



National Hispanic and Latino

MHTTC

Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

A Clinician's Guide to
FIRST EPISODE PSYCHOSIS
for Hispanic and Latinx Youth

DISCLAIMER

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The National Hispanic and Latino MHTTC recognize the complexities associated with gender and ethnic identification. With the intention of both facilitating a fluent reading of the text and supporting an inclusive and respectful language, this document uses terms that are linguistically neutral and inclusive of diverse gender groups and identities. In this document, we also use the term Latinx to encompass ethnic identity as well as non-binary gender identification.

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Institute of Research, Education, and Services in Addiction (IRESA)

The Institute of Research, Education, and Services in Addiction (IRESA) of the Universidad Central del Caribe leads the National Hispanic and Latino MHTTC. The Center serves as a national subject matter expert and a key resource for the workforce and communities seeking to address mental illness prevention, treatment, and recovery support to reduce health care disparities among Hispanic and Latino populations across the United States and its territories. In partnership with state and local governments, mental health providers, consumers and family organizations, Hispanic stakeholders, Substance Abuse Mental Health Services Administration (SAMHSA) regional administrators, and the MHTTC Network, the Center seeks to accelerate the adoption and implementation of mental health-related evidence-based practices.

National Hispanic and Latino Mental Health Technology Transfer Center

The mission of the National Hispanic and Latino Mental Health Technology Transfer Center is to provide high-quality training and technical assistance to improve the capacity of the workforce serving Hispanic and Latino communities in behavioral health prevention, treatment, and recovery. We disseminate and support the implementation of evidence-based and promising practices to enhance service delivery, promote the growth of a diverse, culturally competent workforce, and bridge access to quality behavioral health services. We are committed to increasing health equity and access to adequate culturally and linguistically grounded approaches.

The School-Based Mental Health Project (SMH)

The School-Based Mental Health Project (SMH) of the National Hispanic and Latino MHTTC works specifically with schools, organizations, and professionals to strengthen their capacity to provide culturally and linguistically responsive school mental health services. This initiative facilitates training, technical assistance, and capacity-building efforts led by experts in the field. Our goal is to increase awareness to attend to Latino students' mental health needs, promote the implementation of school mental health services that are culturally appropriate, encourage the use of promising and evidence-based practices, and disseminate information on practical strategies and implementation efforts of mental health services within a cultural context.



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PREFACE

The following manual focuses on providing clinicians, from differing backgrounds and disciplines, with information on Hispanic and Latinx youth experiencing a first episode of psychosis (FEP). The main objectives include:

- 1) Providing an overview of current literature regarding early psychosis specific to Hispanic and Latinx youth and differences with the rest of the United States population
- 2) Discussing clinician growth and awareness in ability to assess and explore cultural/ethnic identity, engage clients and families, and build rapport
- 3) Reviewing current evidence-based psychosocial and pharmacological interventions for FEP and applicability to this unique population

Introduction
FIRST EPISODE PSYCHOSIS
in Hispanic and Latinx Youth

CHAPTER 1

WHAT IS PSYCHOSIS?

Psychosis can be described as a change in how an individual experiences or interprets the world and their perceived reality. Psychotic disorders, including the more commonly known diagnosis of schizophrenia, are characterized by positive (psychotic) symptoms, negative symptoms and cognitive symptoms. Positive symptoms must be present for a diagnosis of a psychotic disorder and often receive the most attention from providers, families and/or caregivers. Positive symptoms are new thoughts, feelings or behaviors that were previously absent such as delusions or the presence of hallucinations of different senses e.g., visual, auditory, and tactile. Conversely, negative symptoms are a lacking of or deficit in thoughts feelings or behaviors that are normally present such as amotivation or blunted affect. In addition, individuals suffering from psychosis often experience cognitive impairments including disorganized thoughts, behaviors or language (Early Assessment and Support Alliance [EASA], 2016; Headspace, 2018; & National Alliance on Mental Illness [NAMI], 2020).

Onset of psychosis is most common in late adolescence and early adulthood and often occurs earlier for males than females. Experiencing a first episode of psychosis (FEP) during early adulthood is often frightening. In addition, it can be disruptive to normal social development, such as hindering or delaying plans for the future or further complicating the difficult process of establishing a personal identity. Further, stigma related to psychosis and severe mental illness can prevent a young person from seeking help (EASA, 2016; Headspace, 2018; & NAMI, 2020).

It is estimated that the global prevalence of any type of psychotic disorder is roughly 3% (National Institute of Mental Health [NIMH], 2015) while the prevalence of schizophrenia is estimated at just under 1% (Howes & Murray, 2014). In Latinos, lifetime prevalence of self-reported psychotic symptoms indicates a 13.6% rate. (Cohen and Marino, 2013). Current estimates indicate that each year 100,000 young adults in the United States will experience a FEP each year (Azrin, Goldstein, & Heinssen, 2016). However, the often-insidious onset of psychosis creates a challenge for researchers to attempting to estimate incidence rates. In addition, the variability of course and outcome of psychotic disorders has made it difficult for researchers to further describe differences in prevalence or recovery rates across specific diagnoses (Salvatore, Khalsa, Tohen, & Baldessarini, 2020; Tohen et al., 2000a, 2000b). Furthermore, diagnostic stability is not the rule as many patients will switch diagnosis during their first two years (Salvatore et al., 2010; Tohen et al., 2012, 2016).

To further complicate things, recent studies have shown that psychotic experiences are also common in the general population although these experiences are often transient. For example, many individuals across cultures and nations can describe a time when they thought they heard their name being called or believed they saw something out of the corner of their eye that wasn't there. Due to these epidemiological challenges and the increased recognition of the continuum of psychotic experiences, some experts in the field are recommending utilizing a spectrum based diagnostic system rather than the current categorical approach (Guloksuz & Van Os, 2018).

Research has shown that the first five years following the initial onset of psychotic illness to be a 'critical period' in which interventions are more likely to improve outcomes both in nonaffective (Fusar-Poli, McGorry, & Kane, 2017) and affective psychosis (Tohen et al., 2003; Vieta E, et al., 2018). Because of this, Early Intervention Services (EIS) for the treatment of FEP have been developed and implemented across the world. EIS aim to reduce the time to appropriate treatment for FEP, also called the duration of untreated psychosis (DUP) and provide multidisciplinary specialized outpatient services to improve clinical and functional outcomes (Azrin, Goldstein, & Heinssen, 2016; Dixon et al., 2018). DUP varies in duration depending on the diagnostic category with brief psychosis being the shortest and schizophrenia the longest (Tohen et al., 2016). In the United States, Coordinated Specialty Care (CSC) programs provide multidisciplinary clinical services for young adults experiencing a first episode of psychosis and emphasize rapid referral processes to reduce the DUP and improve clinical and functional outcomes. To do this, CSC programs use targeted community outreach and education to increase public awareness and improve access to specialized services (Azrin, Goldstein, & Heinssen, 2016).

WHAT CAUSES PSYCHOSIS?

Current research suggests that psychosis is a result of multiple cumulative and interacting biological and environmental risk factors (Howes & Murray, 2014). In other words, there is no single cause of psychosis. Rather, researchers have identified many potential risk factors that can increase a person's vulnerability to developing psychosis. Individuals whose family members have a history of severe mental illness (SMI) are at a greater risk of developing a psychotic disorder. However, there is no specific gene associated with psychosis. Biological risk factors associated with the onset of psychosis may include:

- hormonal changes during puberty or due to stress,
- physical illness (NMDA receptor encephalitis or tumors), and
- physical injury such as head trauma.

Recent epidemiological studies of FEP have also demonstrated the role of numerous environmental risk factors in contributing to risk of psychosis. For example, substance use, particularly cannabis, can increase risk of psychosis (Baethge et al., 2005). Childhood adversity and trauma have also been associated with increased risk of psychosis (Greenfield et al., 1994). Young adults who have experienced psychosis are 2.72 times more likely to have faced adverse childhood experiences (ACEs) than individuals without psychosis (Usher, 2016). The dopamine hypothesis is a recent etiological theory of psychosis, which takes into account genetic, neurodevelopmental, cognitive and sociocultural theories of psychosis. Researchers have begun to demonstrate how risk factors across each of these categories can contribute to dopamine dysregulation in the brain (Howes & Murray, 2014).

In addition to the numerous biological and environmental risk factors that contribute to onset of psychosis, there are also sociocultural and demographic differences associated with increased risk. Non-LatinX Blacks are five times more likely to be diagnosed with schizophrenia and minorities in general experience higher rates of involuntary hospitalization, interaction with law enforcement and have less access to outpatient mental health services. In a study examining differences between individuals with FEP receiving standard care or EIS in the United States, researchers found that minorities receiving standard care had higher symptom severity and were less likely to engage in services than non-LatinX whites when compared to young adults receiving specialized EIS. However, even with EIS, it is often found that engagement is more challenging with minorities and individuals from low socioeconomic backgrounds which may result in long DUP and poorer outcomes (Oluwoye et al., 2018). Other studies have shown that first- or second-generation immigrants are also at higher risk for developing a psychotic disorder and that this risk increases if the individual lives in a community in which he/she is a minority. This could be due to the trauma associated with immigration as well as the stress of integrating with dominant cultures. Young adults living in urban environments are also at increased risk for developing psychosis. Although the reasons for the association between urbanicity and prevalence of psychosis are still unclear, some evidence has suggested that the over stimulation and stress of urbanity could be contributing factors (Howes & Murray, 2014).

FIRST PSYCHOSIS EPISODE IN LATINX YOUTH

Some disparities in mental health service use have been recently reported for Latinxs experiencing FEP. Using commercial insurance data, van der Ven et al. (2020) found that the probability of outpatient mental health services use was 30% lower among Latinxs aged 14-30 compared with non-Latinx whites after adjusting for household income as an indicator of socioeconomic status (SES). This study was unable to examine service use specifically within CSC programs, which aim to engage youth more so than standard outpatient services. In addition, the study was limited to individuals with commercial insurance and therefore excluded participants who utilize Medicaid and may come from lower SES.

