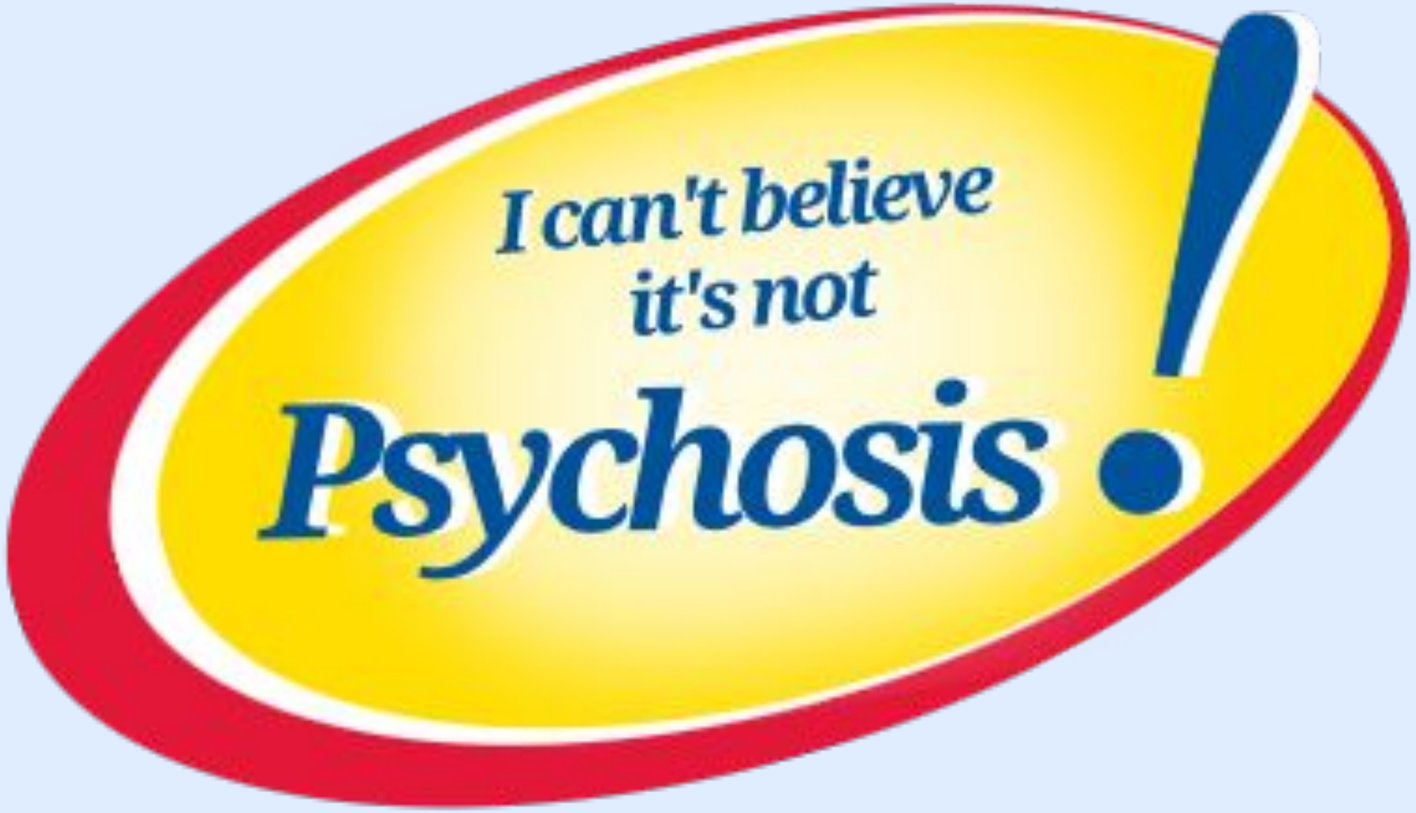

I can't believe
it's not
Psychosis!

PAMELA RAKHSHAN ROUHAKHTAR, PHD

Clinical Psychologist

Assistant Research Scientist @ UMBC

Clinician & Researcher

rakhshp1@umbc.edu

https://equips.umbc.edu

TOVAH COWAN, MA

Predoctoral Psychology Intern @ UM School of Medicine

AGENDA

Highlight the importance of Early Intervention, and distinguish psychosis as a syndrome from primary psychotic spectrum diagnoses

AGENDA

Highlight the importance of Early Intervention, and distinguish psychosis as a syndrome from primary psychotic spectrum diagnoses

Identify the main pathways for misdiagnosis or misidentification of psychosis

AGENDA

Highlight the importance of Early Intervention, and distinguish psychosis as a syndrome from primary psychotic spectrum diagnoses

Identify the main pathways for misdiagnosis or misidentification of psychosis

Learn techniques and considerations useful for appropriate and sensitive assessment and diagnosis of psychosis spectrum diagnoses

AGENDA

Highlight the importance of Early Intervention, and distinguish psychosis as a syndrome from primary psychotic spectrum diagnoses

Identify the main pathways for misdiagnosis or misidentification of psychosis

Learn techniques and considerations useful for appropriate and sensitive assessment and diagnosis of psychosis spectrum diagnoses

Discuss the implications of psychosis spectrum diagnoses on client mental health and care systems

EARLY IDENTIFICATION & INTERVENTION

PSYCHOSIS: OUTCOMES

Negative outcomes can be associated with psychosis

PSYCHOSIS: OUTCOMES

Negative outcomes can be associated with psychosis

Despite this, even among those with chronic illness:

- **Full and successful lives**
- **Positive changes from psychosis**
  - **Personal strength**
  - **Spiritual growth**

PSYCHOSIS: OUTCOMES

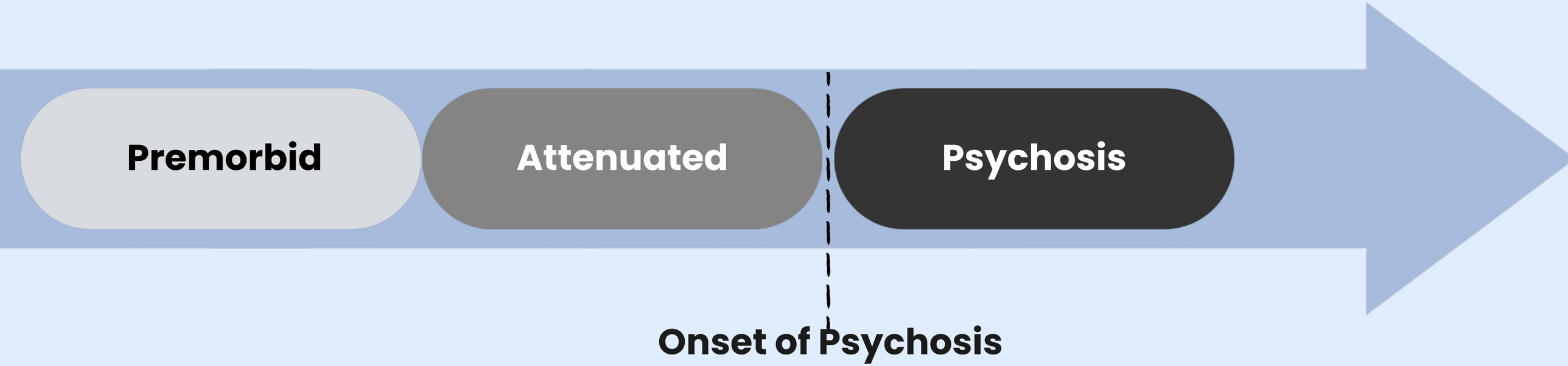
Negative outcomes can be associated with psychosis

Despite this, even among those with chronic illness:

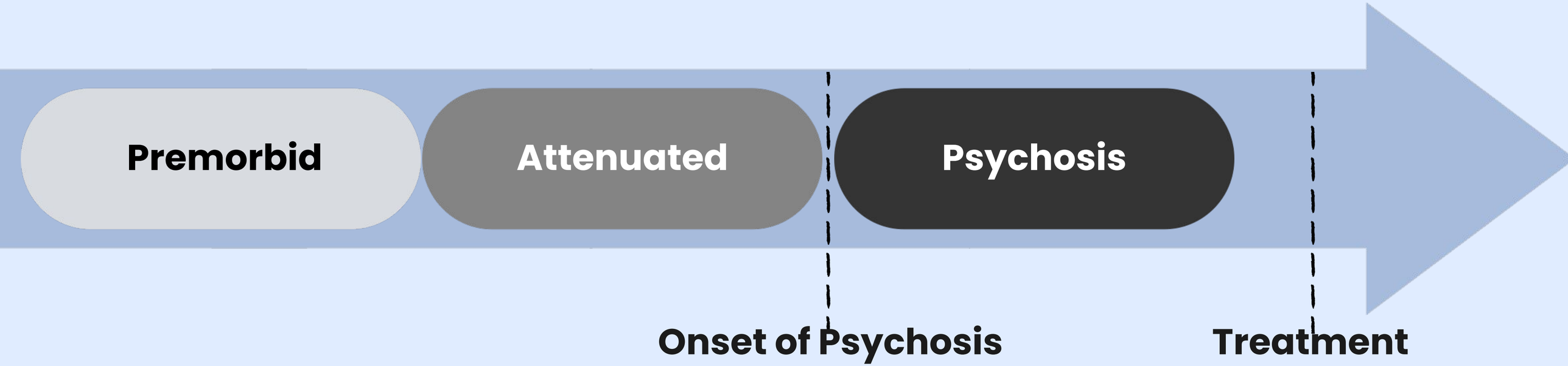
- **Full and successful lives**
- **Positive changes from psychosis**
  - **Personal strength**
  - **Spiritual growth**

Early intervention = maximize quality of life & reduce impairment

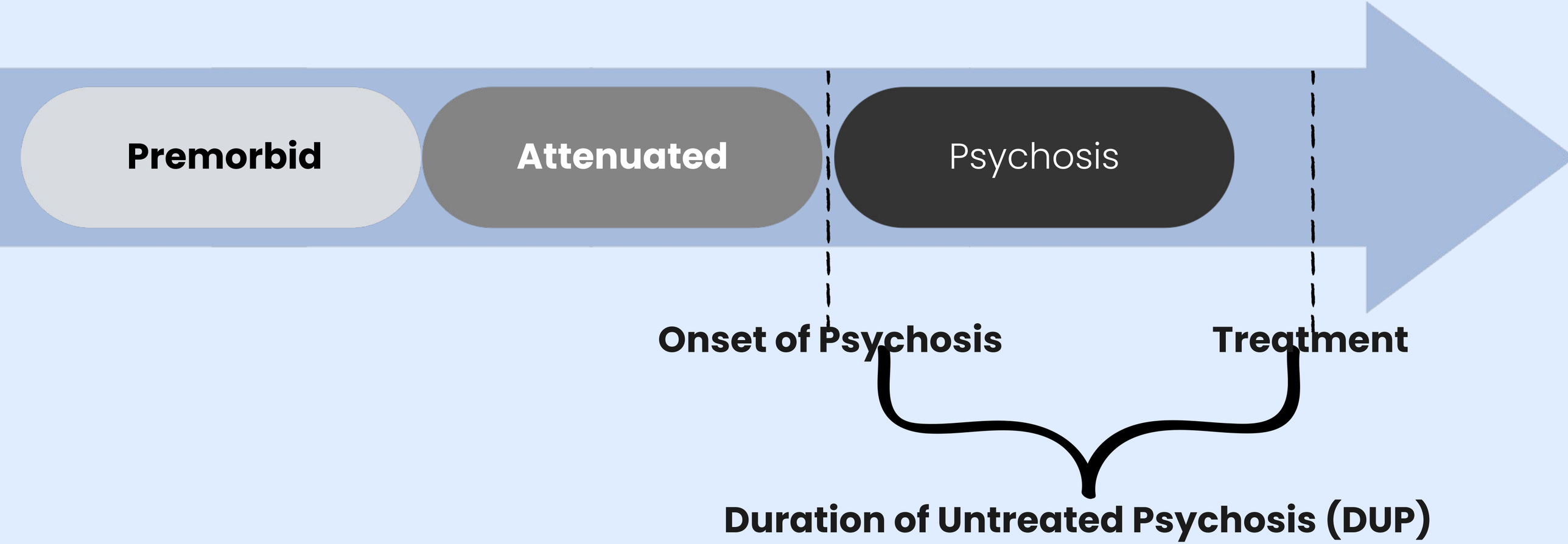
DURATION OF UNTREATED PSYCHOSIS



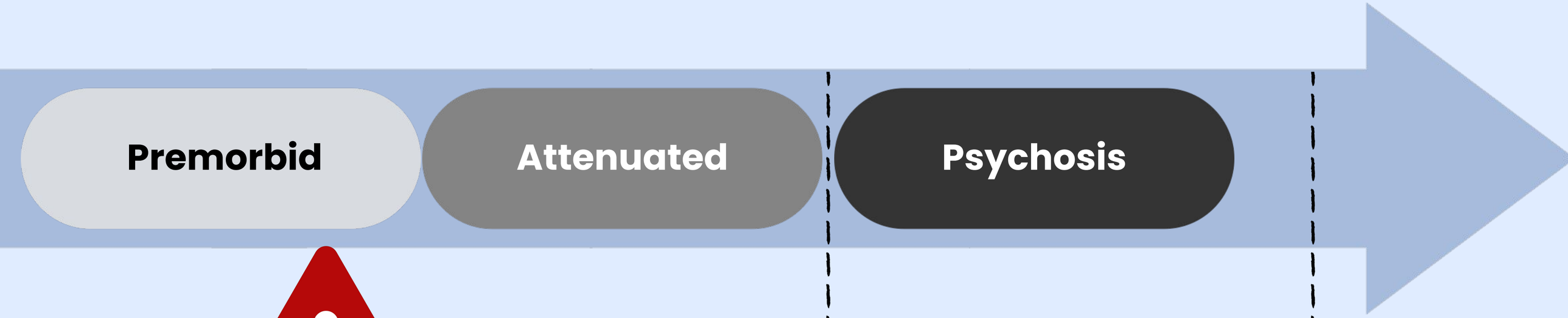
DURATION OF UNTREATED PSYCHOSIS



DURATION OF UNTREATED PSYCHOSIS



DURATION OF UNTREATED PSYCHOSIS



Average DUP in the US:
2 years

Onset of Psychosis

Treatment

Duration of Untreated Psychosis (DUP)

WHO EXPERIENCES PSYCHOSIS?

