Behavioral Health Update on First Episode Psychosis and Suicide in Children and Adolescents

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WHAT IS PSYCHOSIS?

• Psychosis is the term used to describe a mental state in which the individual experiences a distortion or loss of contact with reality, without clouding of consciousness. It is part of several serious mental illnesses including schizophrenia and bipolar affective disorder.

• Characterized by delusions, hallucinations, and/or thought disorder.

• Affect blunting, and loss of motivation can occur.

• Secondary features can include: depression, anxiety, sleep disturbance, social withdrawal and impaired role functioning during a psychotic episode.
WHAT IS PSYCHOSIS? Continued

CAUSE

• Organic such as drug intoxication, metabolic and infective causes

• Functional disorders such as schizophrenia, bipolar disorder, schizophreniform psychosis and schizoaffective disorder

• About 2% of the population will experience a psychotic episode at some stage in their life.
CONTINUUM OF EXPERIENCE

• The first or only episode of psychosis is most likely to occur between the ages of 18 and 28.

• A psychotic experience presents with unusual sensations and thoughts.

• Likely to feel set apart from family and peers so they may feel specially chosen or persecuted.

• There is no typical reaction.

• May include feeling anxious, depressed or enlightened.

• Sensory deprivation, sleep deprivation, or drug use can induce psychotic states in otherwise mentally healthy individuals.
FIRST EPISODE PSYCHOSIS

• Approximately 100,000 adolescents and young adults in the US experience First Episode Psychosis each year. The Nebraska First Episode Psychosis pilot through The Department of Health and Human Services Division of Behavioral Health has begun taking its first clients and will provide enhanced services serving first episode psychosis in youth and young adults ages 15-25 with a diagnosis of Schizophrenia, Schizophreniform Disorder, Schizoaffective Disorder, Delusion Disorder, Brief Psychotic Disorder and Psychotic Disorder NOS.

• 9% of 7/8 year olds have experience of hearing voices in a given year – more than adolescents.
FIRST EPISODE PSYCHOSIS

• The National Institute of Mental Health reports participants in Coordinated Specialty Care:
  • Experienced significantly greater improvement in quality of life
  • Were more likely to be working or going to school
  • Showed a significantly greater degree of improvement on overall symptoms, including depression
  • Showed the greatest improvement when treatment was offered within the first 18 months of illness
THE PILOT PROGRAM IN NEBRASKA

• Implemented in two of the six behavioral health service regions of the state, based on the target population of adolescents and young adults, where they are located and where services are being delivered. One in Omaha for Region 6 and one in Kearney Region 3. These areas were selected because of concentration of youth identified as experiencing FEP as well as existing concentration of specialty youth services.

• For more information about “On Track Central Nebraska” serving young people and their families or would like to make a referral for the pilot, please contact Jessica Vickers at 308-234-6029 or e-mail her at jvickers@centerforpsychsrvs.org

• To contact “On Track of the Heartland” serving Omaha area contact Mindy Blair at 402-552-7003 or email mblair@heartlandfamilyservice.org.
WHO IS AFFECTED?

It is postulated that the onset and course of psychosis is determined by an underlying vulnerability to psychosis coupled with the impact of environmental stressors which may then trigger active psychotic symptoms. Major determinants of this vulnerability appear to be biological and influenced by both psychosocial and physical triggers like substance abuse. Precise identification of individual vulnerability is not possible, certain people are at more risk of developing a psychotic illness.
RISK FACTORS

Family history of psychosis
Schizotypal, schizoid and paranoid personality disorders
Adolescence and young adulthood.

An estimated 80% of patients affected by a psychotic disorder experience their first episode between 16-30 years of age.
EARLY INTERVENTION

The loss of contact with reality characteristic of psychosis can be a very frightening and traumatic experience.

The first episode of psychosis can be particularly distressing and confusing for the individual, their family and peers, since the experience is so unfamiliar and difficult to understand.

