PSYCHOTICISM

BEHAVIORAL DEFINITIONS

1. Verbalizes bizarre content of thought (delusions of grandeur, persecution, reference, influence, control, somatic sensations, or infidelity).
2. Demonstrates abnormal speech patterns including tangential replies, incoherence, perseveration, and moving quickly from subject to subject.
3. Describes perceptual disturbance or hallucinations (auditory, visual, tactile, or olfactory).
4. Exhibits disorganized behavior, such as confusion, severe lack of goal direction, impulsiveness, or repetitive behaviors.
5. Expresses paranoid thoughts and exhibits paranoid reactions, including extreme distrust, fear, and apprehension.
6. Exhibits psychomotor abnormalities such as a marked decrease in reactivity to environment; catatonic patterns such as stupor, rigidity, excitement, posturing, or negativism as well as unusual mannerisms or grimacing.
7. Displays extreme agitation, including a high degree of irritability, anger, unpredictability, or impulsive physical acting out.
8. Exhibits bizarre dress or grooming.
9. Demonstrates disturbed affect (blunted, none, flattened, or inappropriate).
10. Demonstrates relationship withdrawal (withdrawal from involvement with the external world and preoccupation with egocentric ideas and fantasies, feelings of alienation).

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LONG-TERM GOALS

1. Control or eliminate active psychotic symptoms so that functioning is positive and medication is taken consistently.
2. Eliminate acute, reactive, psychotic symptoms and return to normal functioning.
3. Increase goal-directed behaviors.
4. Focus thoughts on reality.
5. Normalize speech patterns, which can be evidenced by coherent statements, attentions to social cues, and remaining on task.
6. Interact with others without defensiveness or anger.
7. Achieve and maintain an active, personally effective recovery approach.

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SHORT-TERM OBJECTIVES

1. Provide the history and the current status of psychotic symptoms. (1, 2)

2. Participate in psychological testing that will help increase understanding of the condition. (3)

THERAPEUTIC INTERVENTIONS

1. Demonstrate acceptance to the client through a calm, nurturing manner, good eye contact, and active listening; approach an acutely psychotic client in a calm, confident, open, direct, yet soothing manner (e.g., approach slowly, face toward the client with open body language, speak slowly and clearly).
2. Assess the client's history of psychotic symptoms including current symptoms and the impact they have had on functioning.
3. Coordinate psychological and/or neuropsychological testing to assess the extent and the severity of the client's psychotic symptoms.

3. Allow family members to participate in the assessment of the condition. (4)
4. Cooperate with a physician's evaluation of medical health. (5)
5. Disclose substance abuse as a precipitating trigger for psychotic symptoms. (6, 7)
6. Provide behavioral, emotional, and attitudinal information toward an assessment of specifiers relevant to a *DSM* diagnosis, the efficacy of treatment, and the nature of the therapy relationship. (8, 9, 10, 11)

4. Request that a family member provide information about the client's history of psychotic behaviors.
5. Refer the client for a complete medical evaluation to rule out possible general medical and substance-related etiologies.
6. Use a Motivational Interviewing approach toward engaging the client in the process of discontinuing substance use, including drugs, alcohol, nicotine, and caffeine (see the Substance Use chapter in this *Planner*).
7. Refer the client to a substance abuse treatment program.
8. Assess the client's level of insight (syntonic versus dystonic) toward the "presenting problems" (e.g., demonstrates good insight into the problematic nature of the "described behavior," agrees with others' concern, and is motivated to work on change; demonstrates ambivalence regarding the "problem described" and is reluctant to address the issue as a concern; or demonstrates resistance regarding acknowledgment of the "problem described," is not concerned, and has no motivation to change).
9. Assess the client for evidence of research-based correlated disorders (e.g., oppositional defiant behavior with ADHD, depression secondary to an anxiety disorder) including vulnerability to suicide, if

appropriate (e.g., increased suicide risk when comorbid depression is evident).