Adolescents & Young Adults

Onset:

- **Generally occurs between the ages of 15-25**
- **May begin in adolescence & continue into young adulthood**

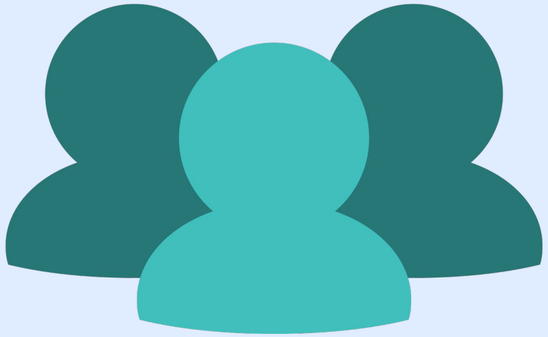
~2,000 young people in MO each year with first episode of psychosis

ADOLESCENCE & YOUNG ADULTHOOD

Critical Period for Key Developmental Tasks

School

Work



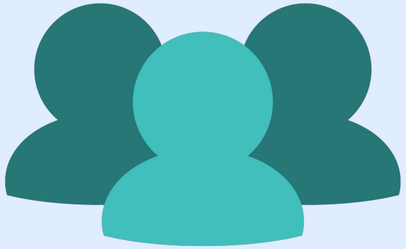
Relationships

Independence

Shorter DUP

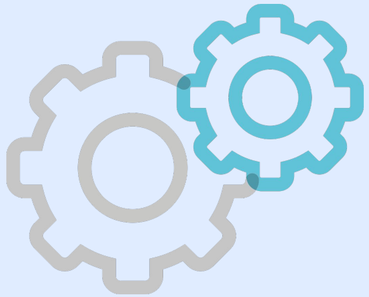
Better long term outcomes

Less occupational impairment

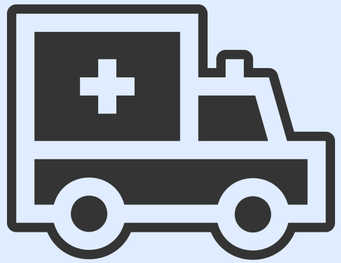


Less social impairment

Less negative symptoms



Less cognitive deficits



Less emergency/ intensive service use

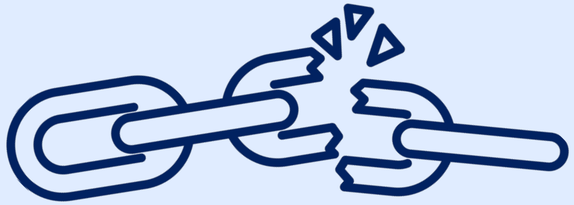
Less psychological distress

Without Early Intervention

Obstacles to enter system

Bad first experience with treatment

Miscommunication or no communication

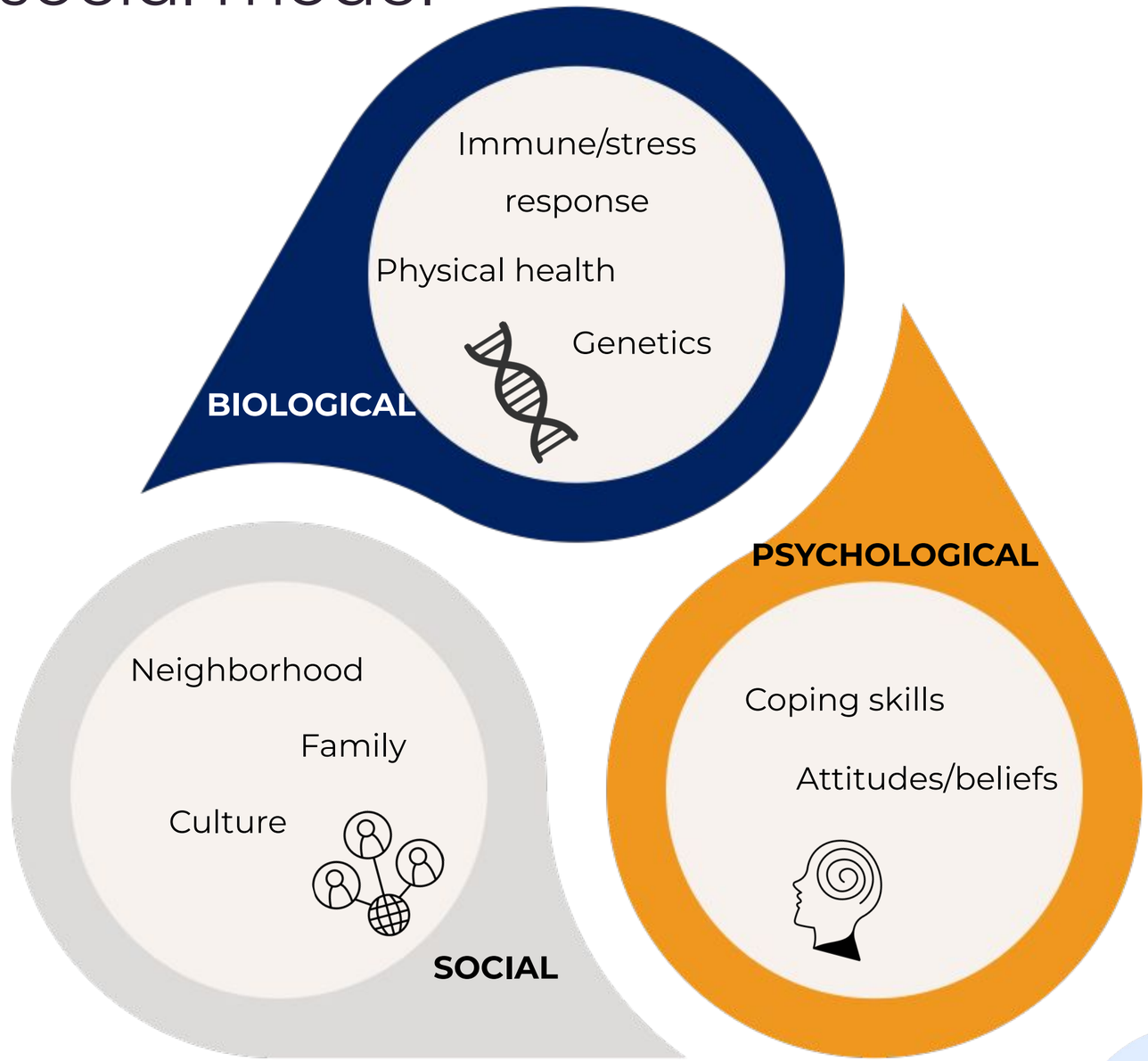


Discontinuity between care teams

PSYCHOSIS SPECTRUM

Development of Psychosis

Biopsychosocial model



PSYCHOSIS IN CONTEXT

EMIL KRAEPELIN

1899

PAUL EUGEN BLEULER

1911

1918

SCHIZOPHRENIA DESCRIBED

Disproportionate diagnoses:

- Black men diagnosed 5-7x more often than white counterparts

PARANOID SUBTYPE APPEARS

1960S

1960S

Shift in diagnostic rates of schizophrenia to increasing number of Black individuals, with differential presentation across Black and White people. Concurrent with US civil rights movement.

"Split mind", almost exclusively linked to white bodies.

- Psychiatrists described patients with schizophrenia as white academics poets, eccentrics, and women.

1920S-1950S

WHITEWASHING OF PSYCHOSIS


CLEAN, COOPERATIVE, AND COMMUNICATIVE"
Serpasil
high dosage for

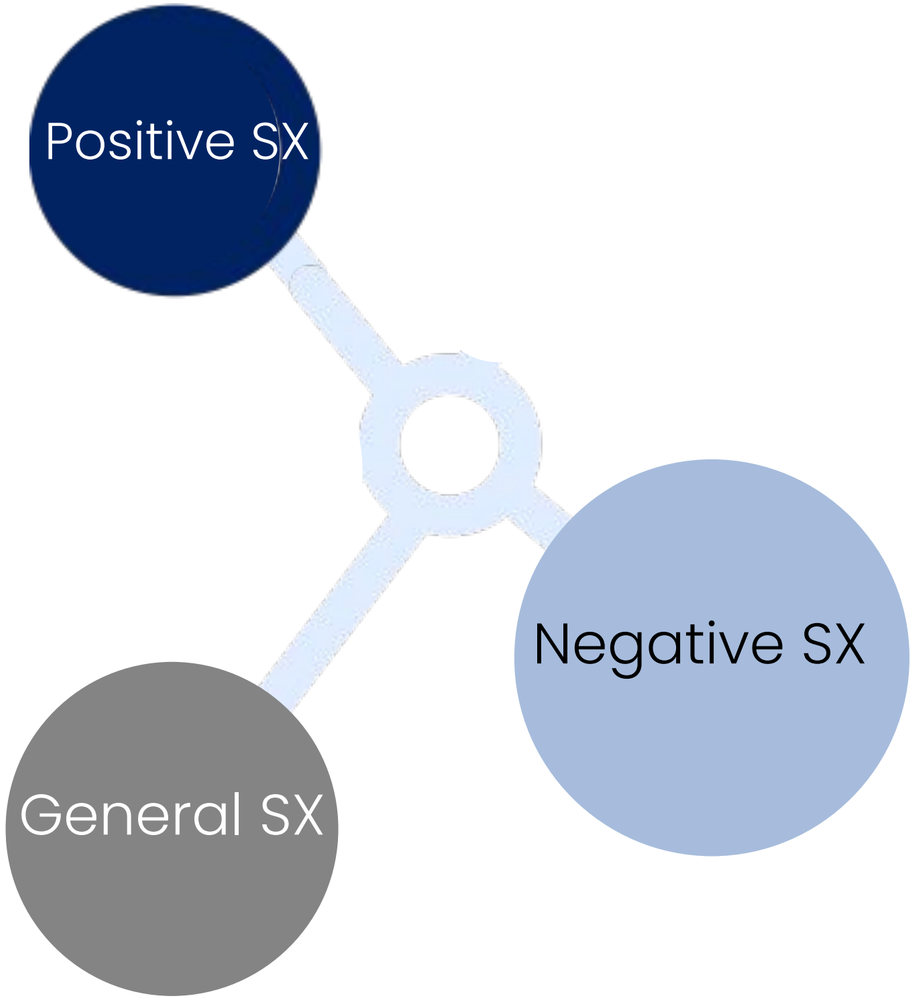
1950s


STELAZINE
trifluoperazine HCl
STELAZINE
trifluoperazine HCl
Cooperation often begins with
HALDOL
(haloperidol)
a first choice for starting therapy
Acts promptly to control aggressive, assaultive behavior
Usually leaves patients relatively alert and responsive
Reduces risk of serious adverse reactions
Assaultive and belligerent?