• Given the first episode commonly occurs in adolescence or early adult life, an important time for the development of identity, independence, relationships and long-term vocational plans, the onset of psychosis can therefore cause considerable disruption and numerous secondary problems can develop.
A psychotic episode commonly isolates the person from others and disturbs peer relationships. The person’s personal and social development will be put on hold, or may even slip backwards. Impairment of school and work performance is common with the potential for profound damage to future vocational prospects and consequent financial insecurity. Substance abuse may begin or intensify and the risk of suicide is increased. The longer the illness is left untreated the greater the risk of permanent derailment of the person’s psychosocial development.
There is evidence to suggest that delayed treatment may cause the illness to become more biologically entrenched and less responsive to treatment. Longer periods of untreated psychosis have been related to slower recovery rates and poorer degrees of recovery, greater relapse rates and lower levels of social and occupational functioning and this effect appears to be independent of other prognostic factors.

By contrast, early diagnosis and treatment leads to improved recovery and outcome. Many individuals experience prolonged periods of untreated psychosis during their first episode. Major delays between the onset of psychotic symptoms and the initiation of appropriate treatment. These delays are often in the order of many months to a year or more.
THE COURSE OF THE ILLNESS

The typical course of the initial psychotic episode can be conceptualized as occurring in three phases. These are the prodromal phase, the active phase and the recovery phase.
The Prodrome Phase

Psychotic illnesses rarely present out of the blue. Almost always, they are preceded by a gradual change in psychosocial functioning, often over an extended period. This period during which the individual may start to experience a change in themselves although they have not yet started experiencing clear-cut psychotic symptoms can be thought of as the prodromal phase of the illness.

Some changes seen include:
- Changes in affect such as anxiety, irritability and depression
- Changes in cognition such as difficulty in concentration or memory
- Changes in thought content, such as a preoccupation with new ideas often of an unusual nature
- Physical changes such as sleep disturbance and loss of energy
- Social withdrawal and impairment of role functioning.
PRODROMAL PHASE

The person may also experience some attenuated positive symptoms such as mild thought disorder, ideas of reference, suspiciousness, odd beliefs and perceptual distortions which are not quite of psychotic intensity or duration. These may be brief and intermittent at first, escalating during times of stress or substance abuse and then perhaps subsiding before eventually becoming sustained with the emergence of frank psychosis.

It is clear that persistent or worsening psychological changes in an adolescent/young adult may herald the development of a mental disorder such as psychosis and this possibility needs to be kept in mind, particularly if other risk factors are present.
THE ACTIVE PHASE

The active phase of psychosis is characterized by the presence of positive psychotic symptoms which include thought disorder, delusions, and hallucinations.

Hallucinations are sensory perceptions in the absence of an external stimulus. The most common type are auditory hallucinations. Other types of hallucinations include visual, tactile, gustatory and olfactory.
DELDUSIONS

Delusions are fixed, false beliefs out of keeping with the person’s cultural environment. They may be sustained despite proof to the contrary. These beliefs are often idiosyncratic and very significant to the patient but hard for other people to understand. Delusions often gradually build up in intensity, being more open to challenge in the initial stages before becoming more entrenched. They can take many forms.

Common types of delusions include:
• Persecutory delusions
• Religious delusions
• Grandiose delusions
• Delusions of reference
• Somatic delusions and
  Passivity delusions (thought insertion / broadcasting / withdrawal.)
It is important to remember that many patients with an underlying psychological / psychiatric disorder will initially present with physical symptom, which concern them, such as tiredness, repeated headaches or insomnia. An underlying psychological disturbance should always be considered in an individual presenting with persistent or ill-defined somatic complaints in the absence of demonstrable physical pathology on examination or investigation.
RECOVERY PHASE

The majority of young people experiencing their first psychotic episode will make a complete recovery, although a significant minority (10% to 20%) will develop persistent symptoms. Once treatment is instituted, some people will get better slowly, but surely, while others will go through a period of seeming lack of progress them make sudden shift in well-being.