A secondary analysis of the national Recovery After an Initial Schizophrenia Episode (RAISE) trial, which compared specialized CSC to standard care, explored racial and ethnic disparities in FEP treatment outcomes (Oluwoye et al., 2018) and found that race and ethnicity were not associated with differences in psychiatric symptoms within the group receiving specialized CSC. However, Latinx participants' families were significantly less likely to receive family psychoeducation and more likely to receive only medication management relative to non-Latinx white participants. While the programs included in the RAISE trial varied demographically depending on their location, Latinx participants comprised only 19% of the sample in the secondary analysis.

Research regarding pathways to care for Hispanic and Latinx youth experiencing FEP is even more limited. Some data suggest that minorities experiencing a FEP are more likely than non-Latinx white counterparts to interact with law enforcement and may experience higher rates of involuntary inpatient hospitalizations (Anderson et al., 2014; Oluwoye et al., 2018). In a cross-sectional study, Lopez et al. (2018) found that United States Latinos with FEP and their caregivers had low psychosis literacy, which was associated with reduced likelihood of recommending professional help seeking.

Consistent with current epigenetic etiological models of psychosis, studies of non-US populations suggest that the reported higher incidence rates of FEP among migrant groups and ethnic minorities may be due to specific socio-environmental factors, such as urbanicity, ethnic density or deprivation related to low SES (Heinz, Deserno & Reininghaus, 2013; Kirkbride, Morgan & Fearon, 2007; Shah, Mizrahi & McKenzie, 2011). These same factors have also been associated with disparities in accessing care (Morgan & Hutchinson, 2010). The majority of these studies focus on black minority groups from Northern Europe.

Researchers in the United States have not yet explored the impact of socio-environmental factors, beyond some basic measures of SES, on incidence of psychosis or access to care among Latinxs experiencing FEP (Friedman et al., in press).

The lack of research specific to early psychosis within the United States Hispanic and Latinx populations may be a result of several reasons. First, the RAISE trial and subsequent studies using this data, have excluded non-English-speaking participants (Kane et al., 2016). In addition, significant challenges have been reported in the recruitment of Latinxs experiencing FEP for research studies due to psychological barriers of patient-researcher alliance and due to patient discontinuation of the planned outpatient treatment (Hernandez et al., 2019). Given that Latinxs are 14% of the United States population (U.S. Census, 2019), more effort needs to be made to include them in research.

The First Episode of Psychosis Early Program at the University of New Mexico (UNM) has a larger proportion of Latinx clients than most CSC programs across the country, providing a unique opportunity from which to gather information. In a recently published manuscript, researchers from UNM explored the characteristics of Hispanic youth referred to and enrolled in CSC and factors associated with enrollment among eligible referrals (Friedman et al., in press). A retrospective review was conducted on all individuals referred to the Early Program between January 2018 and January 2020. Extracted data included referral sources, demographics and clinical characteristics. Zip code-level data from publicly available sources were cross-referenced with each record. Non-parametric tests and appropriate secondary analysis were used to determine significant differences across racial/ ethnic groups referred to or enrolled in the Early program. A random forest model was used to determine which factors or interacting factors were associated with eligible referrals enrolling in services. Compared to non-Hispanic whites, Hispanic individuals were more likely to be referred from inpatient or outpatient mental health providers and not from other sources within the community (OR=0.30(0.13, 0.68), p=0.004). In addition, Hispanic referrals were more likely to live in areas with higher rates of Spanish spoken in the home (MdD=7.41(1.13, 9.15), p=0.012). The Random Forest model identified that Hispanics or non-Hispanic whites were more likely to enroll compared to other minorities (OR=4.97(1.82, 13.55), p=0.0009) and (OR=4.42(1.52, 12.87), p=0.006), respectively. Finally, a significant interaction emerged in classifying enrollment. Despite Hispanic referrals living in areas with higher rates of Spanish spoke in the home, compared to non-Hispanic whites, eligible Hispanics were 2.4 times more likely to be enrolled if living in areas with a lower prevalence of Spanish speaking (p=0.025). These results suggest a need for community outreach and psychoeducation targeting Spanish-speaking communities to increase

referrals directly from community sources. Further work is needed to better understand the pathways to care for Hispanic individuals and how primary language affects referral processes and enrollment rates for different race/ethnicity groups. The Early Program has an opportunity to contribute to knowledge of FEP in Hispanic youth that otherwise is underrepresented by nationwide clinical and implementation research. Continued exploration of factors associated with referral and enrollment processes for the growing Hispanic ethnic group in the United States can help to inform CSC program development.

Even with the encouraging work to include this population in clinical and translational research, it is essential to understand the limitations of this research. The first limitation of relevance to clinicians working with Hispanic and Latinx clients experiencing FEP is generalizability. The term Hispanic or Latinx encompasses many groups that differ across geographic region, region of origin, primary language and dialect, age or generation of immigration, etc. For example, New Mexico is a minority majority state with 49.3% of New Mexicans identifying as Hispanic. New Mexico is also unique in that many residents identify as Hispanic in terms of their Spanish ancestry and has a smaller proportion of first- and second-generation immigrants than most states (US Census, 2019).

Similarly, the evidence base for treatments and interventions for youth experiencing psychosis, or any mental illness, should not be generalized but rather, be based on each individuals' experience. While the authors may suggest or recommend specific approaches for working with Latinx youth experiencing FEP, it is essential that clinicians always be flexible and open to the diversity within ethnic identify. Clinicians, including the authors, are not the true experts. The client is the only person who is an expert on their experience and what they need. The following sections will begin to explore this approach to clinical work and how it can be applied across interventions at all phases of the treatment process.

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INITIAL ENGAGEMENT,
ASSESSMENT AND
FAMILY INVOLVEMENT

CHAPTER 2

INITIAL ENGAGEMENT

Initial engagement is a critical aspect to providing care. However, there is no single approach to engaging youth experiencing FEP and there is not a standard protocol for engagement based on ethnicity. Initial engagement may look differently for each individual. Numerous factors influence a clinical strategy or approach for engaging youth experiencing FEP in services. For example, the individual's natural support and how the client wishes to involve them in treatment or not. How the individual accessed care may impact how they perceive services and require adjustments in engagement techniques. Many individuals with FEP enter services after an involuntary hospitalization. Others are referred by concerned family or friends and have never had previous mental health services. Another factor of importance is symptomology specific to psychosis such as persecutory delusions that make it difficult to create trust or lack of insight into why they may benefit from services. There may be differences across these areas of consideration that are specific to Hispanic and Latinx youth experiencing FEP. As previously discussed, Latinx youth may be more likely to enter services through interaction with law enforcement or involuntary hospitalizations. However, this is yet a relatively unexplored topic. Regardless of current or future findings, clinicians may find that the best strategy for initial engagement is to act as a learner rather than an expert. The following recommendations should be considered with the overarching goals of building rapport, maintaining engagement, and empowering the young adult by utilizing a strategy best suited for the individual. An important starting point for clinicians working with Latinx youth experiencing FEP is clinician awareness. This most often begins prior to an initial assessment and is ongoing throughout treatment.

DISCUSSING SERVICES

For many individuals, it is often beneficial to start initial meetings or conversations with staff introductions and a general discussion of services and the mental health system. This discussion can help inform who should be present for a more formal assessment. It will also help prepare the client for what to expect. Informing the client of processes, procedures, and the services available to them can allow clients who are not necessarily help seeking or who are lacking insight to gain back some control and independence that they may feel has been lost. This initial discussion is important for all populations, including Hispanic and Latinx clients and families. Having open communication with the client and their family about the structure of the mental health system and treatment options is an essential first step and requires clinicians to be aware that this system is not always a familiar one and may be associated with outdated stereotypes.

Whether or not the clinician having this discussion with clients is part of, or even able to refer to a CSC program, introducing services based on the general model of early intervention can be helpful for multiple reasons. Firstly, early intervention models function differently than what the client might expect from traditional mental health services. The models emphasis on interdisciplinary services may assist with engagement as it demonstrates the ability to support the individual and family's goals in multiple ways. Secondly, early intervention emphasizes the selection of services based on the clients, and not the clinician's, priorities. Quite often, offering immediate community support services/case management can decrease anxiety around areas of great stress/fallout. For example, if the client has recently started college and dropped out due to poor grades, clinicians may provide supporting documentation aligned with the American Disabilities Act that will enable appeals, withdrawals, and reinstatements that will allow the individual to be in good academic standing, as well as prevent their penalization of poor performance/dropout due to a medical condition. Interactions with a peer support worker with lived experience can also be a great first step for clients who are feeling hopeless and not understood. Working with someone in recovery who understands, first-hand, some of the individual's experience can be a life-changing encounter that not only gives hope for healing but can also feel comforting in having shared experience.

Certain procedures and legal requirements are also important to review at this time. For example, families and clients may not be aware that at age 14, individuals can refuse or agree to mental health treatment. Young adults also have the capacity to refuse to share information with their families. Discussing this aspect

of clinical services with the family and the client can help to guide decisions about how the client and family prefer to have things communicated. If a client wants their family involved in everything, the system requires them to sign legal documents. If the client does not want family involved, the clinician must provide education to family around this decision and how this may affect communication around their loved one's care and progress. Additional topics may include the client's rights and introducing the possibility of completing a psychiatric advance directive.

Having these conversations early on can help clients and families to orient to the process and know what to expect. It also allows clinicians to maintain rapport further down the line in treatment should something come up that they need to refer back to, such as the availability of specific supports or the medical system's legal processes.

INCLUDING THE CLIENT'S IDENTIFIED FAMILY

Family involvement is an essential component of care for early psychosis. However, in this context it is up to the individual to identify those who comprise their natural supports as their 'family'. For some, this is a biological family, and for others, this is a chosen or developed family. As previously discussed, early intervention services for psychosis typically include individuals within their teenage years to late twenties. Research has shown that family involvement increases the likelihood of sustained therapeutic progress and can lead to improved outcomes (Lobban & Barrowclough, 2016; Lucksted et al., 2018; McFarlane, Dixon, Lukens & Lucksted, 2003; Oluwoye et al., 2019). This is particularly important for this age group, as well as for any culture that prioritizes family. Failure to recognize and gather information about an individual's view of family/support is a mistake that may result in challenges to engage and develop trust. Clinicians must educate themselves on the needs/views of the individual and their family in order to provide good care.