1970s

Psychosis

Syndrome, not diagnosis



POSITIVE SYMPTOMS

Delusions

False and fixed beliefs

“I think people are talking about me”

“Someone is following me”

“People are talking about me to plot against me”

“Aliens are sending me messages through the TV”

POSITIVE SYMPTOMS

Hallucinations

perception/sensory abnormalities

Auditory, visual, olfactory, gustatory, or tactile

Auditory or “hearing voices” is most common

NEGATIVE SYMPTOMS

Decrease/loss of normal function

Social withdrawal

Decreased motivation

Difficulty feeling pleasure

***often most difficult to treat & most interfering**

DISORGANIZED SYMPTOMS

Disorganized Speech

Difficult to follow

Slipping off-topic

Going off on a tangent

Not making sense to others

Speech seeming unrelated to conversation

DISORGANIZED SYMPTOMS

Disorganized Behavior

Behaviors that don't fit; decline in goal-directed behavior; catatonic

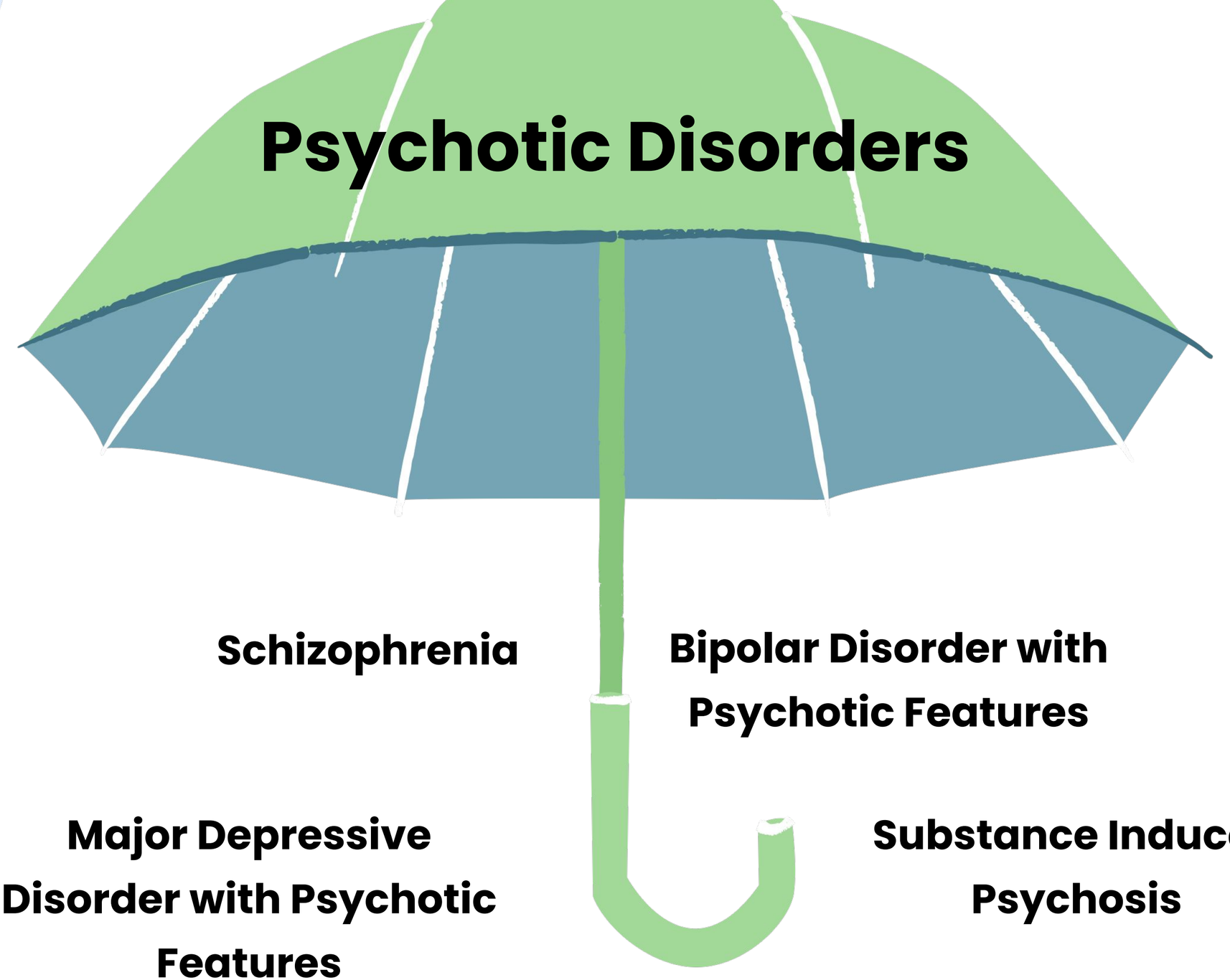
Dressing in unusual manner

Incongruous emotional response

Difficulty with daily living activities

Not responding or reacting to enviornment

Psychotic Disorders



Schizophrenia

Bipolar Disorder with Psychotic Features

Major Depressive Disorder with Psychotic Features

Substance Induced Psychosis

Primary Psychotic Disorders

Schizophrenia

Schizotypal Personality Disorder

Delusional Disorder

Brief Psychotic Disorder

Schizoaffective Disorder

Schizophreniform

DSM-5 Disorders with Psychosis

Bipolar Disorder with Psychotic Features

Substance Induced Psychosis

Major Depressive Disorder with Psychotic Features

Schizophrenia

Diagnostic Criteria **F20.9**

A. Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be (1), (2), or (3):

1. Delusions.
2. Hallucinations.
3. Disorganized speech (e.g., frequent derailment or incoherence).
4. Grossly disorganized or catatonic behavior.
5. Negative symptoms (i.e., diminished emotional expression or avolition).

Schizophrenia

B. For a significant portion of the time since the onset of the disturbance, level of functioning in one or more major areas, such as work, interpersonal relations, or self-care, is markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, there is failure to achieve expected level of interpersonal, academic, or occupational functioning).

C. Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or by two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

Schizophrenia

D. Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out because either 1) no major depressive or manic episodes have occurred concurrently with the active-phase symptoms, or 2) if mood episodes have occurred during active-phase symptoms, they have been present for a minority of the total duration of the active and residual periods of the illness.

E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

F. If there is a history of autism spectrum disorder or a communication disorder of childhood onset, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations, in addition to the other required symptoms of schizophrenia, are also present for at least 1 month (or less if successfully treated).

Schizoaffective

Diagnostic Criteria

A. An uninterrupted period of illness during which there is a major mood episode (major depressive or manic) concurrent with Criterion A of schizophrenia.

   Note: The major depressive episode must include Criterion A1: Depressed mood.

B. Delusions or hallucinations for 2 or more weeks in the absence of a major mood episode (depressive or manic) during the lifetime duration of the illness.

Schizoaffective

C. Symptoms that meet criteria for a major mood episode are present for the majority of the total duration of the active and residual portions of the illness.

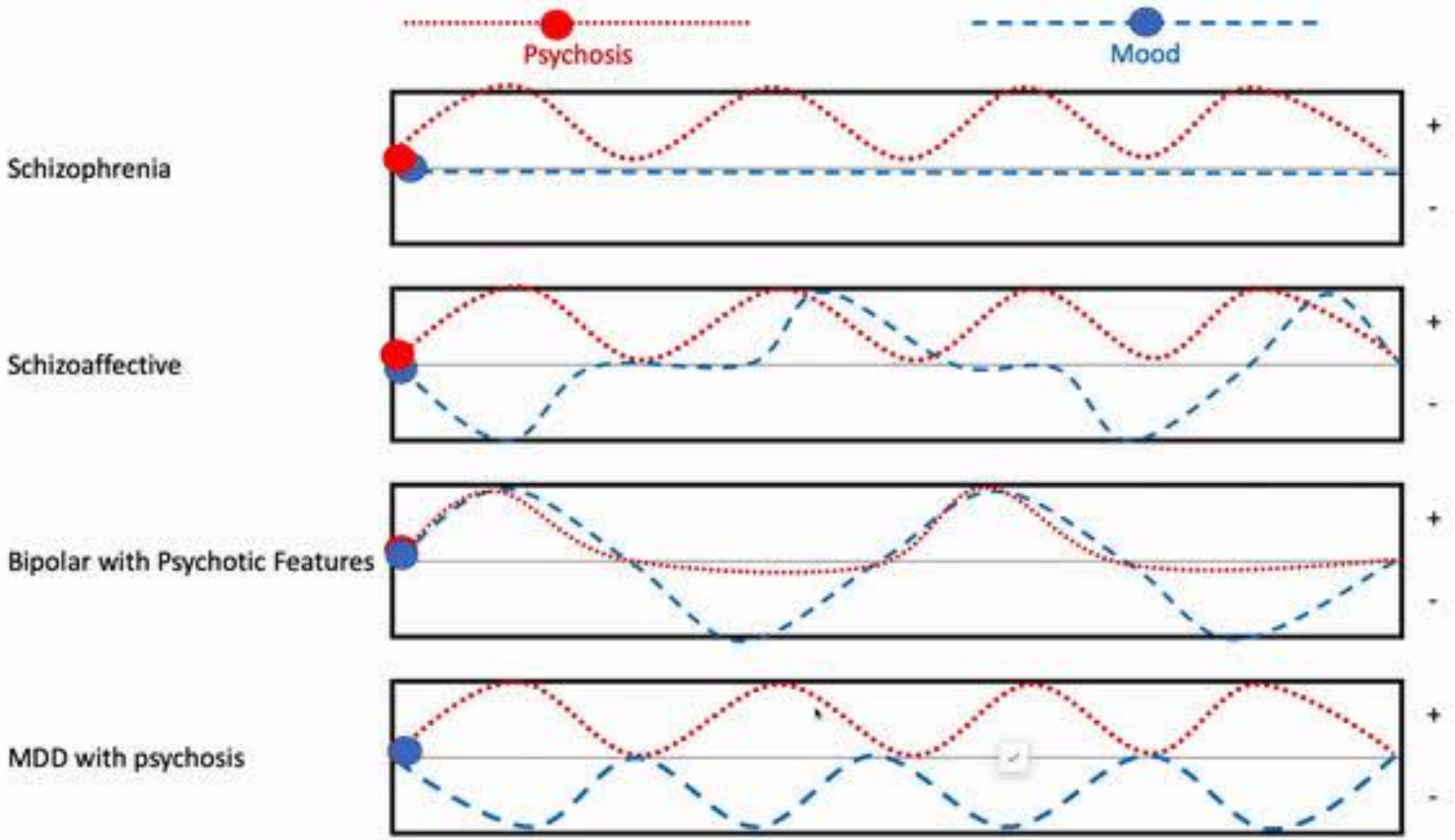
D. The disturbance is not attributable to the effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

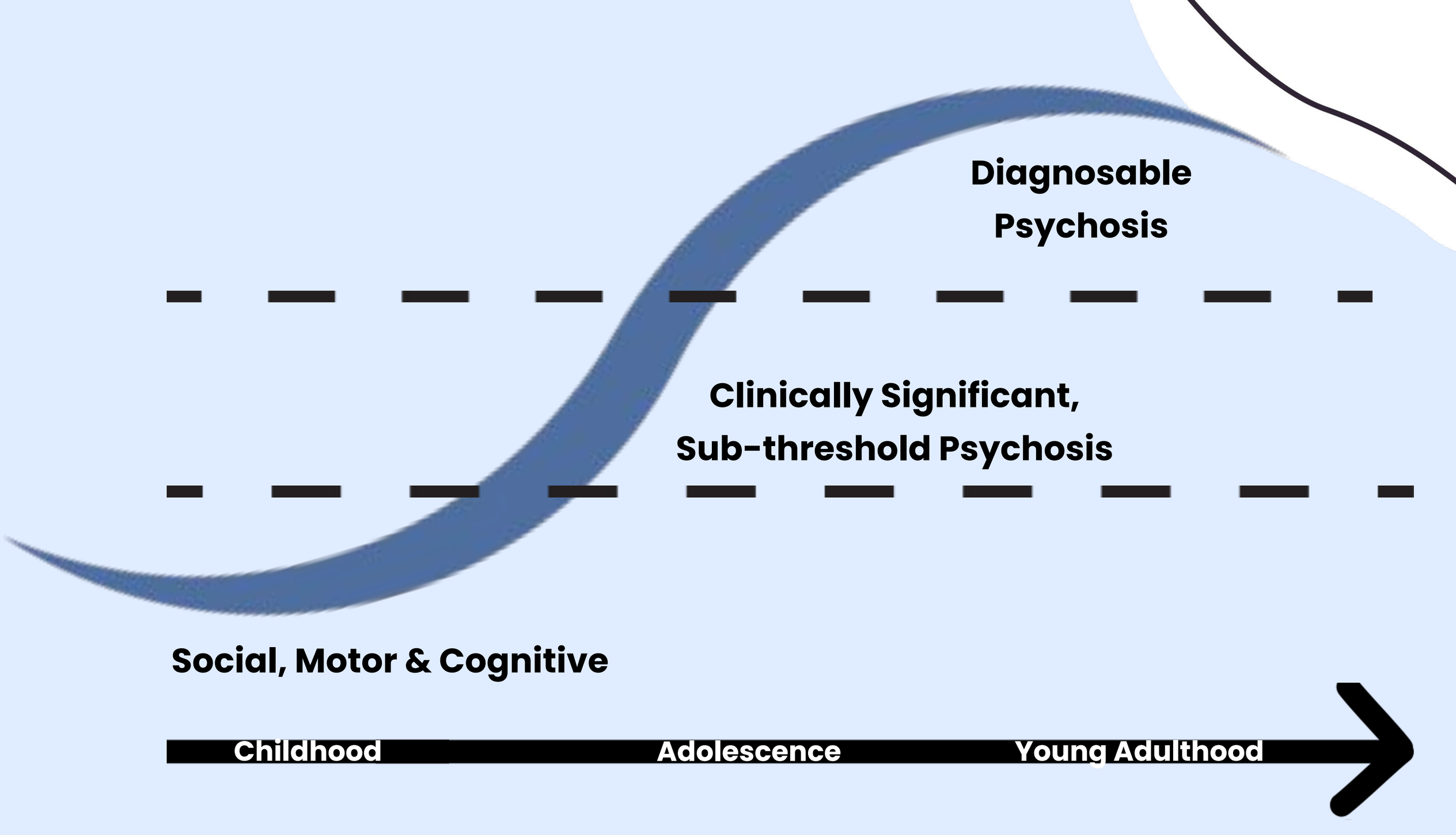
Specify whether:

F25.0 Bipolar type: This subtype applies if a manic episode is part of the presentation. Major depressive episodes may also occur.