10. Assess for any issues of age, gender, or culture that could help explain the client's currently defined "problem behavior" and factors that could offer a better understanding of the client's behavior.

11. Assess for the severity of the level of impairment to the client's functioning to determine appropriate level of care (e.g., the behavior noted creates mild, moderate, severe, or very severe impairment in social, relational, vocational, or occupational endeavors); continuously assess this severity of impairment as well as the efficacy of treatment (e.g., the client no longer demonstrates severe impairment but the presenting problem now is causing mild or moderate impairment).

7. Cooperate with services focused on stabilizing the current acute psychotic episode. (12, 13, 14, 15)

12. Refer the client for an immediate evaluation by a psychiatrist regarding his/her psychotic symptoms and a possible prescription for antipsychotic medication.

13. Coordinate voluntary or involuntary psychiatric hospitalization if the client is a threat to himself/herself or others and/or is unable to provide for his/her own basic needs.

14. Arrange for the client to remain in a stable, supervised situation (e.g., adult foster care [AFC] placement or a friend's/family member's home).

	15. Coordinate mobile crisis response services (e.g., physical exam, psychiatric evaluation, medication access, triage to impatient care, etc.) in the client's home environment (including jail, personal residence, homeless shelter, or street setting). EB
8. Decrease the risk of suicide. (16, 17)	16. Perform a suicide assessment and take all necessary precautionary steps (see the Suicidal Ideation chapter in this *Planner*).
	17. Remove potentially hazardous materials, such as firearms or excess medication, if indicated.
9. Obtain immediate, temporary support or supervision from friends, peers, or family members. (18, 19)	18. Develop a crisis plan to provide supervision and support to the client on an intensive basis.
	19. Coordinate access to round-the-clock, professional consultation (e.g., a 24-hour professionally staffed crisis line) to caregivers and the client.
EB 10. Report a decrease in psychotic symptoms through the consistent use of psychotropic medications. (20, 21)	20. Educate the client about the use and expected benefits of psychotropic medications; encourage consistent taking of prescribed medications (or assign "Why I Dislike Taking My Medication" in the *Adult Psychotherapy Homework Planner* by Jongsma). EB
	21. Monitor the client's medication compliance, effectiveness, and side-effect risk (e.g., tardive dyskinesia, muscle rigidity, dystonia, metabolic effects such as weight gain). EB
EB 11. Participate with family and/or significant others in a therapy designed to improve quality of	22. Conduct a family-based intervention beginning with psychoeducation emphasizing

life for all members and facilitate personal recovery. (22)

the biological nature of psychosis, the need for medication and medication adherence, risk factors for relapse such as personal and interpersonal triggers, and the importance of effective communication, problem-solving, early episode intervention, and social support (see *Family Care of Schizophrenia* by Falloon, Boyd, and McGill).

12. Learn and implement effective communication skills with family and/or significant others. (23, 24)

23. Assess and educate the client and family about the role of aversive communication (e.g., high expressed emotion) in family distress and the risk for the client's relapse; emphasize the positive role of social support.

24. Use cognitive-behavioral techniques (education, modeling, role-playing, corrective feedback, and positive reinforcement) to teach family members communication skills (e.g., offering positive feedback; active listening; making positive requests of others for behavior change; and giving constructive feedback in an honest and respectful manner).