Young adults from Hispanic and Latinx backgrounds often live with their parents and if not usually remain close socially and geographically. Familismo is a concept of cultural importance to Hispanic and Latinx individuals and is the value of family support and dedication. Recognizing the client's dedication to family can help promote the involvement of the family in treatment and is often a protective factor for the individual (National Hispanic and Latino ATTC, 2016). Thus, including families of Latinx youth in the care of a young person experiencing FEP topics and how specific questions are asked may need to be modified to meet each individual client's needs. The clinician should also consider who is present for the assessment and how this could be helpful or not for building rapport. Finally, the clinician should be aware of their physical environment as well as the mode of communication (telehealth vs. in person) and how this might alter a client's experience. How someone experiences an assessment can also provide important information regardless of modifications that are made. For example, the clinician may learn more about the client's perception of the medical system and mental health care.

Discussing culture or ethnicity with a client can be difficult for many clinicians regardless of their own background. Again, there is no perfect or ideal way of doing this. What is important is for clinicians to recognize internal bias when approaching this topic and to be aware of assumptions and stereotypes, especially when assessing cultural influences on a client's experience. Understanding cultural identity is integral to understanding the client's personal identity, their perspective of their world, and the nature of their problem. However, cultural identity is not always static for the individual or for the family. Assimilation and acculturation are important factors that play a big role in a person's culture and experience. A person's culture changes as an individual's experiences change in economic status, group affiliations, and moving to a different culture. As an individual adopts new cultural behaviors, it can impact family relationships as members acculturate at different rates. For example, many Latinx youth are born in the United States and identify more strongly with American culture than older family members do. Identifying as Hispanic or Latinx may not be important to all clients and clinicians should be cognizant of this. Brainstorming how to manage the cultural expectations of his family and community, while also increasing insight into cultural beliefs and behaviors that may be reinforcing use (National Hispanic and Latino ATTC, 2016).

In addition, the clinician should recognize that it is their responsibility to bridge this topic and open the discussion, not the clients.

Psychosocial assessments that agencies use at intake always have questions that probe for ethnic/cultural background. This is often in the form of a yes or no check box for “Hispanic or Latinx” or a multiple response option for “Race”. However, clinicians can learn to ask questions that fulfil the agencies requirements, are respectful, and provide more information than a simple yes or no.

- What is important for me to know about you?
- Can you tell me about how you were raised?
- What are some of the things that you value?

These types of questions can help to create a space for dialogue that is open to discussing culture and ethnicity but are not directly focused on it. Some clinicians may find that they are more comfortable being direct and asking questions straight out about culture and ethnicity. Again, this can be done in a way that provides more information and is respectful and curious rather than checking a box.

- Do you feel your identity is related to a specific culture?
- If yes, how so?
- If not, is that something you even want to explore?

ADDRESSING LANGUAGE BARRIERS

Of course, all of these methods for initial engagement and rapport building are dependent on open communication. If the family and/or client are primarily Spanish speaking, this could be an additional obstacle for the clinician. While there are many options for addressing language barriers, good clinical practice suggests that the client is never asked to act as an interpreter. Having the client interpret for their family is inappropriate, as it is not their role. It can also lead to situations where the client omits certain information in giving the family information or in providing information from the family back to the clinician. Putting a client in this role changes the dynamic from being the person who is receiving support to the person who is providing it. Such a dynamic shift is detrimental to the process of initial engagement, rapport building and intervention. That being said, other options – while they may seem more tedious to the clinician – are available and should be utilized.

The best possible scenario is to arrange for the client to work with a Spanish speaking clinician who has clinical contextual knowledge. Research demonstrates that quality of care for Hispanics and Latino individuals increases with the provider’s Spanish-language proficiency and an understanding of cultural dynamics (National Hispanic and Latino ATTC, 2016). Clinicians who are Spanish speaking may or may not be native speakers. Some families may be more accepting if the provider is a native speaker. Native speakers may have a better understanding of cultural influences or be able to recognize meaning behind subtle language use. However, native Spanish speakers may not be from the same country of origin, speak the same dialect or share cultural and/or socio-economic experiences. It should not be assumed that because a clinician is a native speaker that they are able to cross all cultural barriers. Non-native speakers making an effort can also be humanizing and help to build rapport by demonstrating an effort to connect. That being said, just because a non-native clinician is able to speak Spanish, does not always mean that they should. The clinician should be proficient enough to communicate medical vocabulary and importantly, should feel comfortable doing so.

However, not all agencies have native or fluent Spanish speaking staff and clinicians must use other resources to bridge language barriers. Most agencies will have the option to use interpreter services. Some research has shown that the use of professional interpreters can help to build rapport and improve referral

processes and client satisfaction (Bauer & Alegría, 2010). While these services are often helpful, they can sometimes make it more difficult for the clinician to build rapport as the dialogue becomes less personal. Interpreters may have language abilities but not the emotional or contextual knowledge to convey messages appropriately around difficult topics. In addition, interpreter services are often used telephonically creating more of a challenge for interpreting nonverbal signals such as facial expressions and body language that accompany speech.

Regardless of whether the clinician is using an interpreter or able to speak Spanish themselves, understanding a client’s knowledge of psychosis and the language they use to describe their experience is key. While it is important to understand that not all individuals from a similar cultural background have a lack of knowledge about psychosis, it is important to note that many individuals due to gender, socioeconomic status, and other factors may have not had resources to this information. Research has shown that improving psychosis literacy through community psychoeducation leads to better communication between clients, families and providers and better outcomes for clients (Casas et al., 2014). To this point, it is important that a provider is aware of their client’s knowledge of mental illness and able to discuss concerns or symptoms using the client’s preferred vocabulary.

Clinicians should also be cognizant of how language barriers may impact their interpretations of symptoms during assessment. Psychiatric evaluation hinges on obtaining a thorough history and many key symptoms are not associated with directly observable behaviors but elicited only via self-report. In addition, mental status examination depends on interpretation of disordered speech and language (aphasias and neologisms), thought processes (flight of ideas, disorganization, and tangentiality), thought content (grandiosity, delusions, obsessions, and magical thinking), and perceptions (hallucinations) which are assessed through a client’s speech. A literature review of 26 peer-reviewed articles from across the world revealed that evaluation in the client’s non-primary language could result in incomplete or distorted mental status assessment (Bauer & Alegría, 2010).

CASE EXAMPLE: JOSE

Jose is a 19-year-old Hispanic male who has been referred for outpatient mental health treatment following an involuntary hospitalization. He had no prior mental health history. His diagnosis at discharge was bipolar disorder, manic with psychotic features. He was prescribed lithium and olanzapine. The only psychosocial history you are given is that he lives with his family and prior to the recent hospitalization had been working full time at his uncle's auto-shop as a mechanic. Your agency has asked you to schedule an assessment and provides you with Jose's mother's phone number. You see that she has also been appointed his treatment guardian. When you call, Jose's mother answers in Spanish. She is able to understand and reply to you in English, but she expresses that her preferred language is Spanish. She informs you that Jose is bilingual. You are able to schedule a time to meet to conduct an initial assessment and inform Jose's mother that you will have an interpreter present.

How might you start the initial assessment to best engage Jose in services, build rapport to provide him with the support he needs?

- Discussion of available services with Jose, his mother, and interpreter that includes asking Jose his preferences for involvement of his mother and other identified natural supports. This may include a review of what the role of treatment guardian entails.
- Description of the initial assessment and intake process.
- Conduct assessment according to Jose's preferences for who is present (this may require having his mother and the interpreter leave the room for all or part of the assessment).
- During the assessment, consider if your interpretations of questions regarding symptomology are culturally biased.
- After the assessment, when writing up impressions, are any of your interpretations biased due to the client's use of language? For example, is Jose demonstrating disordered thought processes or is this a result of his switching between languages?

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PSYCHOLOGICAL INTERVENTION

CHAPTER 3

PSYCHOSOCIAL INTERVENTION

After initial assessment, the goal is to continue to engage the client (and their identified supports) in ongoing services. CSC services are recommended for all individuals experiencing early stages of psychosis. This model emphasizes multidisciplinary intervention and recovery. Psychosocial support often includes individual psychotherapy, individual and family psychoeducation, case management or community support services, occupational therapy, peer support and supported employment and education. Not all clinicians who are working with clients experiencing psychosis work within CSC teams. Clinicians who are not part of CSC teams should make referrals to local CSC programs whenever possible. If there is no local team or there are other barriers to accessing this care, the clinician can still provide good care by incorporating some of the approaches used by CSC clinicians providing psychotherapy and psychoeducation. In addition, the clinician can help the client find resources in the community for other needed supports (e.g., programs that help youth with employment).

The psychosocial approaches for working with young adults experiencing early psychosis do not differ based on race, ethnicity or culture. Instead, all psychosocial interventions are designed based upon the individual client and their needs. There may be some common themes that arise while working with LatinX youth, but it is again important for the clinician not to assume that a client is having trouble in specific areas based on their ethnicity.

PSYCHOEDUCATION AND EXPLORING SYMPTOMS

Most often, clinicians will begin treatment by offering individual and family psychoeducation regarding psychosis. Psychoeducation is an area that is critical to early intervention and support. Clinicians who view this as a reciprocal process will have more success than those who view themselves as “expert”. The clinician may have the skills and tools that generally have been helpful but the client and (if included) their family are the experts on their experience and needs/goals. The clinician should be humble in their approach to providing information. This can be accomplished by expressing that, as a clinician, you are still learning and while you are able to provide information others have found helpful, you are open to hearing the client’s specific experience so that together you work collaboratively towards the client’s identified goals. The clinician should empower and encourage the individual/family to educate the clinician on their views, priorities, goals as well as outlook regarding the mental health system. The clinician will provide information compiled from working with many individuals and families within FEP while honoring the unique process to recovery from a place of cultural humility, awareness and desire to learn. This is an important step as it helps to develop a common language about symptoms and experiences, which can build rapport and help the client and family identify areas where support is needed.

