

Addressing social anxiety and paranoia in recovery from early psychosis

Why focus on social anxiety in recovery from early psychosis?

Hypotheses

- Social recovery will be associated with:
 - social anxiety and paranoid symptoms
 - Negative beliefs about the self and others (Schema)
 - Stigma
 - Motivation (Possible Selves)

Design

- Aim to assess social recovery and associated factors both cross-sectionally and longitudinally
- Two samples
 - Norfolk Early Intervention Service
 - ~100 patients – consecutive referrals to service – assessed at 3 months and then again at 1 year
 - Improving Social Recovery in Early Psychosis (ISREP) – MRC funded RCT
 - 77 patients recruited across Norfolk and Cambridge
 - Experimental manipulation of hypothesised pathway to recovery using a trial of Social Recovery oriented CBT
 - Assessed at baseline and 9mths

Sample Descriptions

■ Early Intervention

- N = 99
- Mean age (St. Dev) = 22.45 (4.83)
- Met EI criteria in terms of illness duration
- Gender
 - 77.7% male
 - 28.3% female
- Ethnicity
 - 96% white
 - 2% African
 - 1% Other
 - 1% withheld
- Diagnosis
 - 78.5% non-affective
 - 21.5% affective

■ ISREP

- N = 77
- Mean age (St. Dev) = 28.35 (6.76)
- Average length of time since diagnosis = 5.20 years
- Gender
 - 71.4% male
 - 28.6% female
- Ethnicity
 - 90.9% white
 - 2.6% Asian, 1.3% Afro-Caribbean, 3.9% mixed race, 1.3% other
- Diagnosis
 - 64.9% non-affective
 - 35.1% affective

	Early Intervention	ISREP
PANSS Positive Symptoms	12.81 (5.14)	12.19 (3.81)
PANSS Negative Symptoms	13.22 (5.67)	13.59 (3.70)
Beck Anxiety Inventory	13.84 (11.88)	16.40 (12.22)
Beck Depression Inventory	20.08 (13.58)	21.93 (13.84)
Schema		
- Negative Self	5.98 (6.39)	6.12 (5.84)
- Positive Self	7.69 (5.49)	8.69 (5.99)
- Negative Others	5.99 (5.99)	6.62 (6.41)
- Positive Others	9.26 (6.33)	10.48 (6.17)
Schizotypy	66.66 (48.57)	68.49 (49.77)
- Social Anxiety/Interpersonal	25.91 (17.21)	23.76 (15.91)
- Paranoia	6.81 (7.32)	6.97 (7.01)
- Anomalous	4.74 (6.22)	5.29 (7.25)
Social and Occupational Functioning (SOFAS)	56.92 (15.46)	50.06 (8.47)