13. Implement problem-solving skills with family and/or significant others to address problems that arise. (25, 26)

25. Assist the client and family in identifying conflicts that can be addressed with problem-solving techniques.

26. Use cognitive-behavioral techniques (education, modeling, role-playing, corrective feedback, and positive reinforcement) to teach the client and family problem-solving skills (i.e., defining the problem constructively and specifically;

	brainstorming solution options; evaluating the pros and cons of the options; choosing an option and implementing a plan; evaluating the results; and adjusting the plan).
14. Complete exercises between sessions to practice newly learned personal and interpersonal skills. (27)	27. Assign the client and family homework exercises to use and record use of newly learned communication and problem-solving skills; process results in session toward effective use; problem-solve obstacles; (assign "Plan Before Acting" or "Problem-Solving: An Alternative to Impulsive Action" in the *Adult Psychotherapy Homework Planner* by Jongsma); process results in session.
15. Develop and participate in a family relapse prevention and management plan in the event that psychotic symptoms return. (28)	28. Help the client and family draw up a "relapse drill" detailing roles and responsibilities (e.g., who will call a meeting of the family to problem-solve potential relapse; who will call the client's physician, schedule a serum level to be taken, or contact emergency services, if needed); problem-solve obstacles and work toward a commitment to adherence with the plan.
16. Participate in a psychoeducational program with other families. (29)	29. Refer the family to a multigroup family psychoeducational program (see *Multifamily Groups in the Treatment of Severe Psychiatric Disorders* by McFarland).
17. Identify internal and environmental triggers of psychotic symptoms. (30)	30. Help the client identify specific behaviors, situations, thoughts, and feelings associated with symptom exacerbations.

18. Identify current reactions to symptoms and their impact on self and others. (31, 32)

19. Learn and implement skills that increase personal effectiveness and resistance to subsequent psychotic episodes. (33, 34, 35)

31. Help the client identify his/her emotional and behavioral reactions as well as other consequences of psychotic symptoms toward the goal of increasing his/her understanding of these reactions and how they impact functioning adaptively or maladaptively (e.g., withdrawal leading to isolation and loneliness; paranoid accusations leading to negative reactions of others that falsely support the delusion).

32. Assess adaptive and maladaptive strategies that the client is using to cope with psychotic symptoms; reinforce adaptive strategies.

33. Tailor cognitive behavioral strategies so the client can restructure psychotic cognition, learn effective personal and interpersonal skills, and develop coping and compensation strategies for managing psychotic symptoms (see *Treating Complex Cases: The Cognitive Behavioural Therapy Approach* by Tarrier, Wells, and Haddock).

34. Desensitize the client's fear of his/her hallucinations by allowing or encouraging him/her to talk about them, their frequency, their intensity, and their meaning (or assign "What Do You Hear and See?" in the *Adult Psychotherapy Homework Planner* by Jongsma); provide a reality alternative view of the world.

35. Use education, modeling, role-play, reinforcement, and other

	cognitive-behavioral strategies to teach the client coping and compensation strategies for managing psychotic symptoms (e.g., calming techniques; attention switching and narrowing; realistic self-talk; realistic attribution of the source of the symptom; and increased adaptive personal and social activity). EBP
EBP 20. Identify and change self-talk and beliefs that interfere with recovery. (36, 37)	36. Use Cognitive Therapy techniques to explore biased self-talk and beliefs that contribute to delusional thinking; assist the client in identifying and challenging the biases, generating alternative appraisals that correct biases, building confidence, and improving adaptation. EBP
	37. Assign the client homework exercises in which he/she identifies biased self-talk, creates reality-based alternatives, and tests them in his/her experience; review and reinforce success, providing corrective feedback toward facilitating sustained, positive change (or assign "Journal and Replace Self-Defeating Thoughts" in the *Adult Psychotherapy Homework Planner* by Jongsma). EBP
EBP 21. Verbalize an understanding of the need to learn new and improved social skills. (38)	38. Provide a rationale for social skills training that communicates the benefits of improved social interactions and decreased negative social actions. EBP
EBP 22. Participate in individual or group therapy focused on improving social effectiveness. (39)	39. Provide or refer the client to individual or group social skills training that employs cognitive-behavioral strategies (e.g., education, modeling, role-play,

practice, reinforcement, and generalization) to teach the client relevant social skills (e.g., conversation, assertiveness, conflict resolution) to improve his/her ability to attain and maintain social relationships (or assign "Restoring Socialization Comfort" in the *Adult Psychotherapy Homework Planner* by Jongsma).