For many living with early psychosis, the experience may be confusing. Not everyone sees or hears things that others do not (as psychosis is stereotypically and narrowly understood). For some, having context or a name for what they might be experiencing can bring great relief. For others, with no insight, this approach (naming “psychosis”) would not only be unhelpful but contraindicated. The goal is to join the client where they are and assist in their identifying what may be of help to them. For instance, someone may identify anxiety as the area they would like to address. Trying to get the individual to identify and address psychosis would not be the goal. Treatment should be person-driven as much as possible.

Honoring one’s view is critical (e.g., “nervios” which is less socially damaging than the stigmatizing Western biomedical view of illness). For some psychosis is “something done unto the person” and must be removed. Within some groups, discussions of mental health issues are taboo or even proscribed. For others, it may be a gift in ability to communicate with relatives who have passed on. Gathering more information about where the family feels their loved one’s experience is “outside the realm of a gift” can be extremely helpful. Helping the client to describe their experience can be challenging and requires asking questions without psychiatric

jargon that focuses on identifying sources of distress. For example, a clinician may ask:

- “What is your experience and how do you think your family views your experience?”

This applies to not just LatinX ethnicity but any individual. It can be assumed that if a person is help-seeking, there is something related to their current experiences that is deemed unhelpful or distressing. That should be the opening for intervention/treatment.

Psychoeducation can powerfully normalize the experiences associated with psychosis and its wide range of emotion; relief, grief, anger and questions about what this might mean for someone and their future. These discussions can not only assist someone in having more language/context for their experience, but also create the potential to build rapport and trust. Psychoeducation includes assisting participants and families in understanding resilience. It is likely that people have heard stigmatizing accounts in media and in community perception, but not as likely that people have stories of hope and resilience, growth, and strength. Sharing stories and real-life examples of hope is an important element of psychoeducation. It is critical to link individuals and their families to “possibility”. This can be done with books/memoirs, stories of those advancing the field who have lived experience and getting to talk with peers who are working recovery.

Imparting hope is possibly the most important element of psychoeducation/rapport. The process of experiencing psychosis/receiving a diagnosis can be traumatic. Clinicians should keep in mind that exposure to media and other limited views of psychosis can have detrimental effects. Apprising oneself of the participant’s self-view of mental health concerns (and that of their family) is critical to developing rapport and acknowledging what might be helpful/harmful in proceeding.

CASE EXAMPLE: SOFIA

Sofia is 19-year-old Hispanic female who comes to the clinic at the urging of her aunt and uncle, with whom she lives. Sofia’s aunt explains that Sofia has always been a sensitive child and that she communicates with her abuela (who passed away while Sofia’s mother was pregnant with her). Gathering information, the clinician learns that the family sees Sofia as having a gift. Sofia has been hearing her grandmother’s voice since she was a toddler. This has always been comforting to Sofia as she has always felt like her grandmother has been looking after her. The clinician also learns that about a year and a half ago, Sofia went to live with her aunt and uncle full-time after her mother entered treatment for drug addiction for the third time. Shortly after coming back home, she left again. Since that time, her mother has not been heard from often, and the family suspects she is using and uncertain of her location. Sofia started to isolate and do poorly in school. The family attributed this to the adjustment of events with her mother. In the example below, Sofia’s family helps differentiate what they see as a gift, versus what is outside the realm of this gift and how her experience and function has changed.

Therapist: “Help me understand what prompted you to bring Sofia in at this time?”

Uncle: “She went from being somewhat sad and not doing great in school to way worse. I mean this kid always had straight A’s, but with everything going on, we understood it was hard on her and didn’t want to push her. But then things really started to get out of control”

Therapist: “With her mood and grades? Or are you seeing other things that have you concerned?”

Uncle: “Well, my wife is right. She’s a sensitive kid. And we all know she is able to talk with relatives that have passed on. But then it is like she started hearing all this other stuff. Or all these other people. They are not my mother, her abuela. This is different.”

Therapist: “So, what is happening now, you would not describe as her being able to talk with relatives. I can hear by your description that this seems like something starting that is outside of the realm of what your family sees as a gift, or that can be explained by her gift”.

Uncle: “Yeah, I don’t think any of us see this as what was happening her whole life. She just isn’t even acting like her. She used to be a thoughtful sweet kid. Now she is agitated and won’t let the other kids watch TV and, it doesn’t make much sense to me, something about certain commercials meaning something specific. She sometimes yells; “See? Didn’t you hear that?” She also started playing music loud to talk with us. She says they can hear her otherwise. She thinks the neighbors can hear what she is thinking or saying. Once she even told me she thought I was the neighbor hiding out in my body.”

Aunt: “Yes, she told me she thought Carlos was the neighbor, like the neighbor is using Carlos’ body to get in our house”.

Here the clinician gathers information from the family and how Sofia’s experience has changed. The “onset” of positive psychotic symptoms should be listed as when the family notes the difference (i.e., when Sofia starts thinking the TV is sending messages, when she begins playing music loudly to avoid being heard by neighbors, thinking the uncle is an imposter (Capgras Delusion). It is possible that Sofia’s poor grades, isolating and moodiness are part of a prodromal period where a decrease in function occurs. The timing is worth noting. It is important to include the family’s perception regarding stress related to Sofia’s mother’s disappearance. It is also possible that this stressor tipped this teen past threshold for positive psychotic symptoms.

RECOVERY ORIENTED APPROACH AND PEER SUPPORT

Simply stated, a recovery-oriented approach is one that is strengths-based. It builds on an individual’s skills and abilities, accounting for supports and incorporating these into treatment. The word ‘recovery’ has been a longstanding talking point for which there are different views. For some, recovery means no longer having symptoms or to be free from a condition one once had. A strengths-based approach to recovery is not so absolute or diametric. You will hear the term “working recovery” which accounts for maintenance of self-care and engagement in the things that increase a person’s function. If recovery dictates that someone no longer has any symptoms, we are painting a dismal picture for those who experience psychosis or, any health condition for that matter. Recovery is the concept that the condition no longer prohibits one’s life as it once had. Individuals are functioning successfully, and it is they who define “success”. This might not mean free-from-all symptoms. For some, it may mean being back at work or school after an episode. It may mean having meaningful activities and relationships. For many, it means completing their graduate degree or any other venture which they desire. The individual identifies the goal, and the clinician assists the individual/family in utilizing their strengths and skills towards the goal while assisting with identifying barriers to be removed or lessened. Most who experience symptoms of psychosis will find that self-care strategies and active coping/tool attainment increase the likelihood that symptoms, if they do re-emerge, will have less fallout in all areas (Deegan, 1988; Jones, 2015).

Peer support enables the individual to walk through the experience with ‘someone who has been there’. Certified peer support workers (CPSW’s) have lived experience in the area and go through a certification process in order to support the individual in multiple areas of recovery. Peer support is a primary component of recovery-focused supports and CSC models for FEP. Peer support workers see people in their natural

surroundings and have a very important role in the health and success of those they serve. Core Competencies for Peer Workers (SAMHSA Bringing Recover Supports to Scale) entail that peer support services are voluntary, recovery oriented, person-centered (directed by the person receiving services), collaborative and trauma informed. They used their lived experience as an example of recovery and hope.

CASE EXAMPLE: SOFIA

Joe: Hi Martha, my name is Joe. I work on the team as a peer support worker. That means that I have lived experience in this area and my focus is to work with the clients in a more informal way than some of the team. I will also share some of my experiences or things that may have helped me in my own recovery. I’m here to help support you and advocate for you and walk through this process with you. I was in a similar program to this a few years ago. At that time, I had just been hospitalized for the second time and was feeling pretty overwhelmed and discouraged. The supports really helped me. A couple of years later and I’m working for a similar program helping other young adults.

Martha: Really? So, you kind of understand how this process goes from the other side of it? That’s amazing because I have felt pretty isolated for a long time. I’m not quite sure how to start things. I mean, I feel better than I did when I was in the hospital, and I know I want to go back to school but the mere thought of the steps gets me really overwhelmed. I am not sure I can even handle the workload and I don’t want to disappoint my family. They’re pretty focused on my getting back into things.

Joe: I can relate to that. I remember when I was applying to school and how stressful it was. At one point, I felt like my family was pushing me to start thinking about college, and I would just shut down. I felt so afraid and that made everything feel a bit worse for me. Then I realized it wasn’t all or nothing. I could try out taking a class at the local community college. That felt so much more manageable and helped me work up to working on my bachelor’s degree, which I hope to finish next year. Is a community college course something you’ve ever thought about or that might be worth looking into?”

Martha: I guess I never thought about it that way. I just figured I had to get back to things. Taking one class seems a lot less overwhelming. Maybe I can take something that isn’t required as a core course towards my major. Less stressful.

Joe: It sounds like a good idea. Maybe we can meet and just go through some of your interests and do some research together on what might be available next semester. We could go to campus together, if helpful, and link with an advisor. I would like to support you however I can.

Martha: Joe, this already feels a little bit better. When I think about school, I start to feel panicky. Maybe I will take a class that I will like, and it will help me transition back into the academic mind frame without setting me back or stressing me out too much. I mean I want to keep going forward, I just don’t want to push things too fast and find out it’s making me feel worse.

Joe: Sounds like a good step, Martha. I am here to support you. Also, I’m not sure if you are aware that the local SARDAA group is one that I co-facilitate. SARDAA or the Schizophrenia and Related Disorders Alliance of America was founded in 1985. SARDAA is a self-help/peer support 6-step program run by and for persons who have schizophrenia or a related illness. I can give you the schedule and location if you’re interested in checking it out. This is not an uncommon experience, and you might find being around people who understand may be a good support as well.

Martha: Yes, that sounds great. I’d like to hear about how other people have managed early recovery. Maybe I will get some tips and learn from people who have been in a similar situation to mine.

