Distressed by anomalous experience: Early identification of psychosis

Ian Tierney, Claudia Coelho & Peter Lamont

Research on the effect of early identification and delay in the treatment of psychosis affects academic units contacted by individuals reporting distressing anomalous experience.

ACADEMIC UNITS in the UK with interests in anomalous experiences frequently receive contacts from members of the public. Most callers (or writers) – the large majority – are curious about, but not distressed by, their anomalous experience or belief. However, it was the policy of the Koestler Parapsychology Unit (KPU) University of Edinburgh under the late Professor Robert L. Morris between 1986 and 2004 that, if an individual was distressed by their experience and wished to talk to someone, he or she was offered contact with a suitably qualified individual (a clinical psychologist or psychiatrist), who gave time voluntarily to the unit. These interactions were unstructured; no standard approach was taken or therapy offered. The clinician offered a sympathetic, and informed, ear. These constructive-listening approaches, similar to those described by Knight (2005), involve a non-judgemental acknowledgement of the person's anomalous experience.

Distressed callers were often the worried-well who had been frightened by anomalous experiences. These included sleep-related experiences (possibly hypnagogic or hypnopompic phenomena), unexplained visual or auditory experience in the absence of other clinically relevant experience or behaviour (Bentall, 2000) or unlikely coincidences which were viewed with foreboding. Others were concerned about telepathic harassment, abuse or attack; telepathic external control (manipulation of thoughts, behaviour, language or emotions); or distressing disembodied auditory experiences. Interpretations of such experiences include extra-sensory perception and other psi (parapsychological) concepts, as well as those based on established psychophysiological and psychological phenomena. A number of contacts were with individuals who acknowledged having received psychiatric advice or associated medication. Such people were at some risk of becoming non-compliant with treatment if they believed that the psi explanation accounted for all of their experience.

Occasionally, a distressed individual would be investigating this alternative in what the clinician believed was the early stages of a psychotic illness before, or instead of, seeking advice from health professionals. People in this latter, clinically significant, category constituted a small proportion of those distressed individuals who contacted the KPU. In such circumstances, one approach used by the clinicians was to point out that explanations or interpretations of anomalous experience have various implications or degrees of risk attached, and that these are not equal. If, for instance, a possible explanation for much of an individual's experience was a pathological one, and that this had not been assessed before, then an early assessment of that possibility would be wise. The frightening nature of that explanation was acknowledged, but the person was encouraged to consider that if, after assessment by competent advisors, that explanation were discounted, then the individual might explore other, less risk-laden alternative explanations for their experience with greater peace of mind. If, unfortunately, it turned out to be the appropriate explanation, then the individual had done as much as he or she could to reduce the impact of any psychopathology. This approach, if employed as part

of a thoughtful, responsive and unhurried discussion, appears to have been useful.

It was not possible, or deemed appropriate, to assess distressed callers to the KPU using standard clinical schema. Such individuals were calling the unit because of its non-clinical experience with anomalous phenomena. Furthermore, clinical assessments usually require the assessor to visually observe the individual (not possible for nearly all contacts to the KPU) and ask a number of questions which would probably have been viewed as inappropriate in the context of their approach to the unit.

Recent clinical research has evaluated the clinical significance of:

- the duration of untreated psychosis (DUP), particularly first episode;
- the early identification or detection of first episode or prodromal psychosis;
- strategies for improving this early detection (McGorry, Nordentoft & Simonsen, 2005).

The importance, and benefits, of early identification and phase-specific intervention in the development of schizophrenia have been asserted for both the overall duration and severity of psychotic episodes. However, Cougnard *et al.* (2005) have estimated that, given tests of specificity greater than 88 per cent, the numbers needing to be screened to avoid, in a five year period, one death, one hospitalisation and one unemployment, would be 20,000, 641 and 847 respectively.

Because it was felt that some of the distressed individuals who had contacted the KPU were in the early stages of a psychotic illness and had contacted the Unit before, or instead of, seeking medical advice about their distress, Coelho, Lamont and Tierney (2005) analysed the incomplete and by no means homogeneous data collected over 13 years by clinicians attached to the KPU, and surveyed the seven other academic units in the UK with interests in anomalous experience, asking them about their experience of, and attitudes towards, communications from such distressed individuals. During the period covered the KPU was the only UK unit of this type which had clinical advisors. Some of the findings in the first part of the study, where there were considerable missing data, were:

- The average number of distressed individuals contacting the KPU was 9 per year between 1992–2005 ($N = 120$) distributed equally by gender. Where age was known exactly, people in the 20–29 year age group predominated (34/80).
- A large majority of the records with relevant information (91/103 88 per cent) described recurrent experiences; relevant to the possible issue of duration of untreated psychosis. Of the 90 individuals who gave information, 43 had contacted health professionals about their distressing experience prior to contact with the KPU. Of those remaining 29 had no previous contacts, 3 had contacted parapsychology or psychical research institutions, 6 had contacted spiritual advisors, and 9 had contacted both.
- During the 13 years these data cover, the KPU had access to up to four clinical advisors at different periods. A provisional clinical diagnosis (including that of no clinical relevance) was made for 92 of the distressed contacts on whatever information was available. The experiences of 54 individuals were believed to be best described as falling within one of three categories, pre-morbid psychosis (15/92), first psychotic episode (3/92) and chronic (established) psychosis (36/92).
- Within the 20–29 years age interval, half (14/28) of individuals contacted the KPU as their first point of contact about their distress. Half of these again were provisionally diagnosed as pre-morbid, or first episode psychotic. It is possible that the 9/28 of individuals who had contacted a health professional prior to contact with the KPU were approaching the Unit for verification or confirmation of a more benign explanation for their distress, in contrast to a potentially frightening clinical one.

From the survey of other units in the UK who participated in the study, it was evident that although the academic staff expressed

great interest in these issues and collaborated fully in the data collection stage, their records were very limited. They expressed a consistent reluctance to deal with distressed callers describing spontaneous anomalous experiences. In their frank and helpful comments the respondents almost uniformly described unease about the ethical, legal and professional difficulties posed by their interactions with these callers, but equally acknowledged a sense of some responsibility when individuals disclose their distress to them as, in some sense, experts in the field of anomalous experience. Some unit staff described the difficult or ambiguous descriptions that distressed callers gave as the purpose of their contact. Similarily, in the KPU study, despite initially expressing distress in their description of the experience, some callers then included only the description of the experience and distress, some asked for information relating to their experience, others asked for an explanation for their experience, while still others asked for verification that their experience was indeed paranormal in nature. These convergent results suggest that units may need to deal with these contacts from distressed members of the public with a better understanding of how people express distress and request help in this context.

These results suggest that closer, formal, links should be encouraged between clinical psychologists with an interest in anomalous experience and experimental psychology departments who declare, through various media, an interest in spontaneous anomalous events. These departments are likely to attract a small number of distressed individuals who are prodromal for, or in first episode, psychosis, and who have not contacted anyone else with mental health knowledge. Early identification and minimal delay in treating psychosis is associated with better prognoses. Because these affected individuals are identifying themselves, albeit obliquely, and are seeking help for their distress, benefits to them from early clinical advice (in terms of reduced DUP and therefore improved prognosis) as well as cost savings to the health services, could be significant. Furthermore, there may be benefit to callers already formally diagnosed with a psychotic illness and who are receiving treatment of various kinds, and who, by exploring the possibility that their experiences might be paranormal and not a symptom of illness, and depending on the information they receive and conclusion they came to, may be at risk of non-compliance with their treatment. It is not possible to quantify (because of lack of follow-up) the number of people contacting the KPU for whom that risk was reduced because they could talk to someone with knowledge of both clinical issues and anomalous experience research. While it is difficult to place a cost value on such an outcome, it is likely, given the costs involved in rehospitalisation, that this too is significant.

Affiliations

All authors: Department of Psychology, University of Edinburgh

Address

Psychology School of Philosophy, Psychology and Health Science, The University of Edinburgh, 7 George Square, Edinburgh EH8 9JZ

References

Bentall, R. (2000) Hallucinatory experiences. In E. Cardena, S. Lynn & S. Krippner (Eds.) *Varieties of anomalous experience: Examining the scientific evidence* (pp. 85-120). Washington: American Psychological Association

Coelho, C., Lamont, P. & Tierney, I. (2005). *Distressing anomalous experience: analysis of contacts to UK academic parapsychology units and the early detection of psychosis.* Final report for Fundacao Bial, Grant No. 110/04 (unpublished report)

Cougnard, A., Salmi L.R., Salamon, R. & Verdoux, H. (2005). A decision analysis model to assess the feasibility of the early detection of psychosis in the general population. *Schizophrenia Research, 74*(1), 27–36.

Knight T. (2005). You'd better believe it: Accepting and working within the client's own reality. *Clinical Psychology Forum, 155*, 38–42.

McGorry, P., Nordentoft, M. & Simonsen, E. (Eds.) (2005). Early psychosis: a bridge to the future. *British Journal of Psychiatry, 187* (Suppl 48).