Psychosis Clinical Academic Group (CAG)

Exploring psychotic experiences in ‘non-need for care’ populations: findings from the UNIQUE study

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Unusual Experiences Enquiry study

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Funded by:

Institute of Psychiatry, Psychology & Neuroscience

Bangor (rural)
London (inner city)

UNIQUE study recruitment sites

Aims

• What factors determine whether psychotic experiences lead to pathological or benign outcomes?
• Are psychological processes identified by cognitive models involved in leading to a ‘need-for-care’?
• How can research on individuals who do not cross the psychosis threshold inform CBTp?

A Cognitive Model of the Positive Symptoms of Psychosis (Garety et al 2001; 2007)

Non-Clinical population reporting psychotic experiences

See Linscott & van Os (13), Psych Med, 43, 1133-49

UNIQUE study recruitment sites

London (inner city) (Peters/Garety/Ward)

Bangor (rural) (Jackson)
Participants

Non-clinical n = 92
Age = 18 - 80yrs (mean = 46 yrs)
Male/Female = 25/67

Clinical n = 84
Age = 20 - 78yrs (mean = 42 yrs)
Male/Female = 55/29

Controls n = 83
Age = 21 - 76yrs (mean = 46 yrs)
Male/Female = 26/57

Who are UNIQUE sample?

A Cognitive Model of the Positive Symptoms of Psychosis (Garety et al 2001; 2007)

It’s not what you experience, it’s how much you experience it [but cognitive ‘grip’, persecutory beliefs, and negative symptoms important]

UNIQUE sample: Same or different? (SAPS; SANS; AANEX interviews)

Peters et al (16) World Psychiatry, 15, 41-52
**UNIQUE sample: Same or different?**

(Fowler’s Brief Core Schema Scale; Chadwick’s Mindfulness Q; Q Evaluation of Self; Satisfaction with Life Scale; Psychological Well Being Q post experiences)

**No overlap in psychological profile**

**UNIQUE**

What sense do they make of their experiences?

Peters et al (16) *World Psychiatry, 15, 41-52*

**A Cognitive Model of the Positive Symptoms of Psychosis (Garety et al 2001; 2007)**

Maintaining factors
- reasoning & attributional biases
- dysfunctional schemas of self & world
- isolation & adverse environments

Bio-psycho-social vulnerability

Trigger

Emotional changes

Appraisal of experience

Positive Symptoms

Appraisals of anomalous experiences

**Appraisals of Anomalous Experiences Interview (AANEX)**

- **Biological**: illness, disorder, internal attribution of cause eg something wrong with my brain
- **Psychological**: mental processes, internal eg my mind playing tricks on me, trauma
- **Spiritual**: spiritual or religious processes, experiences have intrinsic spiritual value eg an awakening experience
- **Supernatural**: non-material entities or forces eg hands of invisible beings
- **Normalising**: normal range of human capacities eg episodes of ESP, everybody can have them
- **Other people**: other people causing experiences, paranoid/conspiracy interpretations

Appraisals of anomalous experiences (controlling for AANEX experiences factors)

[Bar chart showing differences between non-clinical (n=92) and clinical (n=83) groups]

Dimensions of appraisals (controlling for AANEX experiences factors)

[Bar chart showing factors such as Valence, Desirability, Abnormality, Concreteness, and Externalization]

It’s not external appraisals, but paranoid world-view

Disentangling experiences and appraisals experimentally

Can symptom analogue be used to investigate appraisals?

Anomalous experience

Appraisal?

The Card Task
Please mentally select a card and concentrate on it.
Do not click on your card or say it aloud.
After you have memorised your card, please press any key to continue....

The card you have chosen will now be selected and removed from the pile.
Please press any key to continue....

How do you think this was done?

Categories of appraisals– Cards task

Appraisals ratings – Cards task

See also Ward et al (14) Schizophr Bull, 40, 845-55
Robust experimental evidence for key role of appraisals

Response styles in clinical & non-clinical groups – Telepath

Response styles in clinical & non-clinical groups – Telepath

Safety behaviours in clinical & non-clinical groups

See also Ward et al (14) Schizo Bull, 40, 845-55

Gaynor et al (2013) Behaviour Research & Therapy, 51, 75-81
Threat appraisals → Safety Behaviours → Anomaly-related distress (or anxiety)

Path A = .55 (p < .001)
Path B = .50 (p = .001)
Path C = .45 (p < .01)

Mediation model between safety behaviours, threat appraisals, & distress


Path C shows initial relationship between SBs & distress, and its reduction when threat added to equation (Sobel test: Z = 3.04, p = .001)

How you deal with experiences matter, but driven by what you think about them

How can the UNIQUE group inform our therapeutic practices?

- Continuum of anomalous experiences
  - ... Normalise
  - .... Aim may not be to get rid of experiences

- But some experiences worse than others
  - ... loss of volition is key
  - ... type of voices/content (& link to negative schemas?)

- And relentlessness part of the problem
  - ... validate distress and difficulties

- Distressing, threatening appraisals are central
  - ... work with meaning
  - ... interpersonal (paranoid) appraisals
  - ... threat to self-esteem, not just ‘reality-based’ appraisals
• Cognitive difficulties & reasoning biases  
  ... don’t just challenge content, work at process level

• Experiences in (psychological & social) context  
  ... not just walking symptoms

• Spiritual & supernatural models of understanding  
  ... tolerance and support of the anomalous?

"... I relayed this experience to psychiatrists in the hospital and was sent for EEG tests, was told that I was hallucinating, was, this guy just didn’t listen to, just obviously hadn’t heard anything really that I’d said... I just felt that this really positive experience was just scrutinised and just not, just like mocked. I didn’t feel offended, I just thought they were being really stupid, and disregarding this kind of, yeah, really important thing...”  [Holly] 


...the weird can be wonderful

THE END
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