PSYCHOTHERAPEUTIC MODALITIES

In terms of psychotherapy, there is no one approach that is best for Hispanic or LatinX clients compared to any other client. It is always individualized and client specific. That being said, CSC programs use a variety of techniques including Cognitive Behavioral Therapy for Psychosis (CBTp), Individual Resiliency Training (IRT), or other psychotherapy modalities. All of these models are recovery-oriented and utilize shared decision making to empower the client to guide their own treatment. The first step in providing support is to help the client identify their goals. With LatinX clients, it may be helpful to discuss how the client goals align with those of their family or culture. If the goals are not in alignment, the client may or may not want the clinicians' support in addressing this. Again, this conversation would ideally happen for all clients from all backgrounds and not only if the clinician and the client are of different backgrounds. Young adults from any ethnicity or culture may encounter generational differences in opinions on life choices.

Cognitive Behavioral Therapy for Psychosis (CBTp)

Psychosocial approaches to managing psychosis have shifted from a purely behavioral focus to an emphasis on the interaction of cognitions and behavior on the symptoms of psychosis. "CBT helps individuals become aware of their thoughts and behaviors, with a focus on exploring how these impacts their emotions" (Hardy, 2017). CBTp targets factors that maintain the experience of residual psychotic symptoms, as well as distress and disturbance associated with symptoms. It also allows for the targeting of secondary morbidity such as depressive and anxious symptoms. The focus is on symptoms rather than syndromes, and on decreasing distress associated with psychotic symptoms. Treatment focuses on understanding and modifying factors (including the person's belief about their symptoms). Other elements include psychoeducation, cognitive therapy for fixed thought processes and sensory experiences, behavioral skills training, and therapy for secondary concerns (depression, anxiety, etc.). In the case of CBTp, the therapist's goal is not to get the patient to question the reality of delusions or hallucinations, but to reduce the damage they can do.

"We're never trying to convince somebody that their experience is not real," Kate Hardy, psychologist who specializes in CBTp at Stanford University's INSPIRE Clinic. The experience of psychosis tends to be so idiosyncratic that it is important for the therapist to work with the patient on describing and assessing their experience. If a patient experiences auditory hallucinations, the therapist is in the role of learning what about this is particularly distressing. Sometimes it is not about hearing voices, but about specific voices, or that they are too loud, too mean, or impair focus. This is where the therapist assists the patient in learning skills to decrease distress and increase function.

CASE EXAMPLE: MARCOS

Marcos is a 17-year-old male who has a 6-year-old half-sister, Becca. Becca has refused to spend time at the house and has informed her mother that it is because she is frightened by Marcos when he "starts yelling at people who aren't there". The therapist ascertains that Marcos likes listening to some of the voices but that others become abusive. The goal of the session is to lessen the negative impact of Marcos' symptoms.

Therapist: Tell me what happened with Becca last weekend.

Marcos: She told my mom that I scared her because I was yelling at ghosts. But really, I was yelling at two of the guys who kept telling me I was a terrible person because I was eating candy and that it is disgusting. They kept calling me names.

Therapist: Is it okay with you if I point out an observation?

Marcos: Yeah, of course.

Therapist: Marcos, we have been working together for a month or so now. I noticed that sometimes during our conversations you become distracted and sometimes talk back to the voices while we are together. I suspect that makes it difficult to be present with me.

Marcos: Yeah, they can be so annoying.

Therapist: Yes, I would imagine so. And it sounds like it is also difficult for you. As well as your sister.

Marcos: Yeah, I hate that it frightens her. I don't want to scare her. I like when she is over and I'm so frustrated.

Therapist: I know you are. We will work together to find a way to work on this. Remember we went over a few coping strategies that others have found helpful? I'd like for us to try another.

Marcos: I will try anything. I'm really at wits end with the voices ruining good things for me.

Therapist: How about we try the technique we mentioned early on, 'scheduling the voices'. This has to do with setting a specific time to listen or tend to the voices. It also has a time limit".

Marcos: Like an appointment? What if they just do whatever they want? I mean they interrupt things all the time. What do I do then?

Therapist: What would you do if you and Becca were playing a game and one of your friends called you wanting to have a conversation even though you had planned on a call for later that evening?

Marcos: I would let him know I am busy and that I would talk with him later. Maybe remind him of the plan we made.

Therapist: Exactly. Do you think you can do that with the voices? Would you be able to give that a try?

Marcos: Yeah. I will try anything. I hate what has been happening.

Therapist: Great. Let's write down a reminder card with some details that might be helpful to test out this next week. This has been helpful for a lot of people. But we will just test it out. There are lots of other tools and skills that we can experiment with.

Marcos: Great. I kind of want to write down the time I will do this and what I might say when they act up. So, I remember and know how to handle it.

Here the therapist joins Marcos in lessening the impact of the voices. He is distressed that his younger sister has not wanted to spend time with him. Note that the therapist does not focus on what is 'real', but rather what is 'helpful'. It is not helpful that Marcos begins yelling at his voices and this scares his sister. Strategies to manage symptoms can increase function and greatly reduce distress.

Individual Resiliency Training (IRT)

Individual Resiliency Training assists clients in learning about psychosis, processing their experience, developing relapse plan, increasing resiliency, learning specific strategies and skills in order to achieve own personal goal. IRT aims to promote recovery from an initial episode of psychosis by identifying client strengths and enhancing self-management skills. IRT has been implemented widely in the United States as part of the RAISE NAVIGATE model (Heinssen, Goldstein & Azrin, 2014). IRT similarly draws on a CBT background and consists of 14 modules (seven standardized and seven individualized modules) covering a range of topics, including education about psychosis, processing the psychotic episode, relapse prevention planning, developing resiliency, managing distress, coping with symptoms, improving social functioning, and addressing substance abuse. This manualized approach includes handouts for each of the module topics that summarize pertinent information and also provides worksheets.

CASE EXAMPLE: BRIAN

Brian, a 19-year-old male college student with extreme paranoia, stopped leaving his dorm room was hospitalized after the resident advisor (RA) linked him with the mental health center in the context of starting to feel confused about what was real and not, having extreme anxiety, fear and inability to attend classes. After discharge from the hospital, Brian started treatment with a CSC program for first episode psychosis. Although he felt more grounded in reality, he continued to have difficulty concentrating, had extreme anxiety and sporadic paranoid thoughts that he might be in harm. During the Orientation module after providing an overview of IRT, Brian shared with his clinician that he wanted to return to college and graduate, as he would be the first person in his family to earn a college degree. By the end of the module, Brian and the clinician mapped out a plan to graduate from college, which was broken down into two shortterm goals of learning strategies to help improve concentration as well as identifying help/accommodations to improve academic success. In the Relapse Prevention Planning module, Brian established a plan with the IRT clinician, and practiced how he would contact his supports, at school if he noticed an early warning sign that things were starting to feel “off”.

FUNCTION FOCUSED APPROACHES

Helping individuals increase their function can directly decrease distress and add to life satisfaction. Focusing on function aims to decrease an individual’s difficulty in successfully completing various activities that they want, need or are expected to perform. Symptoms of psychosis and its effects can negatively impact a person’s function in all areas of their life.

Wellness Recovery Action Plan (WRAP) is a recovery model developed by a group of people in northern Vermont in 1997 in a workshop on mental health recovery led by Mary Ellen Copeland. It has been extensively studied and is now an evidence-based practice, listed in the SAMSHA National Registry of Evidence-Based Programs and Practices. WRAP is a framework with which one can develop an effective approach to manage distressing symptoms and gain insight into patterns of behavior. It is a tool to help individuals gain more control over their problems (Copeland, 2002). WRAP assists individuals in discovering wellness tools, developing things to do daily to stay as well as possible, naming upsetting events, identifying warning signs, discovering wellness tools and developing action plans for responding to each stage. Plans should be developed when one is well. It will take time to develop, and it is essential that it is developed in collaboration with those the individual is asking to support them so that they fully understand and agree to their role within the plan. Once completing the plan, one may wish to provide a copy of the plan or the relevant part of it to the people that play a role within the plan. The Copeland Center for Wellness has details and free tools on their website <https://copelandcenter.com>. There is also a Wellness Recovery Action Plan App that so that individuals can

develop their WRAP and have it with them at all times (Advocates for Human Potential, Inc., 2018).

Occupational therapy (OT) is a health profession focused on promoting health and well-being through engagement in meaningful occupations (American Occupational Therapy Association [AOTA], 2014). Occupations are defined as the activities of everyday life in which we all participate. The main goal of occupational therapy is to enable individuals to engage in daily activities that they need, want, or are expected to do. These are activities that have meaning and value to the individual. Occupational therapists can support individuals in developing, improving, sustaining, or restoring a level of independence that is desired by the individual by using activities throughout the assessment and treatment process.

Occupational therapy, which primarily focuses on recovery and developing functional abilities, can also be extremely helpful for young adults experiencing early psychosis. The difference between an occupational therapist’s role in a general community mental health setting and an early intervention service is the increased knowledge and awareness of the developmental stages and assistance needs during adolescence and early adulthood. The occupational therapist’s role is to provide information and direction to the service user, supports/families and, treatment team with regard to any factors that will influence the recovery or development of functional abilities. Occupational therapists specialize in helping individuals engage in activities, routines, and roles that they want/or are expected to participate in (i.e., school, work, social life, family life). OTs support people in meeting the demands of roles and routines in which they engage while coping with symptoms of psychosis (sensory strategies, cognitive strategies, environmental adaptation) (Lloyd et al., 2008). This role can be broken down into the three domains of assessment and treatment planning, intervention and advocacy.