23. Read about social skills training in books or manuals recommended by the therapist. (40)

40. Use prescribed reading assignments from books or treatment manuals consistent with therapeutic skill being taught to facilitate the client's acquisition of it (e.g., *Your Perfect Right* by Alberti and Emmons for assertiveness skills; *Conversationally Speaking* by Garner for conversational skills).

24. Practice and strengthen skills learned in therapy. (41)

41. Prescribe in- and between-session exercises that allow the client to practice new skills, reality test and challenge his/her maladaptive beliefs, and consolidate a new approach to adaptive functioning and symptom management; review; reinforce positive change; problem-solve obstacles toward consolidating the client's skills.

25. Participate in a therapy to practice mental tasks and learn strategies to improve mental, emotional, and social functioning. (42)

42. Provide or refer the client to a Cognitive Remediation/ Neurocognitive Therapy program that uses repeated practice of cognitive tasks and/or strategy training to restore cognitive function and/or teach compensatory strategies for cognitive impairments and improve cognitive, emotional, and social functioning (see *Cognitive Remediation Therapy*

for Schizophrenia by Wykes and Reeder).

26. Participate in a training program to build job skills. (43)
27. Verbalize the acceptance of mental illness and willingness to engage in recovery, decreasing feelings of stigmatization. (44)
28. Attend a support group for others with severe mental illness. (45)

43. Refer the client to a Supported Employment program to build occupational skills and improve overall functioning and quality of life.
44. Encourage the client to express his/her feelings related to acceptance of the mental illness and engagement in recovery; reinforce thoughts and actions that strengthen the client's engagement in the recovery process.
45. Refer the client to a support group for individuals with a mental illness with the goal of helping consolidate their new approach to recovery and gain social support for it.

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DIAGNOSTIC SUGGESTIONS

Using DSM-IV/ICD-9-CM:

Axis I:	297.1	Delusional Disorder
	298.8	Brief Psychotic Disorder
	295.xx	Schizophrenia
	295.30	Schizophrenia, Paranoid Type
	295.70	Schizoaffective Disorder
	295.40	Schizophreniform Disorder
	296.xx	Bipolar I Disorder
	296.89	Bipolar II Disorder

296.xx	Major Depressive Disorder
310.1	Personality Change Due to Axis III Disorder
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Using DSM-5/ICD-9-CM/ICD-10-CM:

ICD-9-CM	ICD-10-CM	*DSM-5* Disorder, Condition, or Problem
297.1	F22	Delusional Disorder
298.8	F23	Brief Psychotic Disorder
295.30	F20.9	Schizophrenia
295.70	F25.0	Schizoaffective Disorder, Bipolar Type
295.70	F25.1	Schizoaffective Disorder, Depressive Type
295.40	F20.40	Schizophreniform Disorder
296.xx	F31.xx	Bipolar I Disorder
296.89	F31.81	Bipolar II Disorder
296.xx	F32.x	Major Depressive Disorder, Single Episode
296.xx	F33.x	Major Depressive Disorder, Recurrent Episode
310.1	F07.0	Personality Change Due to Another Medical Condition
298.8	F28	Other Specified Schizophrenia Spectrum and Other Psychotic Disorder
298.9	F29	Unspecified Schizophrenia Spectrum and Other Psychotic Disorder

Note: The ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014. Some ICD-9-CM codes are associated with more than one ICD-10-CM and *DSM-5* Disorder, Condition, or Problem. In addition, some ICD-9-CM disorders have been discontinued resulting in multiple ICD-9-CM codes being replaced by one ICD-10-CM code. Some discontinued ICD-9-CM codes are not listed in this table. See *Diagnostic and Statistical Manual of Mental Disorders* (2013) for details.

 indicates that the Objective/Intervention is consistent with those found in evidence-based treatments.