F25.1 Depressive type: This subtype applies if only major depressive episodes are part of the presentation.

Infographic for Differential Diagnosis




Diagnosable
Psychosis
Clinically Significant,
Sub-threshold Psychosis
Social, Motor & Cognitive
Childhood
Adolescence
Young Adulthood

Classical Diagnostic Thinking

Psychotic Disorder

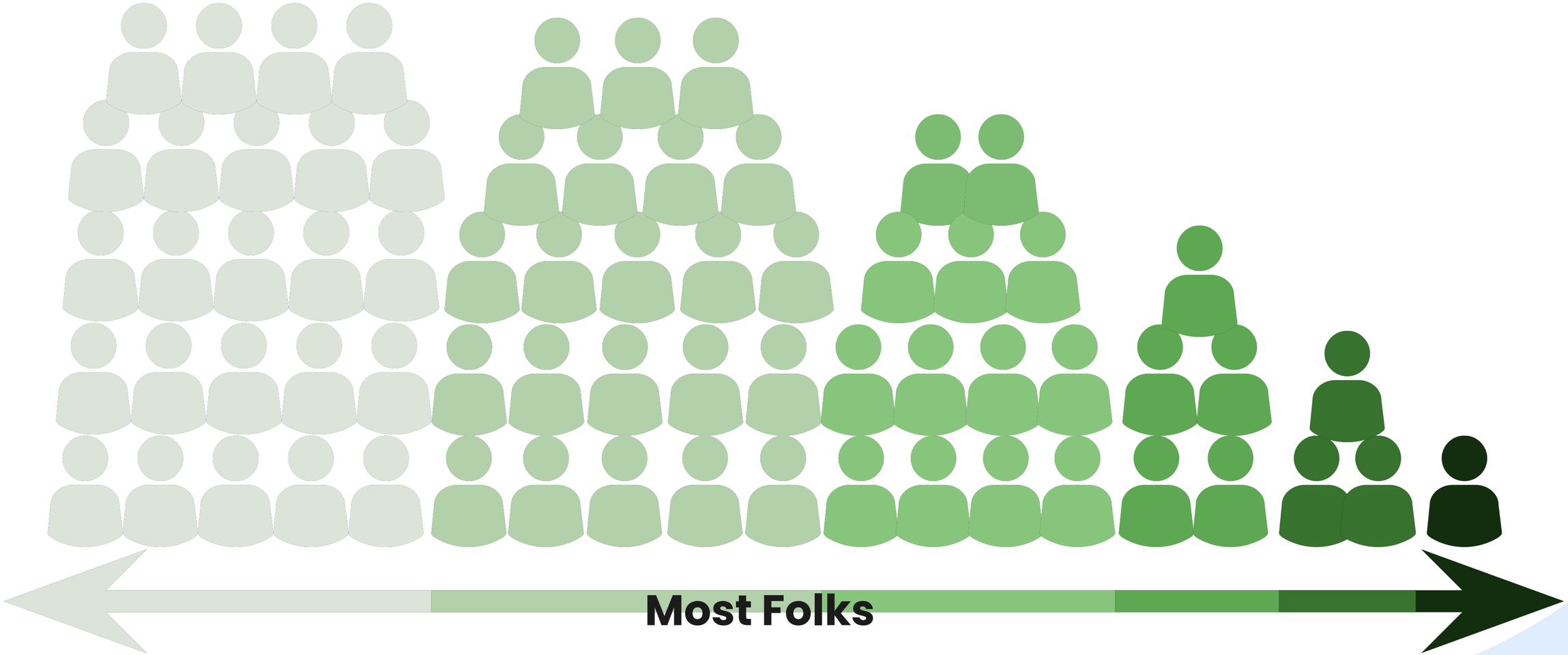
No Psychosis

The Psychosis Spectrum

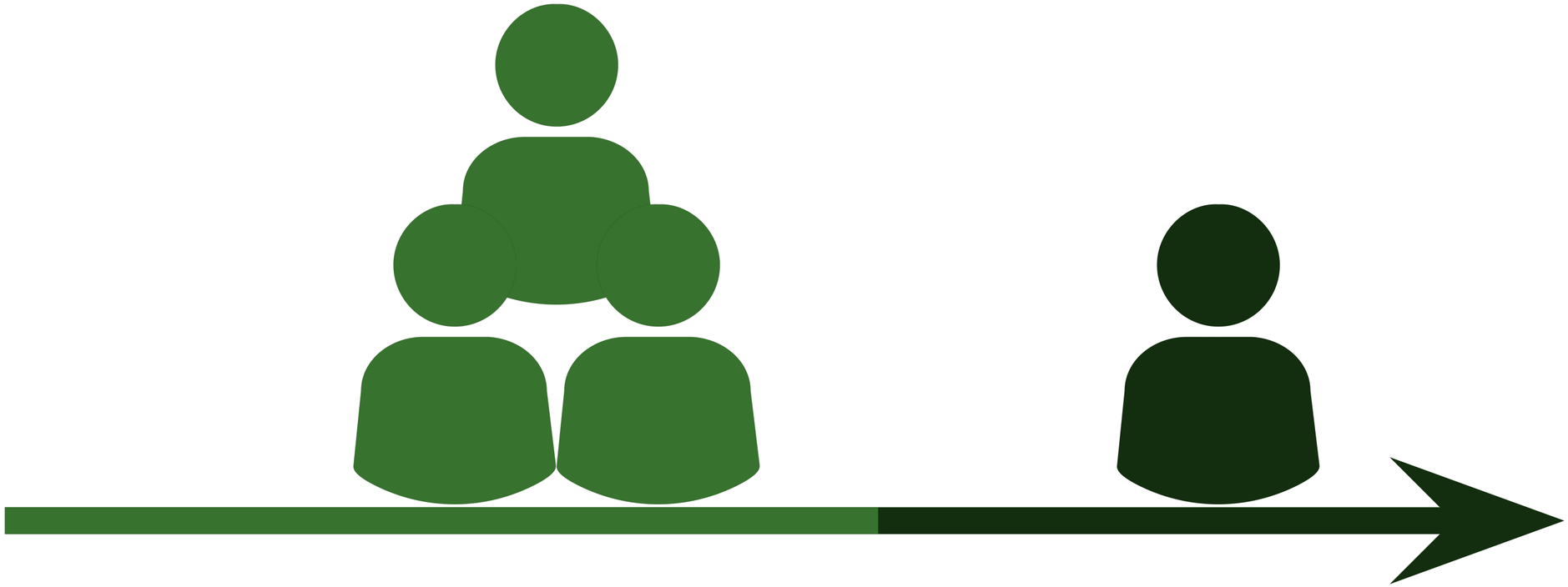
0%
psychosis

100%
psychosis

The Psychosis Spectrum



The Psychosis Spectrum



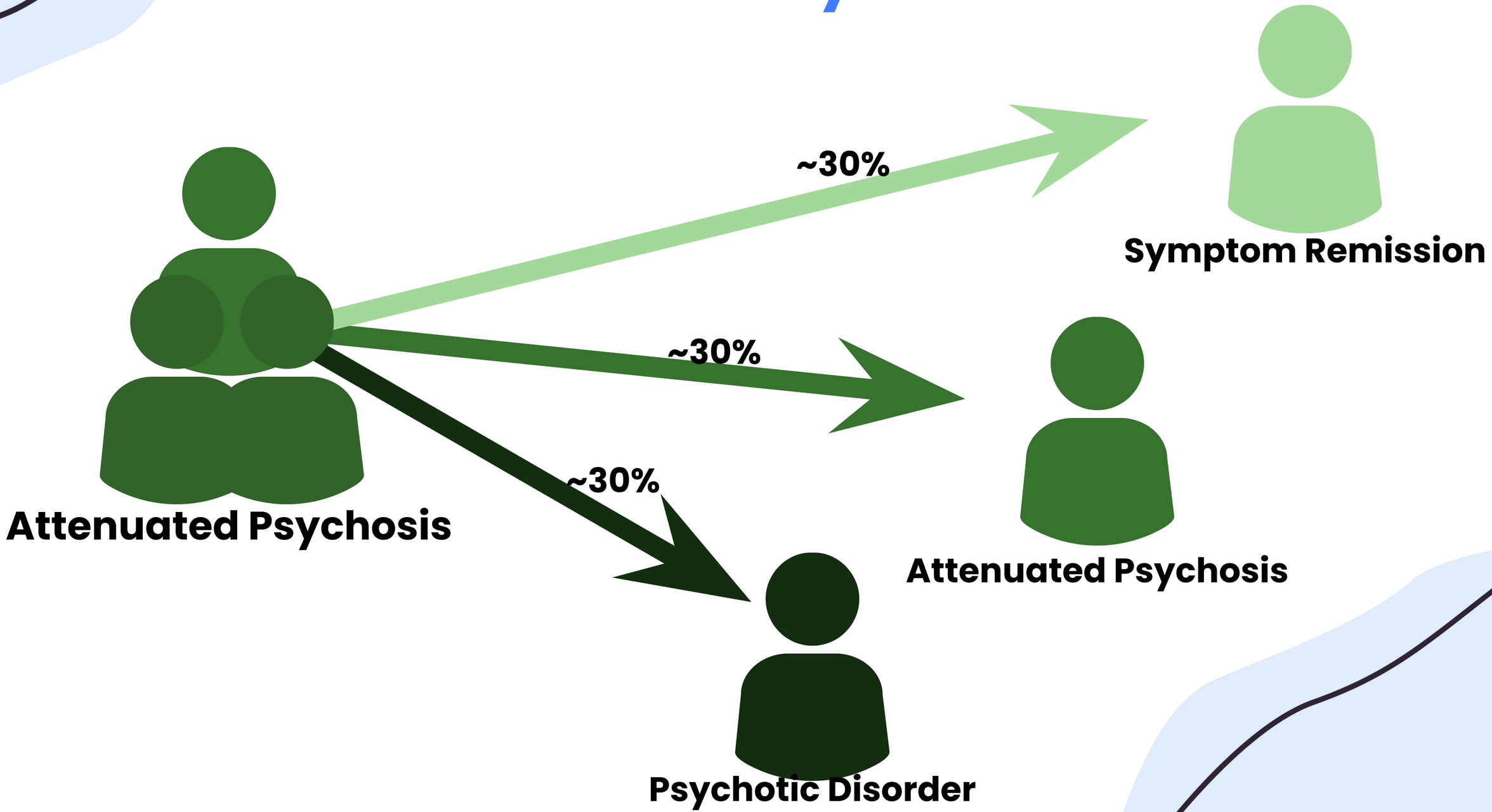
Attenuated Psychosis

~4%

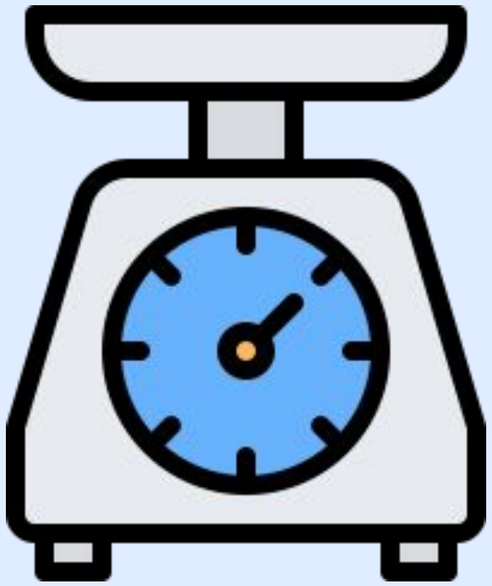
Psychotic Disorder

~1-3%

Attenuated Psychosis



ATTENUATED VS. FULL THRESHOLD



Conditions are differentiated by:

- Intensity and severity of symptoms
- Degree of conviction
- Doubt, question and insight

ATTENUATED VS. FULL THRESHOLD

Delusions

Extreme end of normal	CHR	Full Threshold

ATTENUATED VS. FULL THRESHOLD

Delusions

Going to the park and feeling like people are staring

Refusing to go outside because you are convinced your neighbor is plotting to kill you

ATTENUATED VS. FULL THRESHOLD

Delusions

Going to the park and wondering if people are staring

Wondering if there's a plot against you and people are watching you

Refusing to go outside because you are convinced your neighbor is plotting to kill you

ATTENUATED VS. FULL THRESHOLD

Delusions

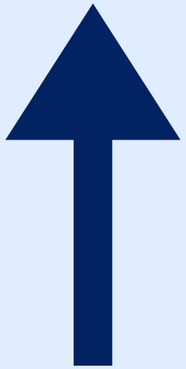
Privately thinking you will become rich in the next year

Convinced that you are rich and famous, even though no one else agrees

ATTENUATED VS. FULL THRESHOLD

Delusions

Privately thinking you will become rich in the next year



Convinced that you are rich and famous, even though no one else agrees

Belief of special talent leading to changes in plans, responsive to other's concerns

ATTENUATED VS. FULL THRESHOLD

Hallucinations

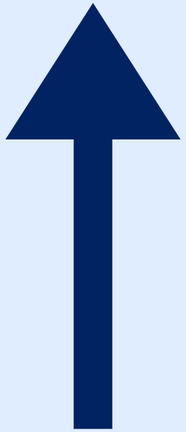
Seeing indistinct shadows or flashing lights, not bothered

Seeing a person hovering outside the 2nd floor window.