CASE EXAMPLE: JOEY

Case Example (taken from the EASA: Occupational Therapy Manual)

Joey has a primary goal of employment. He has difficulty making eye contact, which is currently a barrier to meeting his goal. The occupational therapist has Joey complete the Adolescent/Adult Sensory Profile. The results indicate very high sensory sensitivity and sensation avoiding tendencies, meaning that everyday environments can quickly become overwhelming. Sensory defensiveness is rooted in the brainstem and reticular formation, so when Joey experiences sensory overload (such as the high demand to filter and organize all the sources of sensory information when making eye contact) his autonomic nervous system is activated, initiating Joey’s fight or flight response. Joey echoes this when he describes his feelings while making eye contact, stating, “I almost feel attacked, and I can only concentrate on how to get away as fast as I can.” The occupational therapist works with Joey to explore and integrate sensory strategies into his daily routine to promote balanced self-regulation, and uses activities that require visual scanning and head range of motion, as well as games and other daily activities that require brief moments of eye contact (ex: making eye contact before throwing the football to each other, going to the grocery store to ask a clerk for help finding an item, or initiating brief conversations with the checkout clerk)” (Wen, 2016).

IMPORTANT YET UNDER-DISCUSSED TOPICS

Some topics that are of key importance are often avoided by clinicians. One should develop comfort in initiating and discussing areas that may be less comfortable for clients. One cannot expect that clients will raise concerns that are more vulnerable to discuss. This is an area where pointed, closed-ended questions with specific details are most helpful. Clinicians are generally trained to ask open-ended questions. In areas related to sexual health and wellness, function and fulfilment and suicidal ideation, the more detail the question the better.

Suicidality

Although clinicians may also ask directed question such as “are you having any thoughts of hurting yourself?” Suicidal ideation is an area that should be explored in-depth and spoken about often. Psychoeducation should be provided regarding the prevalence of suicidal ideation (SI) and attempts, the difference between passive and active SI, as well as normalizing the intense difficulty that individuals may face with new onset psychosis or the year following diagnosis. In addition to ongoing discussion and normalization, proactive suicide risk assessment is the best approach in that it is integrated throughout treatment. These assessments can be conducted in regular intervals and include scales such as the Columbia Suicide Severity Rating Scale (C-SSRS). Programs can set timeframes, such as every 6 months, even with no indications of increased risk. Regular discussion, psychoeducation, and formalized screenings at intervals keep risk level and needed supports a consistent topic. In addition, “reactive” risk assessment and management occurs when there is an increased risk of suicide. Team vigilance and clinical action may be necessary in response to keep the person safe.

During the first 6 months after the onset of psychotic symptoms regardless of age, patients may be at greatest risk for suicide. Up to 26% of patients with schizophrenia have attempted suicide by the time they are admitted to the psychiatric hospital for the first time (Falcone et al., 2010; Sanchez et al., 2015). It is not uncommon to feel hopeless and, early recovery is the most dangerous time. It is critical to have consistent discussion about suicidal ideation, psychoeducation and normalization of feelings in early recovery as well as discussing the risk within this timeframe. The risk of suicide during the first year is 12 times higher than that of the general population (***) . The risk of suicide is greater when the individual is unemployed or not regularly engaged in activities such as school, job or volunteering. Most individuals experiencing a first episode of psychosis find themselves unemployed or having difficulty maintaining the degree of involvement and function they had. Approximately 20% of those who have command hallucinations to kill themselves will act on this (NASMHPD, 2016). Suicidal behavior occurs mostly because individuals are distressed or overly preoccupied by the psychotic experiences they are having. Assessment and discussion around risk level is an area with which clinicians working in FEP intervention must be comfortable. The comfort level of the clinician will create a safer space for the individual to discuss thoughts they might be having in this area. Protective factors should also be identified and fostered. A supportive and accepting support system, increasing problem solving skills, feeling purpose, limited access to lethal means, and a focus on increasing skills and abilities to assist with function are all protective in nature and can be bolstered.

Sexual Health and Wellness

Sexual health and wellness are an area almost wholly avoided as it relates to mental health/mental health treatment. It is a great disservice to disregard sexual health. Historically, individuals with SMI are excluded as sexual beings. Frankly, things have not changed much. Discussion around intimacy, boundaries, medication and sex, side effects and sexual wellness, possible effect on psychotic symptoms while engaging in sexual activity, dating, and dialogue with partners is a critical part of holistic function. Although the prescriber will discuss side effects of medication with patients, it is important for the clinician to be comfortable in raising and discussing these topics. It is known that side effects of antipsychotic medications can include disturbances of erection and ejaculation, changes in libido, orgasmic dysfunction and menstrual irregularities to name a few. It is estimated that 30-60% of individuals taking these medications will experience sexual side effects (Sullivan & Lukoff, 1990). Any side effects can be distressing to individuals, but sexual effects can be particularly bothersome and an area that is difficult for individuals to initiate. The positive and negative symptoms of psychosis can also make dating, intimacy and connection a challenge. None of this should be overlooked. Clinicians should initiate discussions in these areas. Even if an individual is not having difficulty or if it is not an area they would like to discuss, it creates the space for the client to know that these are topics that can be discussed within the therapeutic setting.

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PHARMACOLOGICAL TREATMENT

CHAPTER 4

Early intervention is imperative in the management of life-long psychiatric conditions, including schizophrenia and other non-affective and affective psychotic disorders. An example of the value of early intervention includes research findings on the duration of untreated psychosis, which have shown that the outcome of psychotic disorders is associated with time between onset of psychotic symptoms and the initiation of pharmacological treatment (Keating et al., 2017; Tohen et al., 2016). Specifically, optimizing pharmacological treatment at the first episode of psychosis (FEP) leads to better long-term outcomes. The process of selecting appropriate medication for FEP should not only include the clinician referencing current guidelines and evidence base but should also include principles of shared decision-making. In addition, when prescribing to FEP patients, specific considerations should be included depending on the individual demographic characteristics.

PRESCRIBING GUIDELINES

Clinicians frequently choose medications based on previous good or poor response to pharmacological treatment of the patient. The challenge in the selection of pharmacological treatment in the early stages of a psychotic illness is the lack of guidance given the lack of previous pharmacological experience in a particular patient. Therefore, evidence-based reports become essential in the selection of pharmacological compounds. The evidence, however, should be based in first episode patients rather than in patients with multiple episodes (Robinson et al., 2005). Important questions from clinicians working with FEP often include:

- Which antipsychotic should be used first and at what dose?
- Should racial/ethnic characteristics of the patient be considered?
- Which antipsychotic should be used as a second choice if the first is not effective or tolerated?
- How many trials should be done before considering clozapine?
- When are combinations of multiple antipsychotic medications appropriate?
- Should long-acting injectable medications (LAIs) be offered to FEP patients?

Several of the above questions do not have a clear answer as evidence-based data is not available. To address these questions, Keating et al., (2017) recently reviewed existing guidelines published between January 2009 and April 2016 concerning pharmacological treatments in first episode schizophrenia. The authors emphasized that a positive experience with medication of a patient with first episode psychosis is likely to have long-term implications for adherence and outcome. Therefore, the selection of a compound is important not only in terms of its efficacy but also its tolerability as well as patients' adherence to treatment.

Guidelines in general agree that all antipsychotics are equally effective for the treatment of positive symptoms in first-episode schizophrenia (Keating et al., 2017). Clinical efficacy trials of antipsychotic medications have not demonstrated clear superiority for any individual agent for patients experiencing a first episode of schizophrenia (National Institute for Health and Care Excellence [NICE], 2014). There is also a consensus that a key consideration when making the decision about pharmacological treatment is the side effect profile and tolerability of the medication. In addition to efficacy, the prescriber therefore needs to evaluate the safety and tolerability of each medication.

Antipsychotic medications can increase cholesterol, triglycerides, glucose, and weight gain, all contributing to metabolic syndrome which includes truncal obesity, hypertension, dyslipidemia, change in insulin sensitivity, and glucose metabolism. Metabolic syndrome is associated with the development of diabetes mellitus and coronary heart disease (Chadda et al., 2013). Other side effects that need to be considered are extrapyramidal symptoms and sexual dysfunction.

In general, guidelines recommend second-generation antipsychotic (SGA) medications as the preferred initial choice considering that the side effect profiles of this group of medicines are more favorable than

first-generation antipsychotic (FGA) medications (Galletly et al., 2016; Hasan et al., 2012; Osser et al., 2013).

The first head-to-head comparison of a FGA and SGA antipsychotic medication was conducted over two decades ago (Sanger et al., 1999; Lieberman et al., 2003). The authors compared haloperidol and olanzapine. Both treatments were associated with substantial and comparable baseline-to-endpoint reductions in symptom severity, which did not differ significantly. In secondary analysis the authors found that patients who received olanzapine had a significantly greater decrease in depressive symptoms (Lieberman et al., 2003). In terms of treatment tolerance olanzapine-treated patients experienced less treatment-emergent parkinsonism and akathisia but had significantly more weight gain, compared with those who received haloperidol.

Research in FEP patients has shown an increased sensitivity to metabolic side effects of SGAs without greater efficacy when compared to FGAs (Kahn et al., 2008; Sikich et al., 2008). However, the risk of long-term neurological side effects, such as tardive dyskinesia, with FGAs has led to a consensus that SGAs are preferable in FEP (Galletly et al., 2016; Hasan et al., 2012; Osser et al., 2013). Once the provider is ready to start pharmacological treatment the first question is "What antipsychotic medication should be prescribed first? A report by Robinson et al., (2005) found that the most widely prescribed antipsychotic in the US was risperidone, followed in descending order by olanzapine, aripiprazole, paliperidone and quetiapine (Robinson et al., (2015a). Studies have shown (Robinson et al., 2016; McEvoy et al., 2004) similar efficacy between olanzapine, quetiapine, and risperidone, however, an advantage of risperidone in producing less weight gain and less dyslipidemia. A head-to-head comparison between risperidone and aripiprazole was conducted by Robinson et al., (2015b) in patients 15–40 years old suffering from schizophrenia, schizophreniform disorder, schizoaffective disorder, or psychotic disorder Not Otherwise Specified. Patients received aripiprazole (5–30 mg/d) or risperidone (1–6 mg/d) for 12 weeks. Efficacy was similar for Positive symptoms and for response rates, however, patients treated with aripiprazole had a larger improvement in negative symptoms but experienced more akathisia. Weight gain did not differ; however, risperidone caused an increase in low-density lipoprotein cholesterol, fasting glucose, and prolactin levels. The authors recommended aripiprazole over risperidone considering lower risk of metabolic syndrome and some efficacy advantages. The authors also point out that a low dose of risperidone should be considered if akathisia is a concern.