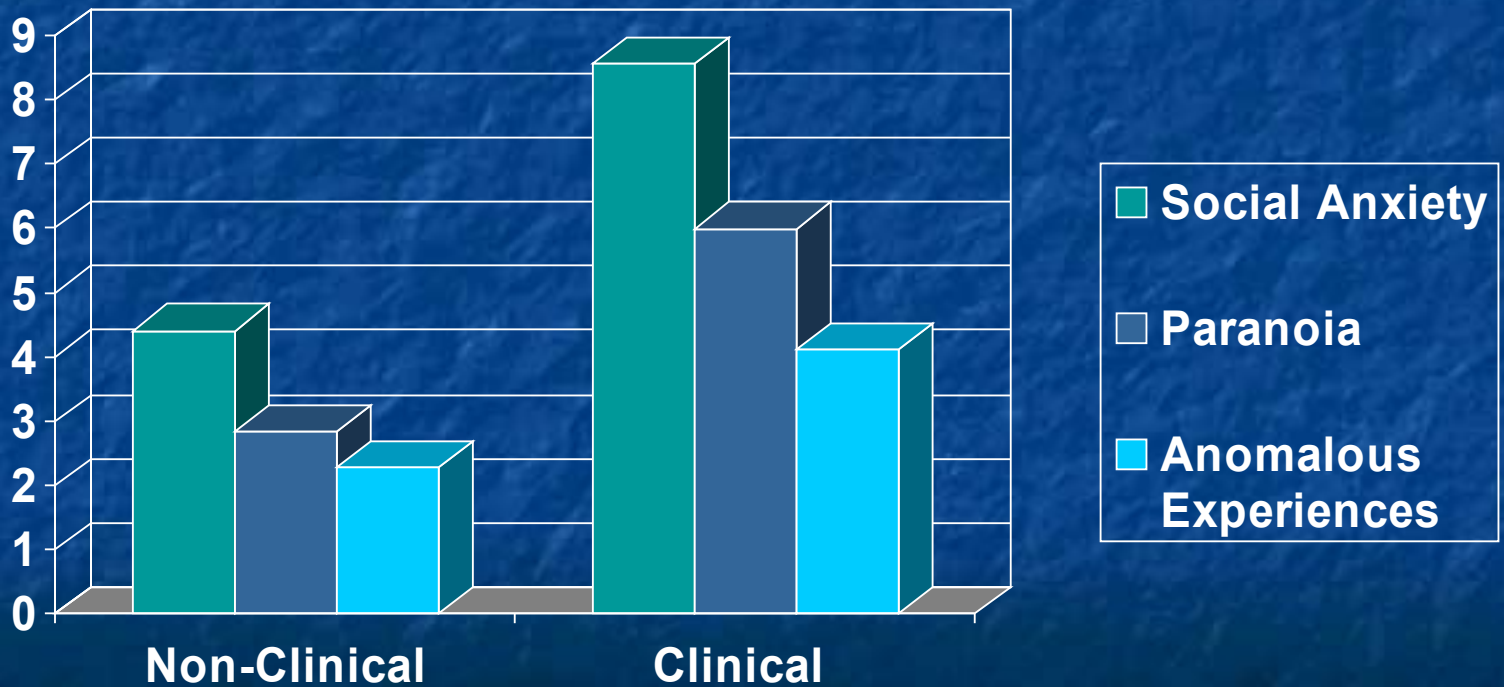
Measuring low level psychotic symptoms (Schizotypal symptoms)

- Interested in low-level symptoms which may remain in recovery but which may not be picked up by traditional measures such as the PANSS
- But... how do we measure these symptoms?
- Developed a new measure – the Schizotypal Personality Questionnaire-Revised (SPQ-R)
 - Modified from Raine (1991)

Brief Schizotypal Symptoms Scale

- 20-item self-report questionnaire assessing state and trait schizotypy over three domains
 - Interpersonal/Social Anxiety (e.g. "I sometimes avoid going to places where there will be many people because I will get anxious.")
 - Paranoia (e.g. "Do you sometimes feel that other people are watching you?")
 - Anomalous Symptoms (e.g. "Have you seen things invisible to other people?")

Comparison of SSI scores



Prevalence of low level psychotic symptoms in recovering early psychosis

- Percentage experiencing one schizotypal symptom in their lifetime
 - Clinical population – 100%
 - 89.2% “I would feel very anxious if I had to give a speech in front of a large group of people”
 - 19.3% “I attach little importance to having close friends”
- Percentage experiencing one schizotypal symptom often/all the time in the last two weeks
 - Clinical population – 88%
 - 43.4% “I tend to keep my feelings to myself”
 - 1.2% “Does your sense of smell sometimes become unusually strong?”