ATTENUATED VS. FULL THRESHOLD

Hallucinations

Seeing indistinct shadows or flashing lights, not bothered



Seeing a person who is not there, knowing it is not real, unsettled

Seeing a person hovering outside the 2nd floor window

ATTENUATED VS. FULL THRESHOLD

Disorganization

Slightly vague or over-elaborated speech

Thought blocking or word salad

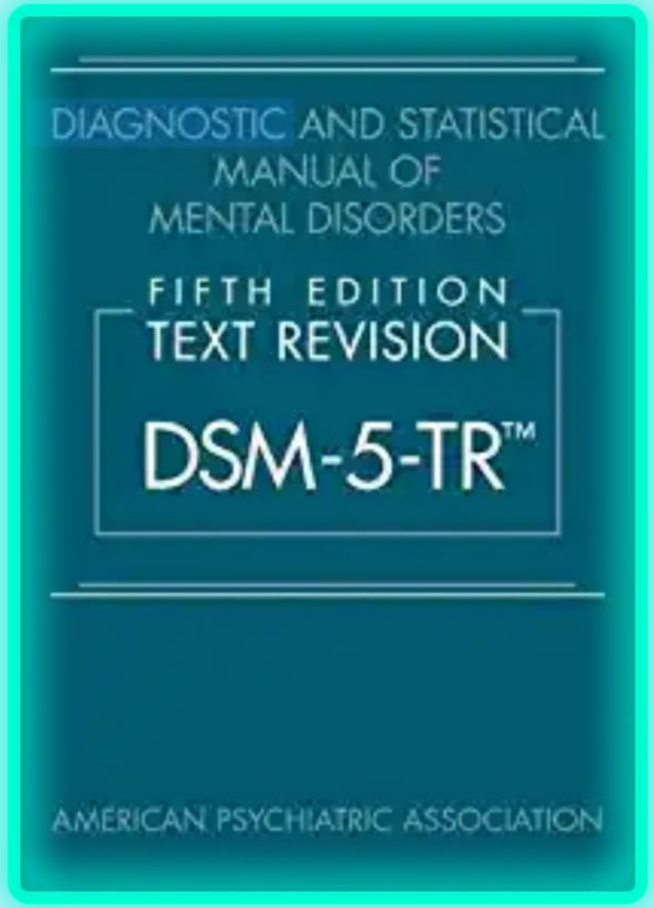
ATTENUATED VS. FULL THRESHOLD

Disorganization

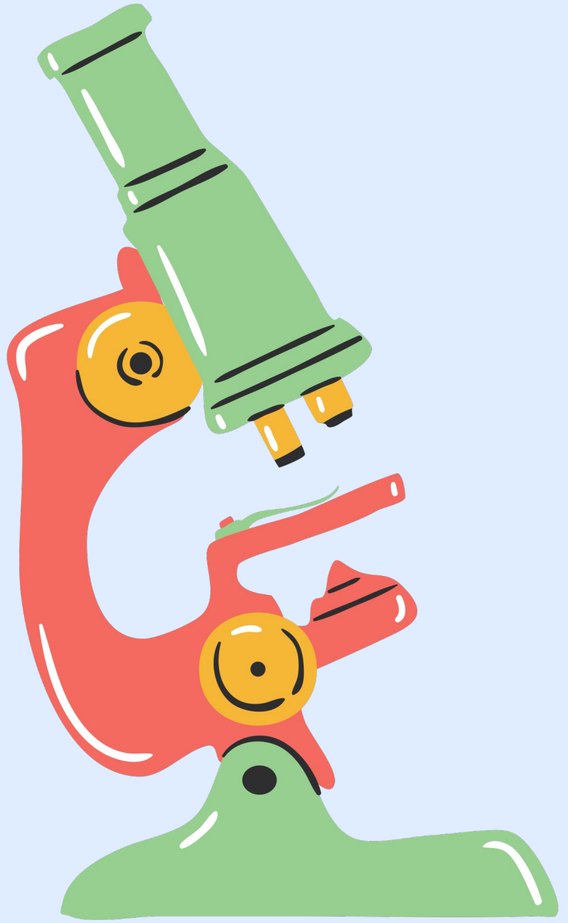
Slightly vague or over-elaborated speech

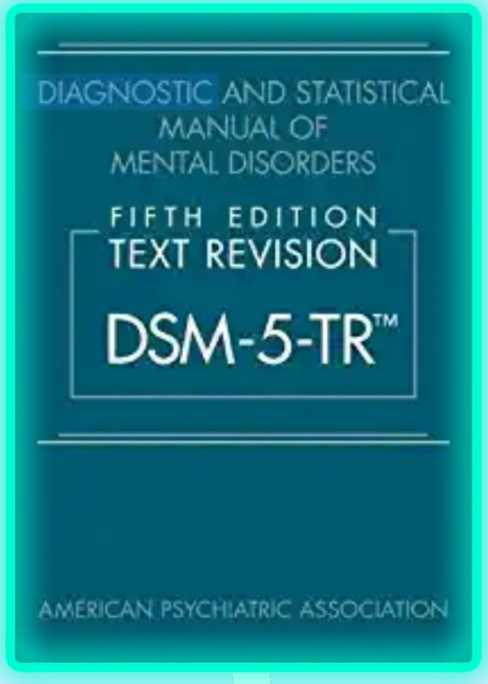
Thought blocking or word salad

Circumstantial speech, can be redirected

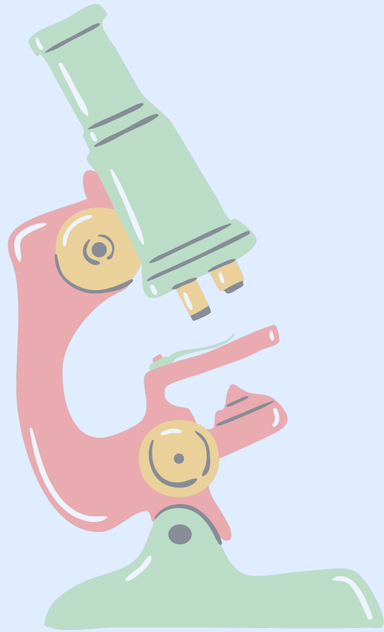

DIAGNOSTIC AND STATISTICAL
MANUAL OF
MENTAL DISORDERS
FIFTH EDITION
TEXT REVISION
DSM-5-TR™
AMERICAN PSYCHIATRIC ASSOCIATION

VS





VS



Other Specified Schizophrenia Spectrum and Other Psychotic Disorder:

Attenuated psychosis syndrome

DIAGNOSES: DSM-5

At least one of **delusions, hallucinations, or disorganized speech** is present in attenuated form and is of sufficient severity or frequency to warrant clinical attention

Minimum 1x/week in last month

Begun or worsened in the past year

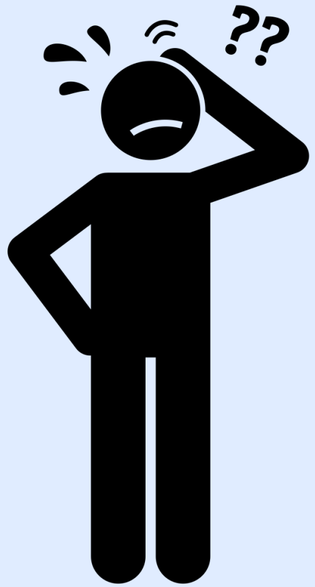
Distressing and disabling

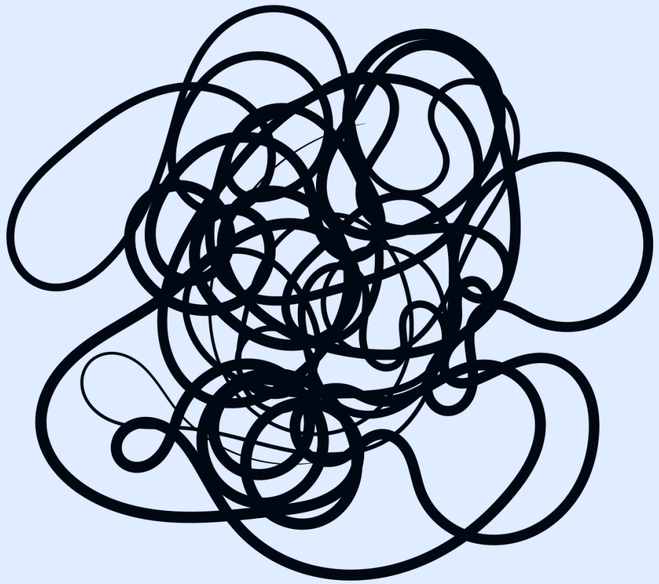
Symptom(s) is not better explained by another mental disorder

Criteria for psychotic disorder(s) never met

ISSUES IN ASSESSMENT AND DIAGNOSIS

DIAGNOSIS IS DIFFICULT!



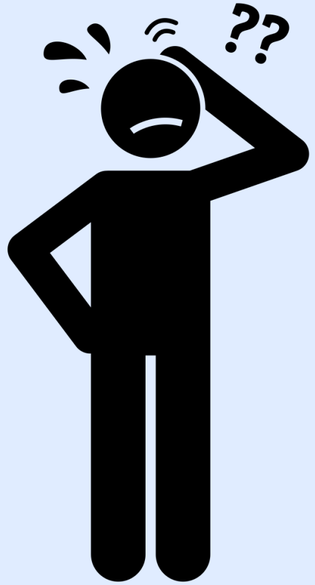


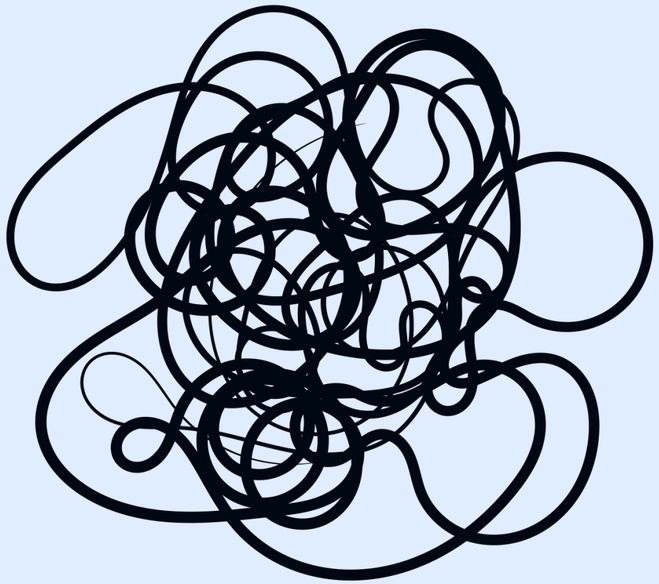
Overlap

In all adult diagnoses in the DSM-5 there are 628 symptoms, and 36.8% of them repeat across multiple diagnoses- a median of 3x repeated

Miri Forbes et al, 2023

DIAGNOSIS IS DIFFICULT!



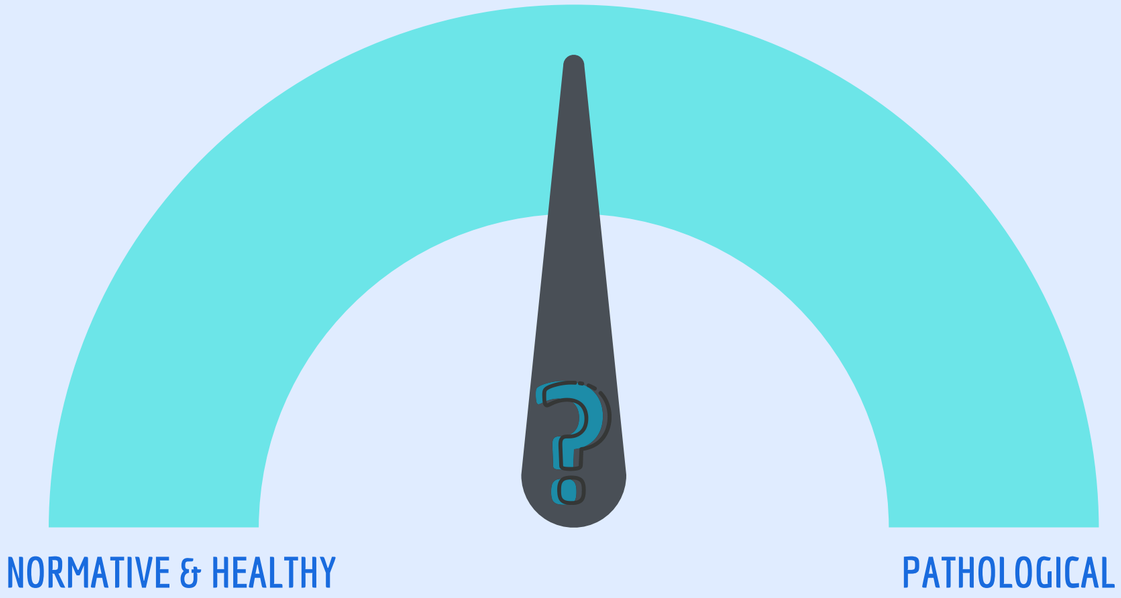


Psychosis = tricky!

51% of people referred to a specialty clinic for schizophrenia were given a different diagnosis by the specialty clinic, and of those, 42% didn't even have a primary psychotic disorder.

