• 9.30 – 11.00  JOHN READ: ‘Schizophrenia’ – History, Reliability and Stigma

11.00 - 11.30 Morning Tea

• 11.30 – 12.00  JOHN READ: Understanding Psychosis: Social Causes; Psychological Models

• 12.00 – 12.45  MELISSA TAITIMU-KAPA: Mate Maori and Psychosis: Navigating Intersecting Realities in Clinical Practice

12.45 - 1.30 Lunch

• 1.30 – 2.15  JEREMY CLARK: Psychological Therapy with People Experiencing Psychosis

• 2.15 - 3.00  DEBRA LAMPSHIRE: Working Effectively with Distressing Voices

3.00 - 3.30 Afternoon Tea

• 3.30 - 4.00  JOHN READ: Assessment and Treatment: Asking and Listening.

• 4.00 - 4.30  JOHN, MELISSA, JEREMY, DEBRA: Questions/Discussion
The Clinical Psychology Team

• Suzanne Barker-Collo
• Claire Cartwright
• Sue Cowie
• Kerry Gibson
• Fiona Howard
• Ian Lambie
• Fred Seymour

• Sheryl Robertson
• Sue O’Shea
Models of Madness

PSYCHOLOGICAL, SOCIAL AND BIOLOGICAL APPROACHES TO SCHIZOPHRENIA

PUBLISHED FOR THE INTERNATIONAL SOCIETY FOR THE PSYCHOLOGICAL TREATMENTS OF THE SCHIZOPHRENIAS AND OTHER PSYCHOSES
‘Schizophrenia’ –

History

Reliability

Stigma
DSM diagnostic criteria for ‘schizophrenia’

Two of:
• Hallucinations
• Delusions
• Thought Disorder
• Catatonia
• Negative symptoms

Or just one if voices commenting or delusions are ‘bizarre’

A DYSJUNCTIVE CATEGORY
Scientifically meaningless
Does schizophrenia exist?

Reliability

1. Schizophrenia
   Personality Disorder
   UK (194) 2% 75%
   USA (134) 69% 7%
   Copeland et al. (1971)

2. 16 diagnostic systems for ‘schizophrenia’ led to between 1 and 203 of 248 patients being diagnosed
   (Herron et al. 1992)

3. ‘On being sane in insane places’
   (Rosenhan, 1973)
STEREOTYPE of the ‘SCHIZOPHRENIC’

• WORTHLESS
• DIRTY
• INSINCERE
• DELICATE
• SLOW
• TENSE
• WEAK
• FOOLISH
• INCOMPETENT

• NOT RESPONSIBLE FOR ACTIONS

• DANGEROUSLY VIOLENT
• UNPREDICTABLE
From attitudes to behaviour

Documented Discrimination:

- Employment
- Housing
- Finances – loans and insurance
- Rejection – by friends, family and health professionals
- Families also experience discrimination
Destigmatization Programmes

• Based on ‘mental illness is an illness like any other’ metaphor
• Intended to bestow the dignity of the sickness role
• Intended to remove blame by educating public that these people are *not responsible* for their actions
• Consistent with dominant bio-genetic ideology (often funded by drug companies)
Relationship between bio-genetic causal beliefs and negative attitudes
(Read et al. in Models of Madness 2 – in press)

• In 28 of 31 studies (90%) bio-genetic causal beliefs are related to negative attitudes.

• In 24 of 26 studies (92%) psycho-social beliefs are related to positive attitudes.

• “In total, 52 of the 57 findings (91%) show that the vast expenditure of drug company and taxpayers’ money on biologically-oriented destigmatisation programmes is not at all evidence-based”.
Safe-Dangerous Ratings Before and After the Video, for the Three Causal Explanations
(Walker & Read, 2002)
Relationship between diagnostic labelling and negative attitudes

Labelling behaviours ‘schizophrenic’ increases belief in bio-genetic causes (Jorm et al., 1997) and also:-

• increases the perceived seriousness of the person’s difficulties (Cormack & Furnham, 1998)

• adversely effects evaluations of the person’s social skills (Benson, 2002)

• produces a more pessimistic view about recovery (Angermeyer & Matchinger, 1996)

• leads to rejection (Sarbin & Mancuso, 1970).
‘Generally, biogenetic causal attributions were not associated with more tolerant attitudes; they were related to stronger rejection in most studies examining schizophrenia’

‘Biogenetic causal models are an inappropriate means of reducing rejection of people with mental illness’.
Understanding Psychosis:

Social Causes

Psychological Models
Public believe mental health problems, including schizophrenia, caused primarily by adverse life events (Read et al. 2006)

South Africa
China
Egypt
Turkey
Fiji
Japan
Malaysia
Switzerland
Ethiopia
Greece
Bali
Brazil
England
Ireland
Germany
India
Australia
Italy
Mongolia
Russia
and …

New Zealand
UK psychiatrists’ causal beliefs

- 2813 UK psychiatrists
  (Kingdon et al, 2004)

  ‘primarily social’ 0.4%
  ‘primarily biological’ 46.1%
  ‘a balance of both’ 53.5%

For every British psychiatrist who thinks schizophrenia is caused primarily by social factors there are 115 who think it is caused primarily by biological factors
No single cause.

