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Original article

Which psychotic experiences are associated with a need for clinical care?

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ABSTRACT

Background: The aims of this study were to identify (1) the factor structure of anomalous experiences across the psychosis continuum; (2) qualitative and quantitative differences in psychotic experiences (PEs) between "non need-for-care" and two clinical groups: psychosis patients and individuals at ultra high risk (UHR) of psychosis. We aimed to distinguish which types of experiences would be related to malign (need-for-care and/or help-seeking) versus benign outcomes.
Methods: Component scores obtained from a Principal Components Analysis of PEs from lifetime scores on the Appraisals of Anomalous Experience Inventory (Brett et al., 2007) were compared across 96 participants: patients diagnosed with a psychotic disorder ($n = 37$), help-seeking UHR people ($n = 21$), and non-clinical individuals presenting with enduring PEs ($n = 38$).
Results: A five-component structure provided the best solution, comprising dissociative-type experiences, subjective cognitive deficits, and three separate components relating to "positive" symptoms. All groups reported "positive" experiences, such as ideas of reference and hallucinations, with the non-clinical group displaying more PEs in the Paranormal/Hallucinatory component than both clinical groups. "Cognitive/Attentional anomalies" was the only component where the clinical groups reported significantly more anomalies than the non-clinical group. However psychosis patients reported more frequent first-rank type symptoms and "hypomanic" type PEs than the other groups.
Discussion: "Positive" PEs were common across the psychosis spectrum, although first-rank type symptoms were particularly marked in participants diagnosed with a psychotic disorder. Help-seeking and need-for-care were associated with the presence of subjective cognitive disturbances. These findings suggest that anomalies of cognition and attention may be more relevant to poorer outcomes than the presence of anomalous experiences.

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1. Introduction

There is accumulating evidence to support the existence of a continuum of the psychosis phenotype across the population, which in combination with sensitizing factors may manifest in the clinical presentations of the psychotic disorders [52]. However there is some debate over the exact nature of the continuum [13], the phenotype may not be unitary [23] and the nature of the continuum may be best captured by a combination of categorical and dimensional descriptors [1,14,49]. The heterogeneity of treatment response amongst people with clinically-relevant psychotic symptoms, including the identification of a subgroup that recover without antipsychotic medication, has led to suggestions that a more nuanced understanding of the continuum and subgroups of psychosis is needed [5,12]. Early detection and intervention programmes also depend on the identification of "At-Risk Mental States" (ARMS) to decide which types of presentation are likely to benefit most from identification and intervention [17].

Factor analyses have identified four or five dimensions of psychotic symptoms, including variations on "manic", "depressive",

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"disorganised", "negative" and "reality distortion" syndromes, in psychotic [34,38,50], ARMS [15], and healthy but psychosis-prone [11,53] samples. These studies have typically used different measures depending on the sample investigated: interviews assessing symptom severity in patient samples [2,3]; the Comprehensive Assessment of ARMS (CAARMS [59]) in Ultra High Risk (UHR) samples; and questionnaires measuring schizotypal traits and attenuated symptoms in non-clinical samples [33].

It is therefore difficult to compare the presentation and clustering of psychotic experiences across samples. On the one hand, diagnostic interviews can be limited, as only specific, illness-related forms of anomalous experience are being elicited. On the other hand, self-report questionnaires include items that are open to individual interpretation. This may be especially problematic in the area of subjective anomalous experiences, which can be subtle or difficult to describe. Furthermore, with some notable exceptions [18], quantitative aspects of the continuum of PEs have rarely been investigated, as questionnaires tend to use probe questions with dichotomous "yes/no" response options. However, there is evidence that more frequent experiences are associated with an increased risk of need-for-care [4,51] and psychotic disorder [25], although it is not known if this relates to specific kinds of anomalies. Negative and disorganized symptoms are predictive of transition to psychosis in ARMS samples [14,48], but it is unclear whether these symptoms also differentiate individuals with PEs with and without a need-for-care.

This study sought to identify qualitative and quantitative differences between three groups of individuals, all presenting with anomalous experiences but differing according to their need for clinical care. Non-clinical (NC) participants were specifically selected for the presence of enduring PEs[1] but with no accompanying distress or need-for-care[2]. UHR participants had sought clinical help after developing PEs, and met criteria for an ARMS for psychosis. Clinical (C) participants had a psychotic disorder and were in receipt of mental health services. The Appraisals of Anomalous Experiences (AANEX–Inventory [7]) was used to measure lifetime anomalous experiences in each group. This semi-structured interview elicits and rates anomalous experiences from a purely subjective perspective, and does not depend on objectively observed symptoms or behaviours linked to particular diagnoses. It therefore provided a means to assess the same phenomena in people who varied in their need-for-care.