Once full recovery is achieved, the major focus is on maintaining and promoting wellness and the prevention of relapse. Each relapse represent a potential risk point for the development of more enduring impairment and disability and appears to contribute to treatment resistance. Long term follow up is essential.
CONTINUING CARE

Recovery is the norm after an initial psychotic episode and around 25% of affected young people will then never experience a further psychotic episode. The rest remain vulnerable to future exacerbations of their psychotic disorder.

Overall, the treatment of adolescents and young adults with a psychotic illness requires that the clinician maintain a balance between assertive care in order to promote harm reduction while allowing the young person to run the show. Collaboration is essential but takes time to achieve.
NURSING ROLE IN PSYCHOSIS MANAGEMENT

People who are caught in a psychotic world may not accept this view. The most natural reaction when faced with psychosis is to try to make sense of it using your own resources to make sense of it. This explains why people who hear voices telling them what to do may attribute these voices to a higher power. Yet this reinforces the voice’s authority and the individuals powerlessness against it.

Another example is people who feel they are being watched and then notice when a police car or a man in black is near. Their experiences reinforce their inner beliefs.

Cognitive and behavioral therapies aim to modify the individual’s beliefs, thoughts and behavior in psychosis. The therapist works collaboratively with the patient to unravel the fabric of their psychosis. This approach helps people to make sense of their experiences. This therapy is buildt on a trusting relationship and the lack of it can be a serious obstacle to therapeutic work.
Takes years to build, seconds to break and forever to repair.
TRUST AND ALLIANCE

Nobody appreciates being told that they are mentally ill, that they have misunderstood what has been going on and that they need to return to consensual reality. IT IS INSULTING and incredible for most of us to imagine being given a psychiatric diagnosis such as schizophrenia. Some people prefer their psychotic world or have invested a lot of time and emotion in it. Gaining the trust of people who are believed to be psychotic demands great skill and sensitivity.

This means you listen to their stories, get inside their world, and acknowledge why they hold particular beliefs. Listening to psychotic people’s stories can reveal how they have made sense of unusual experiences. Gentle challenges such as ‘how can that be?’ or ‘how do you know?’ can prompt reflection on recent events.
TREATMENT

• Psychosis is usually treated with antipsychotic medication if it persists for more than a few days. If the person will not take the medication, this presents a potential threat to the therapeutic alliance. That basic trust between patient and nurse aids the taking of medication.

• It is far better for patients to make an informed choice to take medication than to be coerced. Compliance with medication suggests submission to an authority. Alliance suggests partnership and power-sharing.
SUICIDE AND THE FIRST EPISODE OF PSYCHOSIS

• Our understanding of suicide in psychosis has been greatly assisted by the focus in recent years on the importance of the first episode of psychosis. We now know that the first episode is one of the highest risk periods. On average one person in a hundred will commit suicide each year in the first five years after their first contact with services. Many will have already attempted several times before first contact.

• Not all self inflicted fatalities in psychosis are strictly speaking suicides as individuals may not have intended to end their lives. Some may have been accidental even if due to illness factors such as delusions or acute confused behavior.
What is Suicide and Suicidal Behavior?
Suicidal behavior refers to the range of actions related to suicide including:

- **Suicidal Ideation** – thoughts of engaging in suicidal behavior, with or without a specific plan.
- **Suicide attempt** - potentially self-injurious act intended to end one’s life but which does not result in death.
- **Suicide** – self-injurious act intended to end one’s life which results in death.
FACTS AND STATISTICS

• Suicidal ideation occurs in prepubertal children, but suicide attempts and completions are rare. Between 2008 and 2010, the incidence rate of suicide among children aged 5 to 11 years of age in the United States was 1 per million – a total of 155 children committed suicide.

• Suicide is the second leading cause of death among all children and adolescents in the US in ages 10-19 years of age.
• Every two hours and seven minutes, a person under the age of 25 completes suicide.