Coulter et al., 2019

PSYCHOSIS & CULTURE/CONTEXT: A Unique Challenge



Beliefs & Psychopathology

"Rarely is a mind so disordered, however, that even in illness it does not make extensive use of cultural materials"

Basset & Baker, 2005

DIAGNOSIS IS WEIGHTY

Some people have reluctance to give "heavy" diagnoses because they fear:

- Negative consequences for the client after the diagnosis
- Perceived incompetence
- The process of diagnosis/feedback
- Their diagnosis is inaccurate

Baldwin et al., 2022; Farooq et al., 2019; Outram et al., 2014; Welsh & Tiffin, 2013

HOW DO WE RUN INTO DIFFICULTIES IN DIAGNOSING PSYCHOSIS?

MISATTRIBUTION

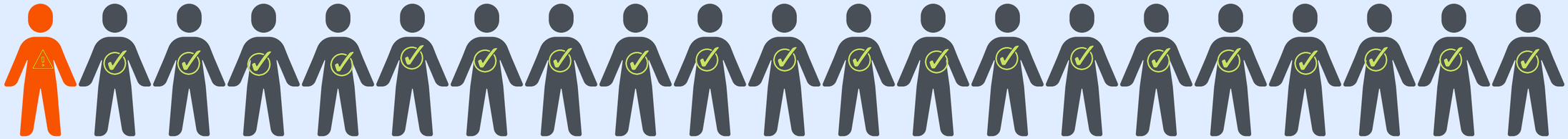
Diagnosing something as psychosis when it's something else

CULTURALLY SENSITIVE ASSESSMENT TOOL

PRN, REDIAGNOSIS

ADEPONLE ET AL., 2012

Non-Psychosis-Spectrum Disorders

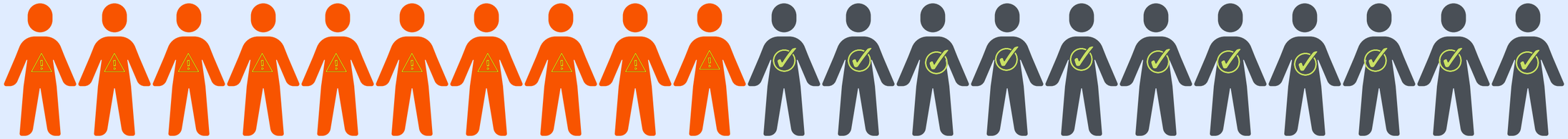


5%

5% re-diagnosis rate

ADEPONLE ET AL., 2012

Psychosis-Spectrum Disorders



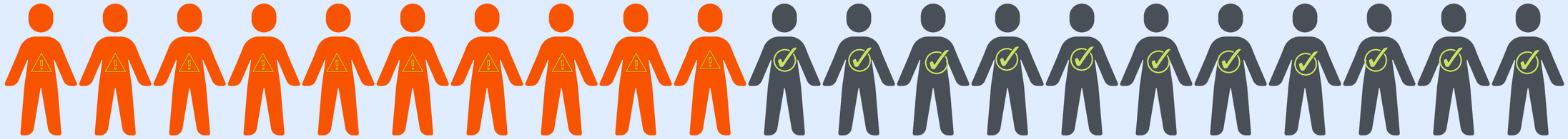
49%

49% re-diagnosis rate

ADEPONLE ET AL., 2012

PTSD &

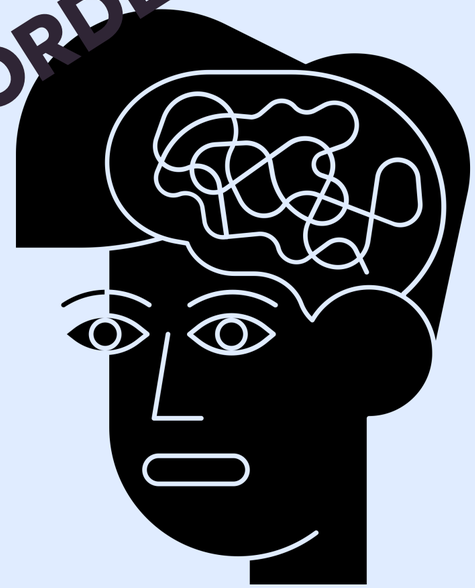
Adjustment Disorder



Psychosis-Spectrum Disorders Re-diagnosed

ADEPONLE ET AL., 2012

TRAUMA &
OTHER DISORDERS



PSYCHOSIS

ADEPONLE ET AL., 2012

THIS CAN BE TRUE FOR OTHER DSM-5 DISORDERS

psychosis?

THIS CAN BE TRUE FOR OTHER DSM-5 DISORDERS

THIS CAN BE TRUE FOR OTHER DSM-5 DISORDERS

THIS CAN BE TRUE FOR OTHER DSM-5 DISORDERS

OVERPATHOLOGIZING

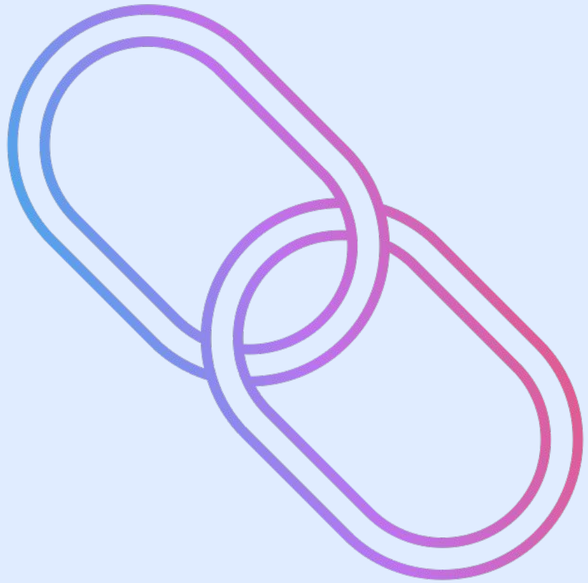
Diagnosing something as psychosis when it's not a disorder

Perceptual abnormality can be culturally bound

PELTIER ET AL. 2016

Perceptual abnormality can be culturally bound

A/V Hallucinations



Diagnosis of SSD

PELTIER ET AL. 2016

A/V Hallucinations → SSD Diagnosis

Spiritual A/V Hallucinations Alone ⊘ SSD Diagnosis

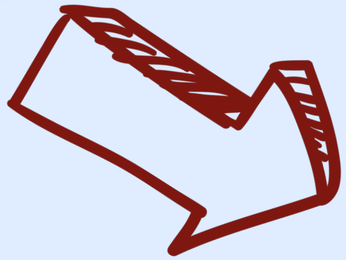
PELTIER ET AL. 2016

A/V Hallucinations of a spiritual nature can be culturally normative

PELTIER ET AL. 2016

ETHNIC OWN-GROUP DENSITY & RISK FOR PSYCHOSIS

10% decrease
Ethnic Own-Group Density

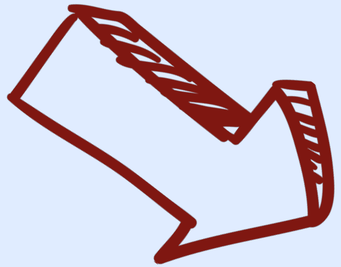


20% increase
Risk for Psychosis

BAKER ET AL., 2021

NEIGHBORHOOD CRIME & ATTENUATED PSYCHOSIS

Neighborhood Crime



Symptoms of Suspiciousness

*controlling for other attenuated psychosis symptoms

WILSON ET AL., 2016

Racialized minority group individuals

Inadequate healthcare & Dismissed in healthcare interactions

Lack of trust and delay in seeking healthcare

Staff tend to construct healthcare as impartial & organizational practices not in place to readily discuss racism in workplace

HAMED ET AL., 2022

MISDIAGNOSIS CAN BE TRUE FOR OTHER EXPERIENCES

psychosis?

MISDIAGNOSIS CAN BE TRUE FOR OTHER EXPERIENCES

MISDIAGNOSIS CAN BE TRUE FOR OTHER EXPERIENCES

OVERLAPPING

Not diagnosing something as psychosis when it is, but its also something else!

Psychosis can be a comorbid concern

Mood

Substance Use

Trauma

Autism Spectrum

COMORBID PSYCHOSIS CAN BE TRUE

either psychosis or

something else?

COMORBID PSYCHOSIS CAN BE TRUE

OVERLOOKING

Not diagnosing something as psychosis when it is

UNDERDIAGNOSING PSYCHOSIS

Psychosis can often be underdiagnosed due to:

Stigma

Lack of insight, confusion about symptoms

Not asking about it

Symptoms looking like another disorder (e.g. negative symptoms and depression)

UNDERDIAGNOSIS OF PSYCHOSIS CAN BE TRUE

nothing

UNDERDIAGNOSIS OF PSYCHOSIS CAN BE TRUE

BEST PRACTICES & IMPLICATIONS FOR HEALTHCARE

IMPLICATIONS

For some, psychosis may be an indicator of distress -higher distress, looser connections

For others, it may represent a broader neurophysiological primary concern

WHY DOES IT MATTER?

Shaping intervention:

- e.g. choosing trauma treatment vs CBTp/ERP

Stigma/Identity questions:

- as online communities of individuals with lived experience are gaining traction, people have more access to information about mental health conditions.
- Not necessarily all **good** information, but more of it, sure!

Access to care/referrals: CSC clinic

- Using precious resource vs. increasing DUP

BEST PRACTICES

Importance of multiple reporters, when possible!

Use gold standard, structured/semi-structured interview tools whenever possible!

