach by the National Institute of Mental Health (NIMH) has made waves in the USA. This approach, called *Recovery After an Initial Schizophrenia Episode* (RAISE, detailed in Azrin et al. 2015), tries to catch the clients with first episode psychosis quite early in the course of illness. As the name suggests, RAISE was designed to help specifically the individuals who have experienced an initial psychotic episode. Geared toward reducing the duration of untreated psychosis (DUP) and fostering the recovery process quite early in the course of psychosis and thus attempting to reduce subsequent the disability, these evidence-based interventions integrated the many therapeutic components discussed on the various chapters of this book. These interventions are typically delivered by a clinical team specialized in early psychosis, and the services offered include but not limited to psychiatric treatment, medication management, help with finding a job or returning to school, substance abuse treatment, family education and support, and other support services as needed.

1.8 Mobilizing the Client's Existing Support Systems: The Spirits of Collaborative Empiricism

An unintended consequence of deinstitutionalization in the 1950s is that the burden of caring for individuals with serious mental illnesses shifted from institutions to family members (Solomon 1995). While the burden on families has increased, the importance of appropriate family involvement cannot be understated. A third of individuals with first episode psychosis disengage from services, and family involvement is one of the factors that facilitate engagement (Doyle et al. 2014). Similar to family, the size of an individual's social network and satisfaction with the network are shown to be positively correlated with recovery from SMI (Corrigan and Phelan 2004). A proactive and planned method of evaluating social support and engaging appropriate members of the individuals' social support is shown to aid recovery (Perry and Pescosolido 2015). Families can also have a deleterious effect on individuals as evidenced by increased risk of relapse in individuals whose families have high EE. On the other, intervention to lower the EE is shown to reduce risk of relapse (Butzlaff and Hooley 1998). The three issues family members have to deal with are (a) Maintaining an appropriate emotional distance from the loved ones (b) dealing with feelings of shame, fear, guilt, and powerlessness in the face of a socially stigmatized illness and (c) finally the frustration of navigating the complex network of bureaucracies that govern the mental health system (Karp 2001). In addition, if a family member is the primary caregiver for the individual with mental illness, he/she has to deal with additional issues of financial expenses, higher demands on their personal time for care-giving activities, and being more involved

in dealing crises that arise (Lohrer et al. 2007). The burden of care on relatives of mentally ill is considerable, and to the extent their well-being and mental health is seriously impaired (Maurin and Boyd 1990). However, any system of care that is recovery oriented needs to have a family-centered approach. Involving family members fits in with the model of recovery as strengthening an existing support aids in recovery. The core tenets of family-centered approach are (a) non-blaming attitude, (b) developing and maintaining collaborative working relationship with family members, (c) empowering families through choice and control, and (d) an emphasis on strengths and goal of enhancing functioning.

1.9 Conclusions and Future Directions

The ever-growing gap between the needs of the clients with psychosis and the limited therapeutic resources available to them have inspired the innovators in our field not only to develop pragmatic and need-based models of treatment but also have propelled to integrate these with the strength-based and evidence-based models of care. Brief therapeutic interventions probably germinated in those contexts and have proliferated cross-culturally at this time, thereby expediting and personalizing the care for the needy and at the same time not losing their evidence-based foundations. This book amply highlights the current limitations in the care provided for individuals with psychotic disorders, integrates the various evidence-based psychotherapies or psychosocial interventions, and aims to bridge the current gaps in the health-care provision. Care is best provided when we have a longitudinal view of the entire spectrum of psychotic process and devise various interventions appropriate for each stage. We begin by making a case for integrated care pathways for psychosis in Chap. 2, which is followed by chapters on different evidence-based interventions in brief formats.

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