• After puberty, the rate of suicide increases with age. This is thought to be related to the ability to carry out an executed plan.

• Girls who matured early are more likely to have a lifetime history of disruptive mood disorder and attempt suicide more than their peers.
• Girls attempt suicide more frequently but boys are more likely to complete suicide.

• In the past 60 years, the suicide rate has quadrupled for 15 – 24 year old males and doubled for females.

• Guns are the most commonly used suicide method among youth, accounting for 45.9% of all completed suicides.

• Data indicates that there are as many as 50 to 100 suicide attempts for every completed suicide in adolescents.
• Suicidal ideation often precedes suicide attempts. In the US, adolescents who suffered suicidal ideation attempted suicide 34% of the time.

• Substance use disorders contribute substantially to risk of suicide especially in older adolescent males when co-occurring with mood disorder or disruptive disorders.

• More than 50 percent of transgender youth attempt suicide at least once before their 20th birthday.
Contributing Risk Factors
First Episode Psychosis and Other Psychiatric Disorders including:

- Depressive Disorder – most common and most prevalent
- Oppositional Defiant Disorder
- Conduct Disorder
- Bipolar Disorder
- Anxiety Disorder
- Eating Disorders
- Personality Disorders

- Substance Use Disorders
- Family History of Mood Disorders and or Suicidal Behavior
- Biological factors – LGBT – lesbian, gay, bisexual, transgender

The majority of youth who attempt or commit suicide have some type of psychiatric disorder
More Risk Factors
In addition to the psychiatric illnesses we discussed, here are additional risk factors:

Trauma
- Physical abuse –
- Sexual abuse – increases risk of suicide attempt by 8 times
- Exposure to violence – doubles the risk of suicide
- Any stressor that contributes to traumatization of individual

Previous suicide attempts – if they tried it once, they are more likely to try it again

Exposure to another’s suicide, especially a family member or friend

Expression of thoughts of suicide, death, dying

Family instability or significant family conflict
Other Precipitating Factors (also known as Proximal Factors)

• Social stress – peers, school
• Isolation
• Emotional and cognitive factors
• Access to means (guns in house; medications; etc)
• Bullying
Bullying “Bullicide”

- We hear a lot about kids being bullied and how being a victim of bullying can accentuate those already vulnerable at risk for suicide or suicidal behavior. That connection is not difficult to comprehend.

- Suicide attempts are 2-3 times more likely to occur in children who were bullied than those who were not.

- However, children who themselves are the “bully” are also at greater risk for suicide and suicidal behaviors.

- Why?
Bullying has the potential to cause distress for the person, either because their bullying efforts have backfired, or because it is distressing to be feared, avoided, and hated. Often, these bullies are emotionally and psychologically maladjusted suffering from one or more of the psychiatric illnesses previously discussed.

Kids who bully are often more likely to suffer from greater depression and anxiety than the actual victims.
Cyberbullying

• Definition - Cyberbullying is when a child or teen is tormented, threatened, harassed, humiliated, embarrassed or otherwise targeted by another child or teen using the internet, interactive and digital technologies or mobile phones.”

• Cyberbullying is the newest form of bullying and can have devastating effects including suicide. There has been a great deal of media attention lately as it is posing many issues for schools and parents. It has created a new level of stress for our youth. For more information on how to prevent cyberbullying go to www.stopcyberbullying.org.
Identifying Children and Adolescents at Risk for Suicide/Suicidal Behaviors

Behavior’s exhibited can include:

- Sad, anxious or “empty” mood
- Sleeping too little or too much
- Changes in weight, appetite or eating habits
- Deteriorating grooming habits
- Declining school performance
- Talking about or preoccupation with death
- Signs of psychotic thinking
• Intolerance or praise or rewards
• Loss of pleasure or interest in sports or social activities
• Giving away prized possessions
• Dramatic changes in personality
• Suddenly becoming cheerful after a period of sadness/depression
• Deteriorating relationships with friends or family; trouble with boyfriend or girlfriend; withdrawing from people used to feel close to
• Out of character boredom or trouble concentrating
• Abuse of alcohol or drugs
• Physical complaints that seem to have no physical basis
EPIDEMIOLOGY

• The reasons for increases in suicide are not clear; possible explanations include the misclassification of unintentional asphyxia from adolescents playing “the choking game” (i.e., intentionally restricting the supply of oxygenation to the brain, often with a ligature, to induce a brief euphoria) and changes in risk factors for suicide or suicide methods.