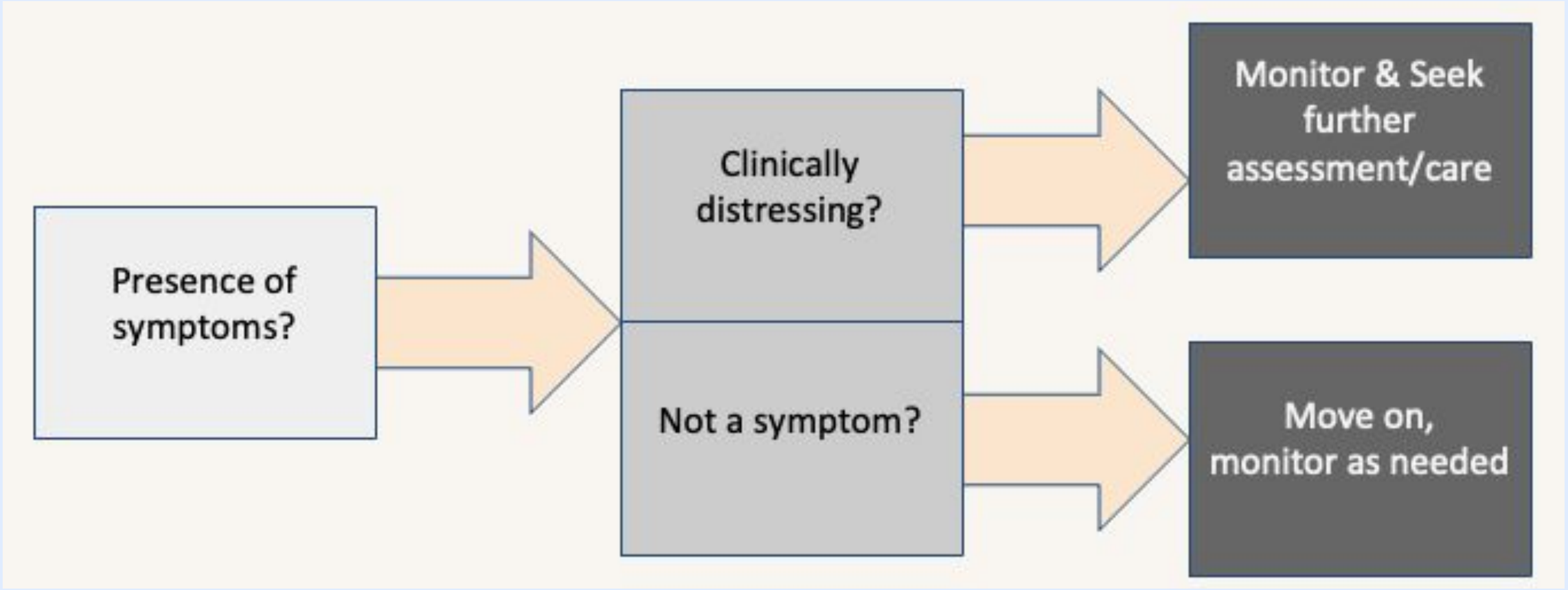
- Stepped care approach to assessment

Clarifying/culturally adapting questions

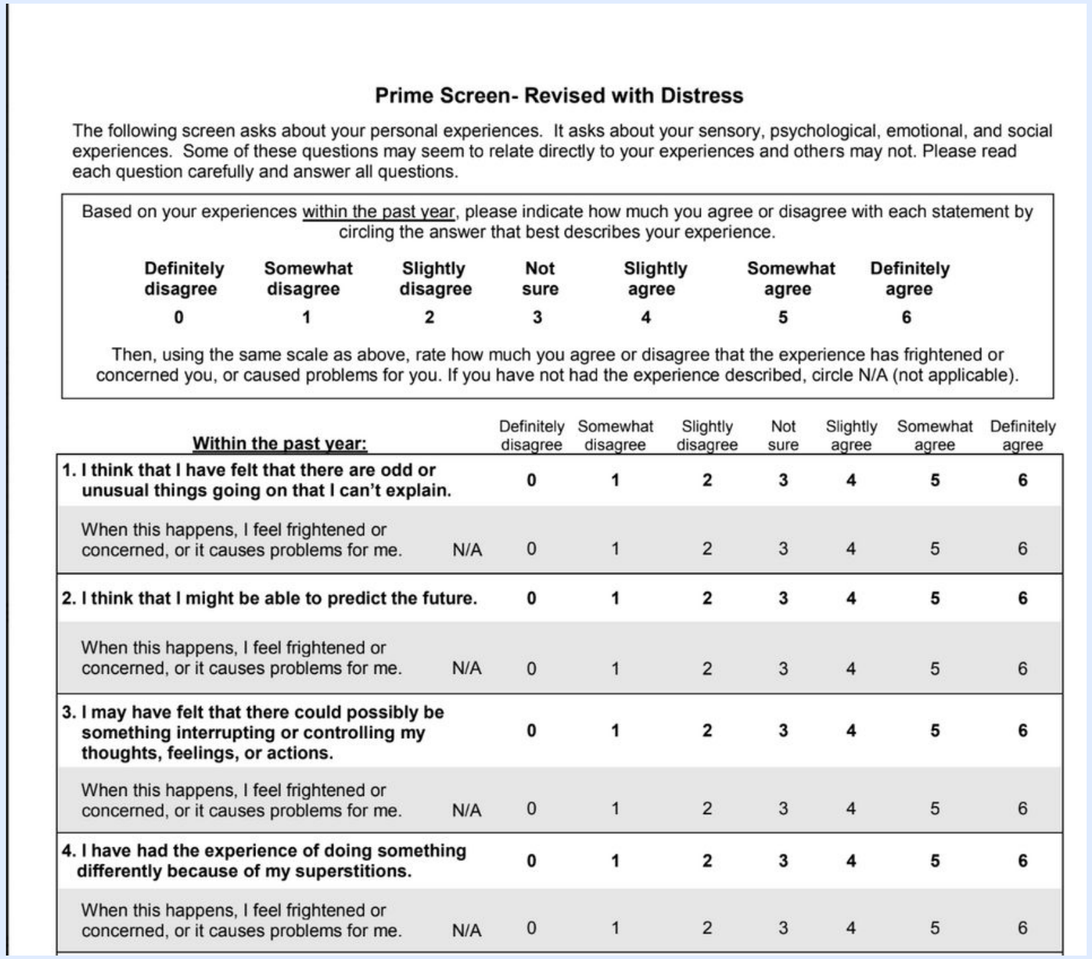
- talk about culturally appropriate suspiciousness

Consult with colleagues, experts, and clients/family!

STEPPED CARE APPROACH TO ASSESSMENT



SCREENING TOOLS



Prime Screen- Revised with Distress

The following screen asks about your personal experiences. It asks about your sensory, psychological, emotional, and social experiences. Some of these questions may seem to relate directly to your experiences and others may not. Please read each question carefully and answer all questions.

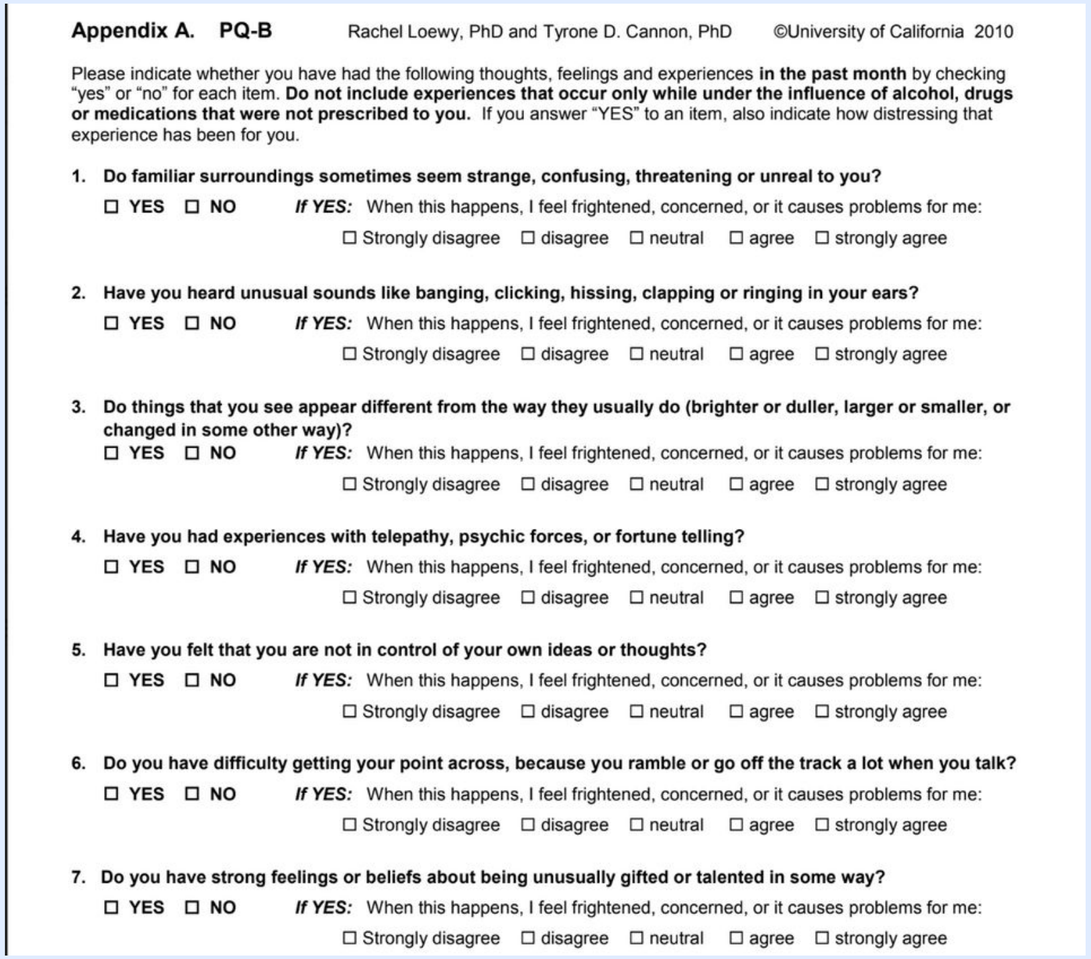
Based on your experiences within the past year, please indicate how much you agree or disagree with each statement by circling the answer that best describes your experience.

Definitely disagree	Somewhat disagree	Slightly disagree	Not sure	Slightly agree	Somewhat agree	Definitely agree
0	1	2	3	4	5	6

Then, using the same scale as above, rate how much you agree or disagree that the experience has frightened or concerned you, or caused problems for you. If you have not had the experience described, circle N/A (not applicable).

Within the past year:		Definitely disagree	Somewhat disagree	Slightly disagree	Not sure	Slightly agree	Somewhat agree	Definitely agree
1. I think that I have felt that there are odd or unusual things going on that I can't explain.		**0**	**1**	**2**	**3**	**4**	**5**	**6**
When this happens, I feel frightened or concerned, or it causes problems for me.	N/A	0	1	2	3	4	5	6
2. I think that I might be able to predict the future.		**0**	**1**	**2**	**3**	**4**	**5**	**6**
When this happens, I feel frightened or concerned, or it causes problems for me.	N/A	0	1	2	3	4	5	6
3. I may have felt that there could possibly be something interrupting or controlling my thoughts, feelings, or actions.		**0**	**1**	**2**	**3**	**4**	**5**	**6**
When this happens, I feel frightened or concerned, or it causes problems for me.	N/A	0	1	2	3	4	5	6
4. I have had the experience of doing something differently because of my superstitions.		**0**	**1**	**2**	**3**	**4**	**5**	**6**
When this happens, I feel frightened or concerned, or it causes problems for me.	N/A	0	1	2	3	4	5	6

Prime Screen Revised



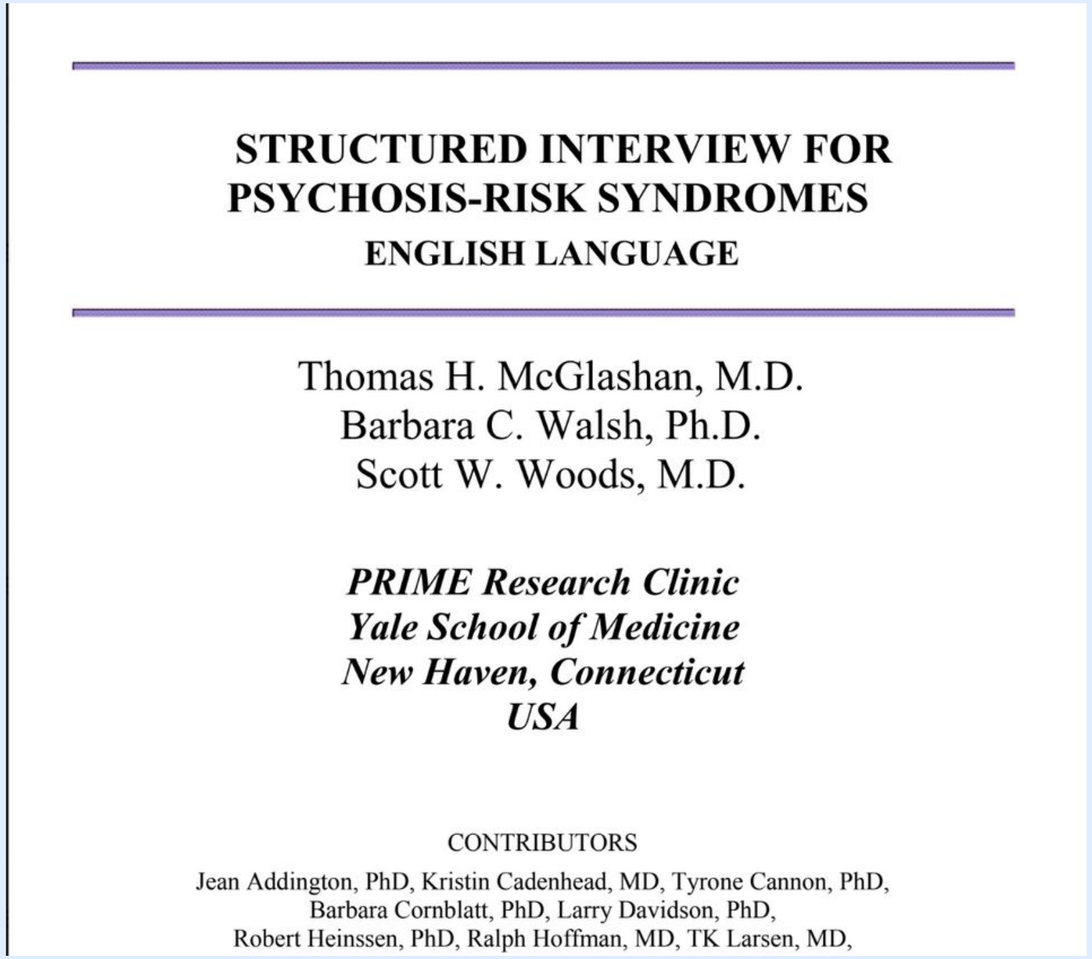
Appendix A. PQ-B Rachel Loewy, PhD and Tyrone D. Cannon, PhD ©University of California 2010

Please indicate whether you have had the following thoughts, feelings and experiences **in the past month** by checking "yes" or "no" for each item. **Do not include experiences that occur only while under the influence of alcohol, drugs or medications that were not prescribed to you.** If you answer "YES" to an item, also indicate how distressing that experience has been for you.