Average Frequency of endorsement of moderate Schizotypal Symptoms by type

	Clinical		
Excessive Social Anxiety	75.6%		
Constricted Affect	58.3%		
Suspiciousness/ Paranoia	58.1%		
No Close Friends	57.4%		
Odd Speech	55.5%		
Ideas of Reference	54.9%		
Eccentric Behaviour	46.3%		
Unusual Perceptual Experiences	42.3%		
Odd Beliefs	34.8%		

Average Frequency of endorsement of severe Schizotypal Symptoms by type

	Clinical		
Excessive Social Anxiety	26.5%		
No Close Friends	24.0%		
Constricted Affect	21.5%		
Suspiciousness/ Paranoia	18.0%		
Eccentric Behaviour	14.8%		
Odd Speech	14.0%		
Ideas of Reference	12.8%		
Unusual Perceptual Experiences	10.8%		
Odd Beliefs	7.2%		

The nature of schizotypal symptoms and social recovery

- Schizotypal symptoms are common in individuals in recovery from an episode of psychosis
 - particularly social anxiety
- BUT... how do they relate to recovery?
 - investigate associations with the Brief Core Schema Scales

Schizotypy and Social Recovery

- Interpersonal ($r = -0.41$) and Paranoid ($r = -0.36$) (but not Anomalous) Schizotypy correlated with hours spent in structured activity
- Interpersonal and Paranoid (but not Anomalous) Schizotypy also correlated with Quality of Life scores
 - Interpersonal $\rightarrow r = -0.46$
 - Paranoid $\rightarrow r = -0.33$