• Suicide attempts are common. Available data indicate that there are as many as 50 to 100 suicide attempts for every completed suicide in adolescents. The reasons for suicide attempts vary by sex and age.

• Suicidal ideation often precedes suicide attempts. In the US adolescents who suffered suicidal ideation attempted suicide 34% of the time.
AGE

• Suicidal ideation occurs in prepubertal children, but suicide attempts and completions are rare. Between 20008 and 2012 the incidence rate of suicide among children aged 5 to 11 years in the US was 1 per 1 million a total of 155 children committed suicide.

• After puberty, the rate of suicide increases with age. Probably due to the ability to carry out a well thought out plan.

• Girls who matured early were more likely to have a lifetime history of disruptive behavior disorder and suicide attempts than their peers.

• Girls attempt suicide more frequently but boys are more likely to complete suicide. This is probably related to the methods they use.
THE ‘AT RISK MENTAL STATE’ PHASE

• Up to 90% of young people attending specialty clinics in the prodromal phase report being suicidal.

• Most people don’t seek help during this phase of illness and on average people endure about two years of prodromal symptoms before their first episode of psychosis.

• How many attempt of complete suicide during this phase is unknown but it is likely to be significant.
SUICIDE RISK ASSESSMENT

• Suicide risk should be ascertained as early as possible when patients with psychosis first present to services. Initial assessment should be as comprehensive as possible as it will usually form the basis for determining later assessments.

• Any assessment tool should be used with caution and only as an adjunct to a comprehensive clinical assessment.

• One such tool is the Suicide Risk Factor Check-list which will help enable a systematic consideration of risk factors to support a formulation, care planning and risk management.
RISK FACTORS

Risk factors for suicidal behavior in children and adolescents can be categorized as predisposing or precipitating factors. **Predisposing factors increase an individual's risk for suicide and include:**

- Psychiatric disorders
- Previous suicide attempt
- Family history of mood disorder and/or suicidal behavior
- History of physical or sexual abuse
- Exposure to violence
- Biologic factors.
PRECIPITATING FACTORS (also called proximal or potentiating factors.)

- Unlikely to contribute to suicide risk in and of themselves. They play a vital role in interaction with predisposing factors. These factors include:
  - Access to means
  - Alcohol and drug use
  - Exposure to suicide
  - Social stress and isolation
  - Emotional and cognitive factors
PSYCHIATRIC DISORDER

• The majority of adolescents who attempt or commit suicide have a psychiatric disorder, with depressive disorder being the most common.

• Other predisposing psychiatric disorders include oppositional defiant disorder, conduct disorder, bipolar disorder, anxiety disorder, eating disorder, personality disorder, and substance use disorders.
HISTORY OF ABUSE

• Physical and / or sexual abuse increases the likelihood of depression and suicide.
• The risk of suicide attempts was 8 times greater among those who had been sexually abused than those who had not.
• Exposure to violence caused the risk of suicide to double.
• Peer victimization: BULLYING. Suicide attempts were 2 to 3 times more likely to occur in children who were bullied than those who were not. Cyberbullying was strongly related to suicidal ideation.
ALCOHOL AND DRUG USE

• Substance abuse disorders contribute substantially to risk of suicide especially in older adolescent males when co-occurring with mood disorder or disruptive disorders.

• Adolescents who were 13 years or younger and who participated in heavy drinking episodes were at 2.6 times greater risk of reporting suicide attempt as those who did not participate. For those youth who were 18 years or older the suicide attempt risk increased by 1.2 times.

