



The role of safety-seeking behaviours in maintaining threat appraisals in psychosis

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ABSTRACT

Aim: This study investigated the interaction between appraisals and safety behaviours in the maintenance of psychotic symptoms.

Method: The study recruited a population who had persistent psychotic experiences but who had no 'need-for-care' (Persistence group; $n = 39$) as well as a population who had a diagnosed psychotic disorder and were receiving current treatment (Impairment group; $n = 28$). The participants were assessed on semi-structured interviews of appraisals and safety behaviours and on anxiety and depression questionnaires.

Results: The two groups did not differ in total or first rank psychotic experiences, but the Persistence group showed less anomaly-related distress, depression and anxiety than the Impairment group. As predicted, the Impairment group displayed more threat appraisals and safety behaviours than the Persistence group, with a greater frequency of safety behaviours being related to higher levels of threat appraisals and anomaly-related distress. Threat appraisals mediated the relationship between safety behaviours and anomaly-related distress, suggesting that threat appraisals may maintain distress, a defining feature of Impairment status.

Conclusions: These data provide support for the cognitive model of psychosis in suggesting that cognitive and behavioural factors are key in differentiating non-clinical anomalous experiences from clinical psychotic status. These data suggest that therapy should target threat appraisals and safety-seeking behaviours in order to decrease distress.

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Introduction

For over 40 years, investigators have explored the idea that psychosis symptoms are expressed at levels below their clinical manifestation (Chapman, Chapman, Kwapił, Eckblad, & Zinser, 1994; Claridge, 1997; van Os, Hanssen, Bijl, & Ravelli, 2000; Strauss, 1969; Wiles et al., 2006). van Os, Linscott, Myin-Germeys, Delespaul, and Krabbendam (2009) described a Proneness–Persistence–Impairment model of psychosis to explain these data. Many are prone to transitory psychotic experiences; for a smaller group the experiences persist but cause no impairment; for an even smaller group the experiences persist and lead to impairment. In this context the authors suggest that clinical psychotic disorders could be seen as “a rare poor outcome” (p. 190) of anomalous experiences. This alters the focus of models of psychosis away from the question of what factors cause unusual experiences to occur (Broome et al., 2005) to what factors cause

unusual experiences to continue and to cause distress. Cognitive models of psychosis, developed from clinical samples, focus on Impairment (Garety, Bebbington, Fowler, Freeman, & Kuipers, 2007; Garety, Kuipers, Fowler, Freeman, & Bebbington, 2001). Differentiating between Persistence and Impairment is an important question which allows us to examine the factors which are hypothesised to maintain distress.

Cognitive models of psychosis have proposed that anomalous experiences become psychotic disorders depending on the appraisal of the experience and the subsequent emotional response (Chadwick & Birchwood, 1994; Freeman, 2007; Garety et al., 2001, 2007; Morrison, 2001). One aspect of cognitive models which may be particularly relevant is the concept of safety-seeking behaviours. Safety-seeking behaviours were first examined in cognitive theories of anxiety disorders (e.g. Clark, 1999; Salkovskis, 1996), but have also been included in cognitive models of psychosis (e.g. Freeman, Garety, Kuipers, Fowler, & Bebbington, 2002; Morrison, 2001). Many delusional beliefs share with anxiety disorders a theme of “anticipation of danger” (Freeman & Garety, 1999; Freeman, Garety, & Kuipers, 2001). Freeman et al. argue that

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individuals with delusions who anticipate danger may take preventative action in order to achieve safety. These actions nullify disconfirmatory evidence of the lack of threat by turning the situation into a “near miss”, thus maintaining the threat belief and never allowing the anxiety to habituate.

Some evidence supports the role of safety behaviours in maintaining impairment in psychosis (Campbell & Morrison, 2007; Freeman et al., 2007; Hacker, Birchwood, Tudway, Meaden, & Amphlett, 2008; Nothard, Morrison, & Wells, 2008). For instance, Freeman et al. (2007) examined 100 people with current persecutory delusions. Ninety-six percent of patients reported that they had used a safety behaviour in the last month, and a greater use of safety behaviours was related to higher levels of anxiety, depression and delusional distress.

Hacker et al. (2008) looked at safety behaviours in 23 voice hearers with psychosis diagnoses. Over 80% of the voice hearers had used a safety behaviour in the last month, and safety behaviour use was related to distress. The relationship between safety behaviours and distress was almost fully mediated by beliefs about the omnipotence of the voices. These results were in line with the cognitive formulation that the voice hearers engaged in safety behaviours to reduce the threat from powerful voices, not to reduce their distress per se.