1. **Do familiar surroundings sometimes seem strange, confusing, threatening or unreal to you?**
   ☐ **YES** ☐ **NO** ***If YES:*** When this happens, I feel frightened, concerned, or it causes problems for me:
   ☐ Strongly disagree ☐ disagree ☐ neutral ☐ agree ☐ strongly agree
2. **Have you heard unusual sounds like banging, clicking, hissing, clapping or ringing in your ears?**
   ☐ **YES** ☐ **NO** ***If YES:*** When this happens, I feel frightened, concerned, or it causes problems for me:
   ☐ Strongly disagree ☐ disagree ☐ neutral ☐ agree ☐ strongly agree
3. **Do things that you see appear different from the way they usually do (brighter or duller, larger or smaller, or changed in some other way)?**
   ☐ **YES** ☐ **NO** ***If YES:*** When this happens, I feel frightened, concerned, or it causes problems for me:
   ☐ Strongly disagree ☐ disagree ☐ neutral ☐ agree ☐ strongly agree
4. **Have you had experiences with telepathy, psychic forces, or fortune telling?**
   ☐ **YES** ☐ **NO** ***If YES:*** When this happens, I feel frightened, concerned, or it causes problems for me:
   ☐ Strongly disagree ☐ disagree ☐ neutral ☐ agree ☐ strongly agree
5. **Have you felt that you are not in control of your own ideas or thoughts?**
   ☐ **YES** ☐ **NO** ***If YES:*** When this happens, I feel frightened, concerned, or it causes problems for me:
   ☐ Strongly disagree ☐ disagree ☐ neutral ☐ agree ☐ strongly agree
6. **Do you have difficulty getting your point across, because you ramble or go off the track a lot when you talk?**
   ☐ **YES** ☐ **NO** ***If YES:*** When this happens, I feel frightened, concerned, or it causes problems for me:
   ☐ Strongly disagree ☐ disagree ☐ neutral ☐ agree ☐ strongly agree
7. **Do you have strong feelings or beliefs about being unusually gifted or talented in some way?**
   ☐ **YES** ☐ **NO** ***If YES:*** When this happens, I feel frightened, concerned, or it causes problems for me:
   ☐ Strongly disagree ☐ disagree ☐ neutral ☐ agree ☐ strongly agree

Prodromal Questionnaire-Brief

INTERVIEW TOOLS



STRUCTURED INTERVIEW FOR PSYCHOSIS-RISK SYNDROMES

ENGLISH LANGUAGE

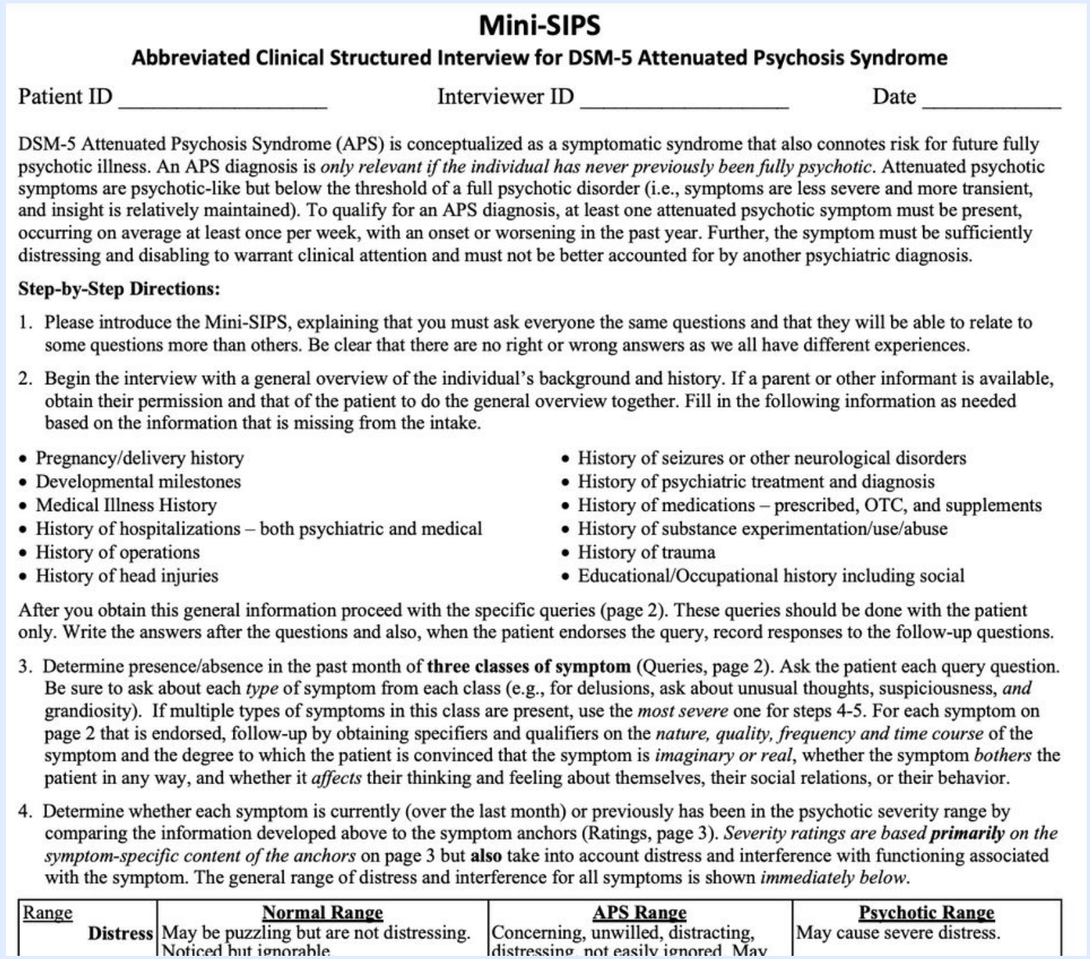
Thomas H. McGlashan, M.D.
Barbara C. Walsh, Ph.D.
Scott W. Woods, M.D.

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

CONTRIBUTORS

Jean Addington, PhD, Kristin Cadenhead, MD, Tyrone Cannon, PhD,
Barbara Cornblatt, PhD, Larry Davidson, PhD,
Robert Heinssen, PhD, Ralph Hoffman, MD, TK Larsen, MD,

Structured Interview for Psychosis-Risk Syndromes (SIPS)



Mini-SIPS

Abbreviated Clinical Structured Interview for DSM-5 Attenuated Psychosis Syndrome

Patient ID _____ Interviewer ID _____ Date _____

DSM-5 Attenuated Psychosis Syndrome (APS) is conceptualized as a symptomatic syndrome that also connotes risk for future fully psychotic illness. An APS diagnosis is *only relevant if the individual has never previously been fully psychotic*. Attenuated psychotic symptoms are psychotic-like but below the threshold of a full psychotic disorder (i.e., symptoms are less severe and more transient, and insight is relatively maintained). To qualify for an APS diagnosis, at least one attenuated psychotic symptom must be present, occurring on average at least once per week, with an onset or worsening in the past year. Further, the symptom must be sufficiently distressing and disabling to warrant clinical attention and must not be better accounted for by another psychiatric diagnosis.

Step-by-Step Directions:

1. Please introduce the Mini-SIPS, explaining that you must ask everyone the same questions and that they will be able to relate to some questions more than others. Be clear that there are no right or wrong answers as we all have different experiences.
2. Begin the interview with a general overview of the individual's background and history. If a parent or other informant is available, obtain their permission and that of the patient to do the general overview together. Fill in the following information as needed based on the information that is missing from the intake.

- Pregnancy/delivery history
- Developmental milestones
- Medical Illness History
- History of hospitalizations – both psychiatric and medical
- History of operations
- History of head injuries
- History of seizures or other neurological disorders
- History of psychiatric treatment and diagnosis
- History of medications – prescribed, OTC, and supplements
- History of substance experimentation/use/abuse
- History of trauma
- Educational/Occupational history including social

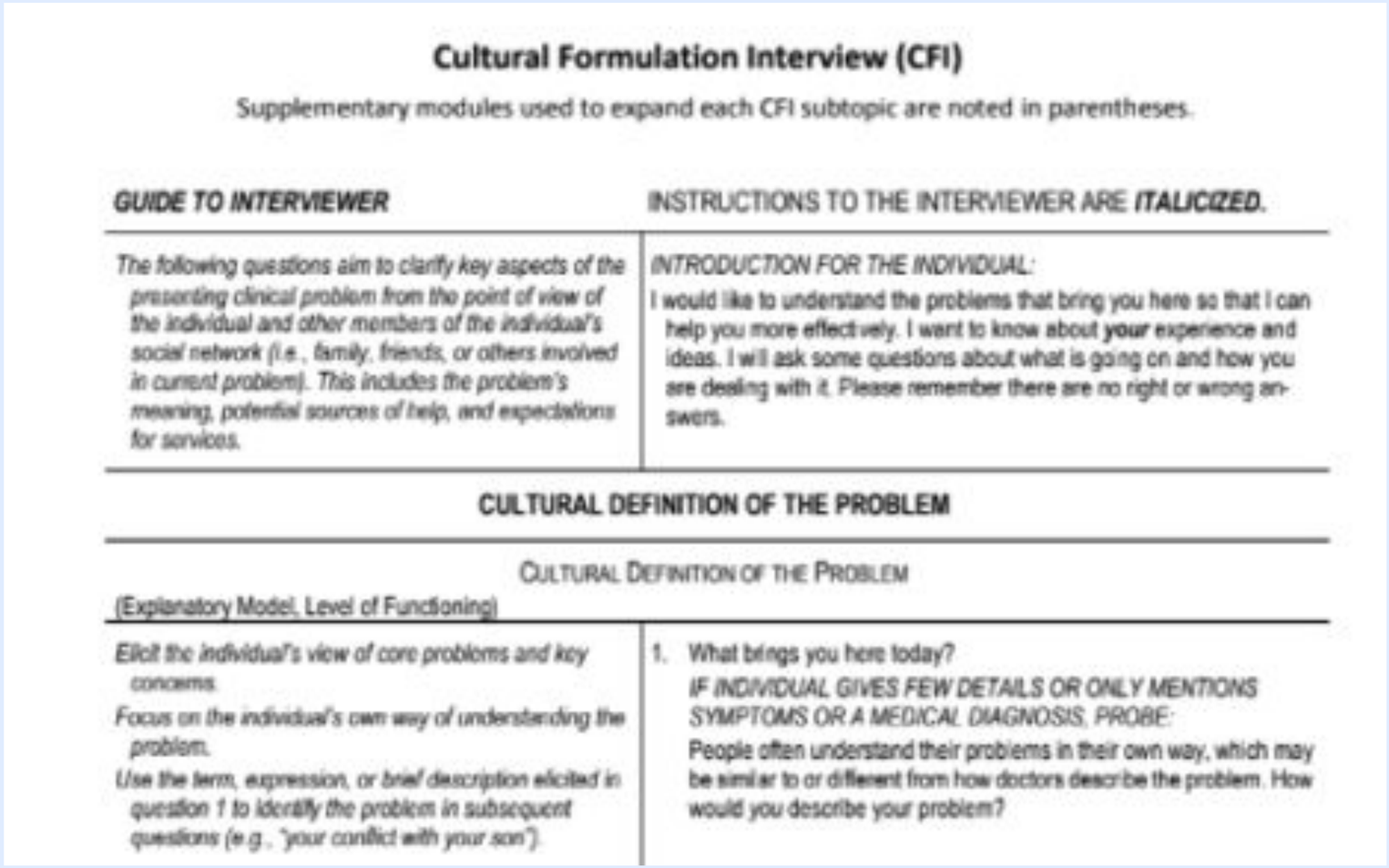
After you obtain this general information proceed with the specific queries (page 2). These queries should be done with the patient only. Write the answers after the questions and also, when the patient endorses the query, record responses to the follow-up questions.

3. Determine presence/absence in the past month of **three classes of symptom** (Queries, page 2). Ask the patient each query question. Be sure to ask about each *type* of symptom from each class (e.g., for delusions, ask about unusual thoughts, suspiciousness, *and* grandiosity). If multiple types of symptoms in this class are present, use the *most severe* one for steps 4-5. For each symptom on page 2 that is endorsed, follow-up by obtaining specifiers and qualifiers on the *nature, quality, frequency and time course* of the symptom and the degree to which the patient is convinced that the symptom is *imaginary or real*, whether the symptom *bothers* the patient in any way, and whether it *affects* their thinking and feeling about themselves, their social relations, or their behavior.
4. Determine whether each symptom is currently (over the last month) or previously has been in the psychotic severity range by comparing the information developed above to the symptom anchors (Ratings, page 3). *Severity ratings are based **primarily** on the symptom-specific content of the anchors* on page 3 but **also** take into account distress and interference with functioning associated with the symptom. The general range of distress and interference for all symptoms is shown *immediately below*.

Range	Normal Range	APS Range	Psychotic Range
Distress	May be puzzling but are not distressing. Noticed but ignorable	Concerning, unwilled, distracting, distressing, not easily ignored. May	May cause severe distress.

MINI-SIPS

CULTURALLY SENSITIVE ASSESSMENT



Cultural Formulation Interview (CFI)

Supplementary modules used to expand each CFI subtopic are noted in parentheses.

GUIDE TO INTERVIEWER	INSTRUCTIONS TO THE INTERVIEWER ARE ***ITALICIZED.***
The following questions aim to clarify key aspects of the presenting clinical problem from the point of view of the individual and other members of the individual's social network (i.e., family, friends, or others involved in current problem). This includes the problem's meaning, potential sources of help, and expectations for services.	*INTRODUCTION FOR THE INDIVIDUAL:* I would like to understand the problems that bring you here so that I can help you more effectively. I want to know about **your** experience and ideas. I will ask some questions about what is going on and how you are dealing with it. Please remember there are no right or wrong answers.

CULTURAL DEFINITION OF THE PROBLEM

CULTURAL DEFINITION OF THE PROBLEM (Explanatory Model, Level of Functioning)	
Elicit the individual's view of core problems and key concerns. *Focus on the individual's own way of understanding the problem.* *Use the term, expression, or brief description elicited in question 1 to identify the problem in subsequent questions (e.g., "your conflict with your son").*	1. What brings you here today? *IF INDIVIDUAL GIVES FEW DETAILS OR ONLY MENTIONS SYMPTOMS OR A MEDICAL DIAGNOSIS, PROBE:* People often understand their problems in their own way, which may be similar to or different from how doctors describe the problem. How would you describe your problem?

QUESTIONS?

PLEASE

REQUEST

Please take this very brief 3 question survey to help our team keep track of and improve our trainings on psychosis!

PLEASE

REQUEST

https://redcap.umbc.edu/surveys/

enter code: XCPKMM74P

OR

Thank you!

MARYLAND EIP