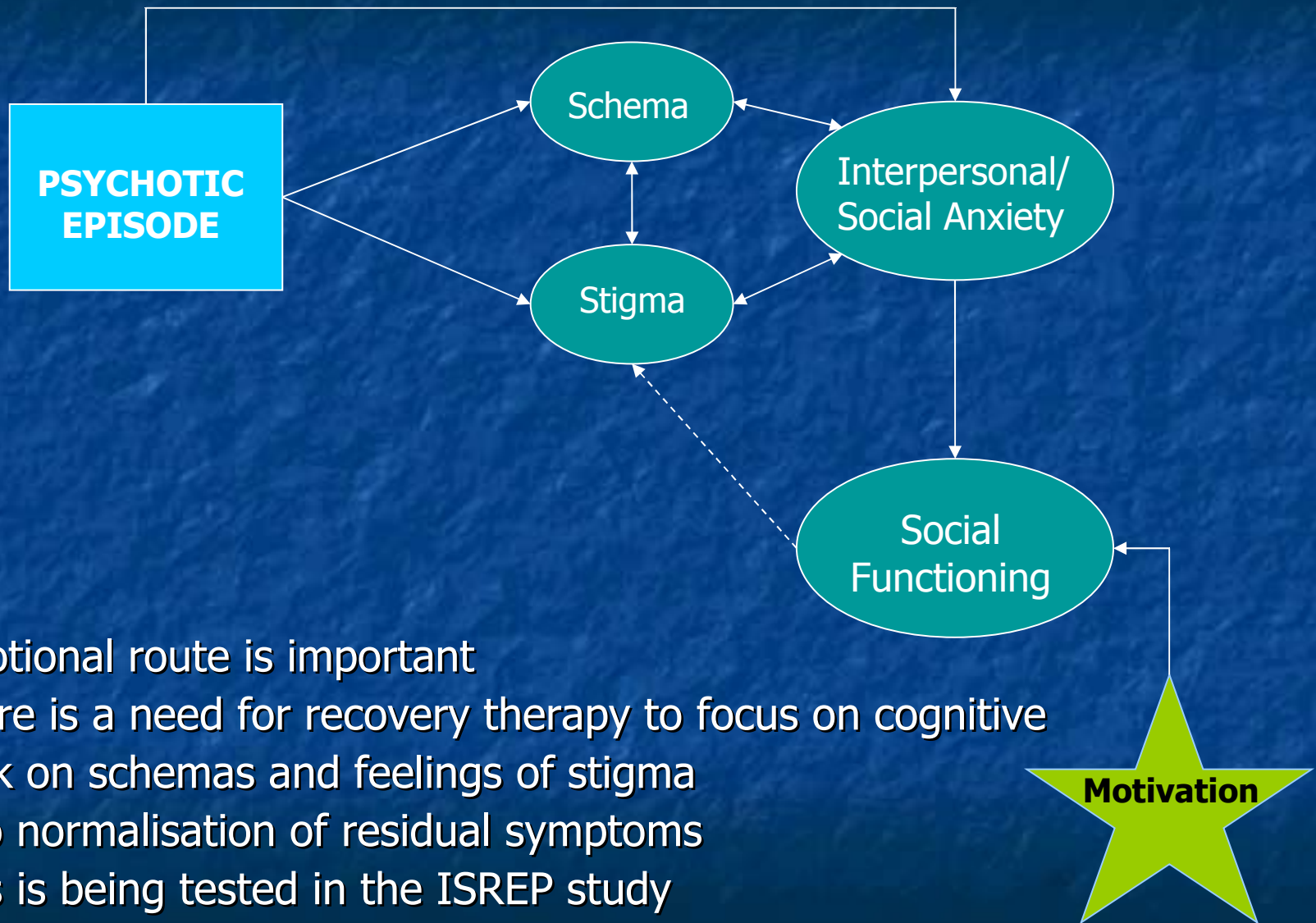
The indirect route to social recovery

- Schema

	Interpersonal	Paranoia	Anomalous
Negative Self	0.58**	0.59**	0.43**
Positive Self	-0.49**	-0.23	-0.70
Negative Other	0.59**	0.56**	0.42**
Positive Other	-0.53**	-0.24	-0.21

- PBIQ scores (assessing stigma, entrapment, control, etc) also correlate with Interpersonal and Paranoid Schizotypy but not with Anomalous Schizotypy
 - $r = \sim 0.50$ on all subscales for Interpersonal schizotypy
 - $r = \sim 0.40$ on all subscales for Paranoid schizotypy
- Highlights an indirect association with recovery?

Clinical Implications



- Emotional route is important
- There is a need for recovery therapy to focus on cognitive work on schemas and feelings of stigma
- Also normalisation of residual symptoms
- This is being tested in the ISREP study
- Watch this space!

Conclusions

- Although symptoms subside in recovery, clinical levels of schizotypal experiences are still present
- The Interpersonal dimension of schizotypy (Social Anxiety and Paranoia) is specifically associated with social recovery and presence of such symptoms also mediated social recovery in ISREP
- Negative beliefs about the self and others (Schema) and Stigma are also associated with recovery, via their influence on Interpersonal symptoms

We need to address social anxiety and low level paranoia in recovery from early psychosis

- At 12 months post first episode these problems affect around 30% of cases severely and up to 75% of cases at a moderate level
- Would specific techniques derived from CBT for social anxiety be useful?
- Is social anxiety in recovery from early psychosis the same as classic social anxiety?

CBT for social anxiety (Butler, 2007)

Key techniques:

- Psycho-education
- Overcoming self consciousness (attentional training in social situations)
- Specific behavioural experiments

Overcoming safety behaviours

Acting more confidently

Testing out worst case assumptions about social situations (You look so stupid, others look at you; sees strange images)

Would these techniques work for cases with early psychosis?

- What adaptations would be required to work with early psychosis cases?
- What are the differences between social anxiety and paranoia?
- What adaptations would you make ?
- What problems might you encounter doing this type of work?

Overcoming self consciousness

- Behavioural experiment
- Go into social situation
- A) Look at environment, focus on others versus
- B) Focus on self
- Preparation: practice
- Focussing on self (dwelling on thoughts, images, own body)
- Focussing on others: being a social scientist, interested in what others actually do in different situations, how people act in different ways, what works?
- Compare how you feel A versus B, what did you discover
- What does this mean?

Self consciousness central to social anxiety theories

- Social anxiety regarded as focus on internal states (rumination on an observer perspective of an image of self humiliated in social context)
- Is this the case in paranoia?
- Focus on projected negative thoughts and images of the other?