2. Objectives of the study

The aims of the study were to identify:

- the factor structure of anomalous experiences occurring across the psychosis spectrum;
- whether PEs in a 'non need-for-care' group were qualitatively different from those with a psychosis diagnosis or meeting ARMS criteria;
- whether there were quantitative differences in frequency and/or duration of anomalous experiences between the three groups.

3. Method

3.1. Participants

The 96 participants comprised three groups of people reporting PEs. Exclusion criteria for all participants included:

- inability to speak and understand fluent English;
- history of neurological problems, head injury or epilepsy;
- current substance dependence;
- estimated current IQ < 70 (based on four WAIS-III [55] subtests). Other data from a subset of this sample have been reported elsewhere [6,7–9].

The Clinical (C) group ($n = 37$) met DSM-IV criteria for any schizophrenia-spectrum disorder as recorded in medical notes, recruited from the South London and Maudsley NHS Foundation Trust (SLaM). Individuals in their first episode ($n = 23$; Lambeth Early Onset service; LEO), and with a longer history ($n = 14$; Psychological Interventions Clinic for outpatients with Psychosis; PICuP) were recruited, to include a range of individuals similar to both the non-clinical group (who are typically in their 40s, with a childhood onset of experiences) and the at-risk group (who are younger with a recent onset of experiences). Their mean age was 32.6 years, 55% were male, and 82.5% were taking psychotropic medication including antipsychotics, mood stabilisers, and antidepressants.

The UHR group ($n = 21$) met the PACE criteria for an ARMS for psychosis [58]. They were recruited from OASIS (Outreach And Support In South London [10]). Their mean age was 23.7 years, 68% were male, and 32% were receiving psychotropic medication.

The non-clinical (NC) group ($n = 38$) comprised participants reporting enduring PEs, who had never sought or received clinical care for their anomalous experiences, and who were not distressed by them. They were recruited from the London area through advertisements on special interest websites, magazines and email groups, to access sub-cultural populations interested in altered states, mediumship, witchcraft etc. Volunteers were screened for suitability using a questionnaire enquiring about the lifetime incidence of a range of anomalous experiences, based on the AANEX-Inventory [7]. Only individuals with at least "occasional" experiences of any Schneiderian symptom[3], in the absence of drug use and in clear consciousness, were invited to participate. This criterion ensured that these were participants reporting PEs of direct comparability to clinical phenomena, rather than merely unusual experiences associated with schizotypy. Those who reported any history of clinical intervention for their PEs, or were judged to be in need of care by the experimenter, were excluded. To differentiate them from the UHR group (who have a high risk of developing a psychotic disorder), only participants whose anomalous experiences had commenced more than five years previously, were included. Their mean age was 34 years, 63% were male and none were taking psychotropic medication.

A one-way Anova and subsequent post-hoc contrasts ($P < .01$) showed no age differences between NC and C groups, which were both older than UHR group (UD > UHR: m.d. = 0.35; 99% C.I.'s = 0.17–0.53; $P < .001$; D > UHR: m.d. = 0.28; 99% C.I.'s = 0.1–0.45; $p < .001$). There was no association between group and gender ($\chi^2(3) = 0.95$; $P = .81$).

[1] We use the terms 'anomalous experiences', 'anomalies' and 'PEs' interchangeably throughout the text. We have deliberately not used the term 'psychosis-like experiences' (PLEs) since the experiences we are referring to are not necessarily sub-threshold.

[2] We have recruited from this population in a number of previous studies, please see [20] Gaynor K, Ward T, Garety P, Peters E. The role of safety-seeking behaviours in maintaining threat appraisals in psychosis. Behav Res Ther. 2013;51:75-81, [21] Heriot-Maitland C, Knight M, Peters E. A qualitative comparison of psychotic-like phenomena in clinical and non-clinical populations. Brit J Clin Psychol. 2012;51:37-53, [32] Lovatt A, Mason O, Brett C, Peters E. Psychotic-Like Experiences, Appraisals, and Trauma. J Nerv Ment Dis. 2010;198:813-9, [54] Ward TA, Gaynor KJ, Hunter MD, Woodruff PWR, Garety PA, Peters ER. Appraisals and Responses to Experimental Symptom Analogues in Clinical and Nonclinical Individuals With Psychotic Experiences. Schizophrenia Bull. 2014;40:845-55. For further description of the nature of this unique sample.

[3] Ie. symptoms considered indicative of a likely diagnosis of schizophrenia, comprising: delusions of control, thought broadcasting, thought withdrawal, thought insertion, hearing one's thoughts spoken aloud, second and third person auditory hallucinations.

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