Oral medication is recommended over parenteral formulations. Long-acting intramuscular medications would be indicated in patients non-adherent to treatment. (Barnes & Schizophrenia Consensus Group of British Association for Psychopharmacology, 2011; Buchanan et al., 2010; Galletly et al., 2016; Hasan et al., 2012; NICE, 2014; Osser et al., 2013). Tohen et al., (2020) have also highlighted the use of LAIs in patients with first episode Psychotic Mania as non-adherence is not uncommon in this patient population.

While monotherapy is ideal, there is recognition that combinations of antipsychotic medications may be useful in certain scenarios such as clozapine augmentation (Barnes & Schizophrenia Consensus Group of British Association for Psychopharmacology, 2011; Buchanan et al., 2010; Galletly et al., 2016; Hasan et al., 2012; NICE, 2014; Osser et al., 2013). As mentioned above, there is an increasing interest in the use of long-acting antipsychotic injections early in psychotic disorders both in non-affective (Heres et al., 2014) and affective (Tohen et al., 2020) psychotic disorders because of the high risk of nonadherence in First Episode Psychosis (Tohen et al., 2003; 2016) in order to reduce the risk of new episodes and improve psychosocial functioning. In bipolar disorder the selection of both acute and maintenance treatments are key decisions that need to be made as early as possible in the treatment of this population to reach the best possible outcomes (Vieta et al., 2017).

SHARED DECISION MAKING/COLLABORATIVE CARE

Finding the right medication may require a trial-and-error process – which should be discussed with young patients at the start of treatment to prepare them for the process. As previously mentioned, side effects of

antipsychotic medication can include weight gain and sexual dysfunction. For the population of FEP patients, who are in their late teens or early 20s, these can be big deterrents to taking medication. Prescribers should be comfortable discussing these possible side effects and working with the patient to find the right medication for them based on their individual concerns.

Shared decision-making (SDM) stands a central tenant of collaborative, client-centered care and an important element of FEP treatment. Evidence suggests a collaborative approach to prescribing can increase overall satisfaction with and adherence in treatment, improves long-term patient outcomes, and strengthens the therapeutic relationship between patient and clinician, supporting individuals in establishing a more robust recovery (Lauriello, 2020). In shared decision-making, both patient and prescriber bring their own unique knowledge and perspective to the decision-making process. Prescribers and other clinicians provide expert education around medication risks and benefits, including side effect and relapse considerations, while supporting patients in shaping individualized goals for medication use, and exploring concerns around medication and their overall treatment experience. For individuals with FEP, who are often excluded from making critical treatment decisions, shared decision-making stands to equalize traditional power imbalances and support fuller, a more thoughtful engagement in treatment and recovery (NCBI). Prescribing decisions should therefore reflect individuals' unique treatment needs, preferences, and circumstances and incorporate the input of patients themselves wherever possible. There are many evidence-based tools to support the implementation of shared decision-making including decisional balance worksheets and option grids (Buchanan & Kreyenbuhl, 2016). Helpful shared decision-making tools on anti-psychotic prescription use can be found at:

- SAMHSA- <https://www.samhsa.gov/brss-tacs/recovery-support-tools/shared-decision-making>
- Other tools for clinicians include:
 - Option Grid decision aid, available through The Dartmouth Institute <http://www.optiongrid.org/option-grids/grid-landing/64/>
 - Ottawa Personal Decision Guides, available through The Ottawa Hospital Research Institute - <https://decisionaid.ohri.ca/decguide.html>
- In addition, publicly available training videos on shared decision making can be found through OnTrack NY and The Center for Practice Innovations (<https://www.practiceinnovations.org/CPI-Resources/Shared-Decision-Making>).

Part of the shared decision-making process when working with individuals experiencing FEP, includes acknowledging the impact of medication side effects, some of which can be significantly disruptive, impeding medication and treatment adherence and jeopardizing recovery. Common side effects of anti-psychotics include weight gain and other metabolic side effects, sexual side-effects related to hormonal changes, motor side effects, and sedation. Prescribers should strive to prevent side effects whenever possible by using the lowest effective medication dosage. Due to individual variability in sensitivity to medications, patients should be closely monitored for the development of side effects, particularly when first administering new medications, and monitoring should include regular laboratory tests work when appropriate. Early side effect detection and management will help to mitigate negative impacts on individuals' quality of life and reduce the risk of complicating adherence issues and/or discontinuation.

For individuals experiencing FEP, side effects like weight gain and sexual impairment can be particularly upsetting. A sensitivity to the impact of these and other side-effects on individuals' quality of life will serve to strengthen the therapeutic alliance and support better communication regarding medication issues in future. Psychosocial and pharmacological interventions should be explored wherever possible to mitigate the impact of side-effects which may threaten individuals' comfort and quality of life. CSC treatment models for First Episode care provide many opportunities for therapists and auxiliary support staff to facilitate a wide range of interventions aimed at managing medication side effects like weight gain, metabolic changes, and sedation via targeted activities, supports, and education (Buchanan & Kreyenbuhl, 2016).

Another important issue for clinicians to address in collaboration with the patient is medication inconsistency or non-adherence, which can reduce symptom control and may, in turn, compromise a patients' ability to engage in treatment. Adherence issues are common and may be impacted by the experience of side effects, actual or perceived efficacy, limited understanding of the function of psychiatric medications, and other factors (including substance use, housing or familial instability, cultural or religious beliefs...). In this vein, it is important to educate patients on the need for regular medication adherence to support full efficacy and reduce the risk of breakthrough symptoms. Clinicians should work creatively and collaboratively with patients to address adherence issues when they arise and develop individually tailored interventions to support enhanced adherence, engaging family members and supports when agreed upon and appropriate. Again, consistent effort should be made to anchor medication decisions within the framework of individual's own recovery goals to support increased adherence.

While families can provide critical support to individuals in recovery from FEP, individual dynamics will vary and there may be situations when direct family involvement, particularly in medication decisions, can be detrimental. Clinicians should proceed with caution and support individuals in developing personal skills and strategies to enhance adherence including setting reminders, using organizational tools such as pill boxes, and incorporating medication administration into one's regular routine. As mentioned above there is evidence that longacting injectable anti-psychotics may support individuals experiencing barriers to adherence in maintaining a regular medication regimen (Buchanan & Kreyenbuhl, 2016).

MAINTENANCE AND DISCONTINUATION

It has been estimated by some groups (Norman et al., 2011) that approximately 20% of those who meet the diagnostic criteria for a FEP will likely not experience any subsequent episodes (Owen et al., 2016). The optimal duration of treatment following a first episode of psychosis is a key decision. In a recent study (Mayoral-van Son et al., 2016) the relapse rate for those who discontinued medication following 18 months of treatment (and were in clinical remission for more than 12 months with 6 months or more of functional recovery) was twice that of those who continued maintenance antipsychotic medication over the 3-year study period. Therefore, if the decision is to stop the medication, close observation is paramount and recommended for as long as 5 years.

Recommendations regarding the duration of maintenance treatment following a first episode of schizophrenia vary between 1 and 2 years (Galletly et al., 2016; Hasan et al., 2013; NICE, 2014; Osser et al., 2013). However, some guidelines do not make a specific recommendation. The Royal Australian and New Zealand College of Psychiatrists recommends continuation of pharmacological treatment for at least 5 years following a first episode of psychosis (Galletly et al., 2016).

Most guidelines recommend that the antipsychotic medication used for relapse prevention be generally the antipsychotic medication prescribed in the acute management and at the dose that was effective in the acute phase (Buchanan et al., 2010; Hasan et al., 2013; Osser et al., 2013). Evidence for the superiority of medications such as olanzapine and risperidone, or inferiority of quetiapine in relapse prevention, is reflected in the recommendations of some guidelines (Scottish Intercollegiate Guidelines Network, 2013; Hasan et al., 2013; Osser et al., 2013). However, in some guidelines (Buchanan et al., 2010; Osser et al., 2013; Galletly et al., 2016) olanzapine is specifically excluded as the initial choice of antipsychotic medication because of the concern of metabolic side effects and weight gain. Quetiapine is also not recommended because of a poor evidence for maintenance of remission.

Current practice at the Early First Episode Program at UNM, follows evidenced-based choices to be made at an individual level regarding continuation of antipsychotic medication at -2 years following symptom remission of the first episode (Karson et al., 2016). While efforts to support individuals' continued engagement in antipsychotic treatment, including discussion of the role of medication in supporting personal recovery goals should be made, a percentage of individuals will ultimately decline psychiatric medication or elect to discontinue their current regimen. Discontinuation ideally should occur under the guidance and supervision

of the individual's treating physician and effort should be made to engender an open and noncoercive discussion of the risks and benefits of suspending anti-psychotic treatment. For individuals that elect to discontinue medications all together, prescribers should work with individuals' treatment team, and with consent, client's family members and other supports, to monitor for symptom relapse and plan for appropriate intervention as needed. Individuals may be more likely to revisit resumption of anti-psychotics when they feel they are given appropriate autonomy. Likewise, the decision to discontinue medications should not be presented as final or irreversible. Rather individuals should be encouraged to view medications decision as fluid and responsive to their changing needs. An emphasis should also be placed on medication as one potential therapeutic intervention, working best in conjunction with other interventions, supports, and skills; what Pat Deegan refers to as "personal medicine" (as differentiated from "pill medicine") (Deegan, 2016).