• Drinking while feeling down resulted in a threefold increase in the risk of self-reported suicide attempts.
IDENTIFY THE CHILD IS AT RISK OF SUICIDE

• The child displays or discloses a history of suicide attempt/s
• The child expresses suicidal ideation and/or it is assessed that the child has suicidal ideation
• It is assessed that the child’s self-harming behavior places them at risk of suicide
• It is assessed that the child’s involvement in risk or dangerous behavior is linked to suicidal ideation
• The child is diagnosed with depression or exhibits behavior or symptoms that may be associated with depression.
WHERE DOUBT EXISTS

• Ask to meet with the rest of your team for advice and direction about assessing the risk of suicide

• Consult other relevant professionals who have knowledge about the child or suicidal behavior, to obtain further information and advice.
INFORM RELEVANT PEOPLE

• After recording a suicide risk alert and completing a risk evaluation, inform relevant people about the alert and risk plan.

• During an investigation and assessment – inform the child, parents, and other relevant people such as care givers, medical staff, education staff, other staff as necessary.

• Where a child attempts suicide or a child’s self harming episodes are assessed as attempted suicide, complete a critical incident report and report to parents and authorities as required by law.
Take Action

• The bottom line is, trust your gut feeling.
• Get family involved if possible.
• Utilize all school resources – nurses, counselors, psychology, administration
• Imminent danger – call 911
Utilize hotlines:

National Suicide Hotline – 800-SUICIDE or 800-273-TALK

Teen Hotline – 714-NEW-TEEN
NOW – LET’S TALK ABOUT TREATMENT REGARDING PSYCHOSIS AND SUICIDAL BEHAVIORS.
• SUPPORT!
• SUPPORT!
• SUPPORT!
PSYCHOTHERAPY “TALK THERAPY”

- A general term used to describe the process of treating psychological disorders and mental distress
- Many approaches and types such as family, individual and group
- Seek the right professional
COGNITIVE BEHAVIORAL THERAPY “CBT”

• Helps people understand thoughts, feelings, behaviors
• “Become cognitive”
PHARMACOTHERAPY

- Use in conjunction with psychotherapy
- EBP  Evidence Based Practice
- Psychosis – antipsychotics
- 1990’s   SGA’s    “Atypicals”
- Benefits   Fewer side effects
**COMMONLY PRESCRIBED “FDA” APPROVED ANTIPSYCHOTICS**

<table>
<thead>
<tr>
<th>Trade Name</th>
<th>Generic Name</th>
<th>Age Group</th>
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<tbody>
<tr>
<td>Abilify</td>
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<tr>
<td>Risperdal</td>
<td>Respiridone</td>
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COMMON SIDE EFFECTS

• Weight gain
• Sedation
• Hyperglycemia / diabetes
• Hyperprolactinemia (Resperdal)
PHARMACOTHERAPY FOR SUICIDAL BEHAVIOR

• SSRI's
  • Black box label warning – 2004 Increase risk of suicide in children and adolescents?
  • Benefits outweigh the risks
  • Use has increased dramatically
FDA

- Only FDA approved medication for depression in children ages 8 and above
- PROZAC (Fluoxetine)
## OTHER SSRI’S “OFF LABEL” USE

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<tr>
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<tr>
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<tr>
<td>Paxil</td>
<td>Paroxetemone not recommended 2003</td>
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</tbody>
</table>
COMMON SIDE EFFECTS

- Nausea, vomiting, diarrhea  (hang in there!)
- Weight gain or loss
- Headaches
- Dizziness
- Insomnia
- Nervousness, anxiety
- Sexual dysfunction
MONITOR CLOSELY!

• First Month
• Don’t stop drug abruptly
• Watch for increased agitation and suicidal thinking
• Monitor increased insomnia and withdrawal
• Consult provider with any concerns
• Let’s Keep our Kids Alive and Safe!
QUESTIONS???
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