Social anxiety images typically occurring in early psychosis cases

- Discovery that often the thoughts, images are classic social anxiety in avoidant early psychosis cases at recovery stage
- E.g. Im sweating, acting foolishly, everyone is staring; Im fat and ugly everyone is looking; social anxiety stigma thoughts, they can see, they think Im mad
- Tend to be observer perspective
-

Paranoid thoughts and images typically occurring in early psychotic cases

- Paranoid and psychotic anomalous experiences also occur
- Eg. Faces look distorted and strange, cars and crowds look hostile, feeling, Im going to be attacked, people look at me strangely, judge me, get images of being kidnapped, taken hostage, people are going to attack me
- These tend to be field perspective

Typical safety behaviours

- looking down
- Total avoidance
- Avoiding eye contact
- In paranoia the fear driving avoidance can frequently be fear of discovering that the world really is as bad as it was feared to be, its safer not to discover that!

Typical behavioural experiments

- Others will think negatively about me
- Everyone will be looking at me
- What percentage of people regard you in this way?

Use of virtual reality environments

- Enables greater control over the environment
- Provides direct ability to demonstrate the way individual is projecting their thoughts onto others
- Overcomes safety behaviours

Who is appropriate for SARC?

• Inclusion criteria – 30+ on SIAS

• Exclusion criteria – acute psychotic symptoms, illiteracy

• Other factors taken into account

- anything better?

- length of time in service

SIAS – Scoring

Case Number: _____

Assessment number: _____

Collected By: _____

Date: _____

For each question, please circle a number to indicate the degree to which you feel the statement is characteristic or true of you. The rating scale is as follows:

- 0** = Not at all characteristic or true of me
- 1** = Slightly characteristic or true of me
- 2** = Moderately characteristic or true of me
- 3** = Very characteristic or true of me
- 4** = Extremely characteristic or true of me

	Not at all	Slightly	Moderately	Very	Extremely
. I get nervous if I have to speak to someone in authority (teacher, boss).	0	1	2	3	4
. I have difficulty making eye contact with others.	0	1	2	3	4
. I become tense if I have to talk about myself or my feelings.	0	1	2	3	4
. I find it difficult mixing comfortably with the people I work with.	0	1	2	3	4
. I find it easy to make friends of my own age.	0	1	2	3	4
. I tense up if I meet an acquaintance in the street.	0	1	2	3	4
. When mixing socially, I am uncomfortable.	0	1	2	3	4
. I feel tense if I am alone with just one person	0	1	2	3	4
. I am at ease meeting people at parties etc.	0	1	2	3	4
. I have difficulty talking with other people.	0	1	2	3	4
. I find it easy to think of things to talk about.	0	1	2	3	4
. I worry about expressing myself in case I feel awkward.	0	1	2	3	4
. I find it difficult to disagree with another's point of view.	0	1	2	3	4
. I have difficulty talking to people I find attractive.	0	1	2	3	4
. I find myself worrying that I won't know what to say in social situations.	0	1	2	3	4
. I am nervous mixing with people I don't know well.	0	1	2	3	4
. I feel I'll say something embarrassing when talking.	0	1	2	3	4
. When mixing in a group I find myself worrying I will be ignored.	0	1	2	3	4
. I am tense mixing in a group.	0	1	2	3	4
. I am unsure whether to greet someone I know only slightly.	0	1	2	3	4

THANK YOU FOR YOUR HELP

Early Psychosis Social Anxiety Research Clinic Trial

- Can graduate level staff apply techniques developed by Butler (2008) successfully to early psychosis cases?
- Does virtual environment technology aid therapy?
- Pilot trial: n=48
- 24 treatment vs 24 wait list controls
- Allows
- comparison 24 standard vs 24 enhanced VE

Early results look very promising

- Short term treatments of this type delivered by graduate level staff (under supervision trained cbt therapists)
- Series of cases showing major changes in activity levels and reductions in avoidance within weeks, attentional training and structured behavioural expts v well received