DEMOGRAPHIC CONSIDERATIONS

Knowledge that individuals with psychotic disorders have high cardiovascular morbidity and mortality is well documented. However, risk and preventive factors in the early stages of illness are less clear. Data from the Recovery After an Initial Schizophrenia Episode (RAISE) study, in patients aged 15 to 40 years, reported that at baseline 48.3% were obese or overweight, 50.8% smoked, 56.5% had dyslipidemia, 39.9% had borderline hypertension, 10.0% had hypertension, and 13.2% had metabolic syndrome. Total psychiatric illness duration correlated significantly with higher body mass index, fat mass, fat percentage, and waist circumference but not with abnormal metabolic parameters (except triglycerides to HDL-C ratio). Antipsychotic treatment duration correlated statistically significantly with higher non-HDL-C, triglycerides, and triglycerides to HDL-C ratio and lower HDL-C and systolic blood pressure. Olanzapine was statistically significantly associated with higher triglycerides, insulin, and insulin resistance, and quetiapine was associated with significantly higher triglycerides to HDL-C ratio. The authors concluded that in patients with FEP, cardiometabolic risk factors and abnormalities are present early in the illness and possibly related to the underlying illness, unhealthy lifestyle, and antipsychotic medications. They emphasized the importance of prevention and early interventions, as well as with the use of lower-risk agents, routine antipsychotic adverse effect monitoring, smoking cessation, and other health promotion interventions (Robinson et al., 2015).

Recent evidence has indicated that certain demographic populations within the group of young adults with FEP may be more vulnerable to metabolic syndrome. In the CATIE trial (McEvoy et al., 2005) females of any ethnicity or race had the highest (50% - 57%) prevalence of metabolic syndrome. In addition, Hispanic patients appear to have a higher risk of developing metabolic syndrome, diabetes and dyslipidemia compared to the general population. The risk of metabolic syndrome in patients of any race ranges from 3.3% to 68% in patients with schizophrenia. Its prevalence ranges from 3.3% to 26% in drug naive patients, and 14.7% to 68% in patients on antipsychotics. Metabolic syndrome can develop after just 2 weeks of treatment with antipsychotics. The risk of metabolic side effects in first-episode treatment choice was addressed in the RAISE-ETP study that found that after an average of 47 days of receiving antipsychotic treatment, half of the patients had dyslipidemia and half were already overweight or obese (Correll et al., 2014; McGorry et al., 2013). The authors studied cardio metabolic risk in patients with first episode psychosis. They found that Hispanic patients had more dyslipidemia than non-Hispanics.

A study conducted in Chile (Iruetagoiena et al., 2019) showed that the rate of metabolic syndrome was higher in a first episode psychosis population compared to a similar population in the community. The prevalence of metabolic syndrome was 44.7% in FEP patients compared to 11.4% in the general population. The investigators also found an association between treatment duration and hypertriglyceridemia and obesity. Clozapine/olanzapine use was associated with higher rate of hyperglycemia and high low-density lipoprotein. The authors point out that Latino psychotic patients have a high risk of metabolic syndrome at initial stages of the disease which is not entirely explained by the higher risk in the whole Latino population and does not seem to be just caused by antipsychotic use.

Finally, Kato et al., (2004) conducted a cross sectional study in 48 first and multiple episode patients with schizophrenia. The overall prevalence of metabolic syndrome was 63%. Hispanic patients had a prevalence

of 74% compared to 41% in non-Hispanics. The prevalence among Hispanics varied from 70% for Cuban Americans to 88% in other Hispanic. Metabolic syndrome was associated with larger waist circumference and high cholesterol.

Therefore, in the selection of antipsychotic for Hispanic patients, the risk of developing metabolic syndrome is an important consideration. Clinicians should be aware of this when selecting antipsychotic trials, and as previously discussed, be open in discussing this with patients. Clinicians should also take into consideration the cost of medications and insurance coverage. Some evidence has suggested that insurance coverage may play a role in the prevalence of metabolic syndrome. Puyat et al., (2013) report that ethnic minorities were less likely than non-ethnic minorities to be treated with newer antipsychotics. This finding may be related to insurance coverage, as minority patients due to lower socioeconomic status are more likely to have medical coverage that challenges the use of new treatments if similar medications are available in generic formulations. Importantly, some of the newer agents are less likely to cause metabolic syndrome.

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CONCLUSIONS

CHAPTER 5

DIVERSITY WITHIN LATINX

The terms Hispanic or “Latinx” are broad categories used to encompass a diverse group of people from different racial backgrounds, regions of origin, generations of immigration and varying citizenship status. While the group is loosely based on shared language, even this factor varies greatly in terms of accent, grammar and vocabulary. In the US, Latinx communities may include individuals with origins from Central or South America. Some individuals may identify as Hispanic through Spanish ancestry. Clinicians working with individuals identifying as Latinx will encounter this diversity, as well as specific differences depending on the region or state in which the clinician practices.

In discussions with clinicians working on CSC teams across the US, some common themes arose, as well as some geographically specific dynamics. For example, clinicians working in major east coast cities noted the higher prevalence of Latinx individuals identifying as Puerto Rican as well as a higher percentage of Latinx individuals with religious families and backgrounds. Clinicians working in communities close to the Mexican American border noted the need for special training and consultation regarding immigration issues and the delicacy of working with populations who are in need but may fear legal consequences of connecting with the medical or mental health system. While clinicians may need to attend to specific regional dynamics in their work, they should also be wary of making broad generalizations based on racial or ethnic identity. Clients should always be treated as individuals and effort should be made to explore the unique cultural dynamics at play in each person’s life as well as their own understanding of and relationship to their culture and cultural identity.

Latinx individuals’ experiences of violence, racism, and discrimination, particularly within systems of care, can present significant barriers to building trust and rapport and negatively impact treatment engagement. In light of this, clinicians emphasize the need to attend to issues of power, privilege, and oppression as they inform client care and treatment, as well as individuals’ broader lived experience. An awareness of the current social and political climate in the US, and the impact of widespread anti-immigrant sentiment, racialized violence, and punitive immigration policy is central to the provision of competent, comprehensive care for Latinx communities. Structural and institutional barriers for Latinx clients also impact individuals’ access to basic resources, including housing, transportation, education, and health care. These additional obstacles are also important to address and may require the support of auxiliary staff.

PROVIDING SERVICES ACROSS ETHNIC BOUNDARIES

As clinicians, it is part of our duty and practice to treat individuals from all racial and ethnic backgrounds regardless of our own racial or ethnic identity. Not belonging to the demographic population with which one works is not a unique experience. The authors have made every effort to consider this in their practice with FEP clients. The following section will explore some of the most important areas to consider as a provider when working across ethnic boundaries. Firstly, the authors are not and do not consider themselves to be experts. Instead, the authors are clinicians whose focus is FEP intervention. Working with this population in New Mexico affords the exposure to a unique demographic of the country, culturally comprised of individuals identifying as Latinx, Hispanic, Mexican American, Spanish American, New Mexican, amongst many other cultures. The authors have touched upon topics that may be unique to this population, including the importance of family, language, immigration, stigmatization, and cultural narrative of symptoms but recognize that these themes may not apply to every Latinx client. It is imperative that the clinician practice cultural humility when working cross-culturally with clients. One cannot educate oneself about every aspect of culture; nor would it apply neatly if one could. It is important to continue to learn and not to assume generalizations when working with individuals and families. Cultural competence as an end goal is something that does not exist. Learning and growing is a consistent process. Clinicians should continue to educate themselves and look on the individual/family as the expert of their life experience. Having open discussions with clients about bridging cultural differences creates the space for the conversations to occur. In addition, a clinician demonstrating

in discussing limitations and a willingness and desire to learn builds rapport and trust. In addition to letting go of the role of expert, clinicians must practice self-awareness. Self-awareness is the most important element to being effective in working and supporting others cross-culture. Clinicians can spend time considering how they might be perceived by their clients and creating the space for this to safely be explored. This too fosters rapport as well as facilitating discussion about important areas that may get overlooked. In addition, it is worth taking the time to review your practice and acknowledge the long and complicated history of the field of mental illness. Consider who wrote the assessments and theories that you practice. As discussed in previous sections, clinicians can have conversations about this with clients and families and acknowledge that within our medical system (insurance, ICD codes mandates, etc) we will need to gather certain information. Clinicians can still gather mandated information while engaging with clients in a way that does not feel like “checking boxes” on a form. It is up to the clinician to be flexible with regard to approach.

Finally, recognizing the human side of who people are, and were, prior to psychosis, is another critical and human element of this work. In balancing individual experience with theoretical frameworks, it becomes clear that there are things that unite us as humans. There are things we want as humans regardless of culture such as wanting what is best for our children, wanting happiness or to avoid suffering, to have purpose, contribute to a greater good, to belong and be valued. Cultures that value the individual may differ from cultures which value the collective in the “how” but, as humans, these are areas for which we all seem to strive. Coordinated Specialty Care (CSC) for FEP is a comprehensive multi-disciplinary model and can incorporate many other views and disciplines that may be brought to the table by the individual and family. The “standard” elements have been explained at the start of this manual. However, CSC is also a humanistic model as it lends itself to incorporating additional disciplines and areas of healing. The Early Program in New Mexico has the experience of working with families that have incorporated traditional healers (medicine men, curanderas, shamanic healers) as well as somatic practices such as acupuncture, massage, reiki, meditation, prayer, and spiritual ritual. With a focus on functionality and fulfilment, the CSC model lends itself to the practice of joining people where they are at, learning about them and what they would like to see for their lives, offering tools and supports that may assist in decreasing or removing barriers as well as strengthening and empowering their skills and tools.

Key Points:

- Present with gratitude for the individual/family that invite you into their lives at a difficult time.
- Practice self-awareness and consider how your own identity may impact the client and family.
- Create the space to have a conversation about similarities and differences.
- Ask the client and family to help you understand how they perceive what is happening, what they would like to see change, and to teach you what is important to them.

“Learning about a culture and assuming it generalizes to all who identify within that culture is an offensive and off-base approach. At the same time, approaching everyone in the same manner is tone deaf and nescient. There is a balance between these things.

We should recognize that we too are works in progress and commit to the process of learning, growing and continuing to challenge ourselves within our obligations as service providers. It is imperative to be attune to issues, rituals, gifts, skills, struggles that come with any individual’s life experience. Consistent work needs to occur on awareness around implicit biases while also continuing to educate oneself on the historical and cultural experiences that result in differences in accessibility, equity, equality, and many other areas. We need to continue to create the space to talk about these areas with families, individuals and within the systems with which we work. We must recognize that these tasks are our responsibility as clinicians.”

– Dawn Halperin

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