Current study

The goal of this research was to test whether safety behaviours played an important role in maintaining threat appraisals and subsequent distress in individuals displaying persistent psychotic experiences with a “need-for-care” (‘Impairment’ group) and without a “need-for-care” (‘Persistence’ group). If specific maintaining processes can be identified in an Impairment group, these could then potentially be targeted in therapy.

The hypotheses were as follows:

1. The Impairment group will score higher on threat appraisal dimensions than the Persistence group
2. The Impairment group will have a greater frequency of safety behaviours
3. Those with the greatest frequency of safety behaviours will have the highest level of threat appraisals and the highest rate of anomaly-related distress
4. The association between safety behaviours and anomaly-related distress will be mediated by threat appraisals

Methodology

Participants

Persistence group

The Persistence group consisted of participants aged between 18 and 65 with enduring psychotic-like experiences who had never been diagnosed with, or treated for, a psychotic disorder, or sought help for their psychotic experiences.

Following the procedure of Brett et al. (2007) and Lovatt, Mason, Brett, and Peters (2010), the Persistence group was self-selecting, recruited through advertisements placed in a specialist college (The College of Psychic Studies), spiritualist associations (e.g. The Spiritualist Association of Great Britain) and a circular email sent to students and staff in King’s College London. A snowballing method was used, encouraging participants to pass on information about the study.

Only individuals who reported a Schneiderian first rank symptom (identified using the Appraisal of Anomalous Experiences Interview (AANEX)-Screen; Brett et al., 2007) occurring in the last month, in the absence of drug use and in clear consciousness, were invited to participate. The AANEX Screen was designed to identify

experiences equal to a score of ‘moderate’ or above on an item of the Scale for the Assessment of Positive Symptoms (SAPS; Andreasen, 1983). To be confident that these individuals were not at risk of developing a psychotic disorder in the near future, only participants whose anomalous experiences started more than two years before testing were included. This inclusion criterion was based on findings that most of those ‘at-risk’ of developing psychosis do so within the first 24 months (Yung & McGorry, 1996).

Impairment group

The Impairment group consisted of participants aged between 18 and 65 currently being treated for a psychotic illness (ICD-10 diagnoses F20-29; F30.2; F32.3; F33.3). The Impairment group was drawn from a variety of services in the South London and Maudsley NHS Foundation Trust (SLAM): a specialist psychological therapy service (Psychological Interventions Clinic for outpatients with Psychosis (PICuP)) research register, Community Mental Health Teams, a first episode psychosis unit (the Lambeth Early Onset (LEO) unit) and in-patient units.

All participants reported at least one Schneiderian first rank symptom, identified using the AANEX-Screen (Brett et al., 2007), occurring in the last month, in the absence of drug use and in clear consciousness. Only people with no evidence of organic cause were included.

Demographics

Demographic statistics are described below. There were 67 people in total (Impairment group = 28; Persistence group = 39). The demographic scores for the Impairment and Persistence groups are described in Table 1. The Impairment group had significantly fewer people who were employed, married, and white, they were slightly younger, and had an older age of onset of experiences. They did not differ in gender, religious affiliation, or number of children.

Measures

The Appraisals of Anomalous Experiences Interview (AANEX)

The AANEX (Brett et al., 2007) is a 3 part semi-structured interview.

- (i) The AANEX Screen contains 9 items assessing Schneiderian first rank symptoms experienced in the last month.
- (ii) The AANEX Inventory (17 items, short version; Lovatt et al., 2010) was used in the testing session. It consists of 17 items covering Schneiderian first rank symptoms and anomalies of perception, cognition and affect. Each experience was rated as either ‘not present’, ‘unclear’ or ‘present’, in the last month giving a score of 1–3 respectively. The five factors and their items are: Meaning-Reference Factor (Insight experiences, Mission experiences, Spiritual elation; Reference experiences); Paranormal-Hallucinatory Factor (Passivity, Somatic anomalies, Precognition); Cognitive-Attention Factor (Lost automatic skills, Language disturbance, Thought blockages); Dissociative-Perceptual Factor (Depersonalisation, Derealisation, Loss of emotions); First Rank Symptoms Factor (Thought Transmission; Receptivity, Thought withdrawal, Voice experiences). The factor scores were obtained by summing individual item scores for each factor (range of scores for each factor: 3–9, except ‘Meaning-Reference’ and ‘First-Rank Symptoms’ where the range of scores was 4–12). Total scores on the AANEX-Inventory ranged from 17 to 51.
- (iii) The AANEX-CAR (Context, Appraisals & Responses – short form; Lovatt et al., 2010) examines current appraisals, emotional and cognitive factors associated with the identified

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