As for other mental health problems - causes, usually in combination, include:

- Genetic predisposition
- Brain differences – structural and functional (can be caused by environment)
- Maternal prenatal health and stress
- Birth complications
- Rape and physical assault
- War combat
- Child abuse
- Child neglect
- Parental loss
- Bullying
- Poverty
- Urban living
- Ethnicity (poverty, isolation and racism)
- Heavy early cannabis use
No evidence of genetic predisposition to schizophrenia
(Hamilton, 2008, American Journal of Psychiatry)

• ‘The most comprehensive genetic association study of genes previously reported to contribute to the susceptibility to schizophrenia’ found that ‘none of the polymorphisms were associated with the schizophrenia phenotype at a reasonable threshold for statistical significance’

• ‘The distribution of test statistics suggests nothing outside of what would be expected by chance’
Much Touted “Depression Risk Gene” May Not Add to Risk After All.
New Look at Data Confirms Strong Association between Depression and Stressful Life Events

- Merikangas, K. Journal of the American Medical Association June 17, 2009,

- Re-analyzing data on 14,250 participants in 14 studies...

- .... found a strong association between the number of stressful life events and risk of depression across the studies.

- However, the presumed high-risk version of the serotonin transporter gene did not show a relationship to increased risk for major depression, alone or in interaction with stressful life events.
Time to abandon the bio-bio-bio model of psychosis: Exploring the epigenetic and psychological mechanisms by which adverse life events lead to psychotic symptoms

JOHN READ, RICHARD BENTALL, ROAR FOSSE

Epidemiologia e Psichiatria Sociale, 2009

“The failure to find robust evidence of a genetic predisposition for psychosis can be understood in terms of recently developed knowledge about how epigenetic processes turn gene transcription on and off through mechanisms that are highly influenced by the individual’s socio-environmental experiences.

The implications, for research, mental health services and primary prevention, are profound.”
What causes brain differences?
Poverty

- 30 years ago the relationship between ‘schizophrenia’ and poverty was described as ‘one of the most consistent findings in the field of psychiatric epidemiology’ (Eaton, 1980).

- Deprived children are four times more likely to develop ‘non-schizophrenic psychotic illness’ but eight times more likely to grow-up to be ‘schizophrenic’ (Harrison, Gunnell, Glazebrook, Page, & Kwiecinski, 2001).

Even among children with no family history of psychosis the deprived children were seven times more likely to develop ‘schizophrenia’,
Relative poverty

The Prevalence of Mental Illness is Higher in More Unequal Rich Countries

Ethnicity

• Relationship between high rates of mental health problems and being a member of an ethnic minority or of a colonised indigenous people:

• Australia
• Belgium
• Denmark
• Germany
• Greenland
• Netherlands
• New Zealand
• Israel
• Sweden
• UK
• USA

eg: In the UK Afro-caribbeans are 9 to 12 times more likely to be diagnosed with ‘schizophrenia’
Of the 247 psychiatrists (74%) responding, 40% believe their training had prepared them to work effectively with Maori.

Recommendations for improving mental health services for Maori highlight the need for more Maori professionals and for Maori-run services.

Twenty eight psychiatrists (11.3%), all male, New Zealand born, and with ten or more years clinical experience, believe that Maori are biologically or genetically more predisposed than others to mental illness. Several respondents offered other racist comments.
‘Why are Maori over represented in mental health statistics?’

- ‘Genetic loading’ ‘Their culture may predispose them to mental illness’

- ‘Maori are biologically predetermined to mental illness - especially psychosis’

- ‘Minority races/cultures are more predisposed to mental illness than Europeans’

- ‘Genetically Maori as a culture seem predisposed to mental illness’
I am sick of questionnaires regarding Maori stuff, there is far more important issues than those regarding Maori mental health. Do you really think that psychiatrists need to have an understanding of such concepts like spirituality - come on give me a break.

My effectiveness as a psychiatrist is not dependent on the colour of my skin, my culture, nor my understanding of bloody Maori culture.

I think your study is a waste of time. Why do people like you single out the Maoris for topics of research - what makes them so special?
This questionnaire is worthless! I mean the Maoris are always going on about the importance of land etc. etc. so why did they bloody well give it away. They went on about the importance of forestries and lakes and then that bloody idiot cut down the tree on one tree hill. I feel that they are getting the appropriate services they need, just not using them, medication is the answer- but they just dont take their pills- if cannabis was prescribed Id bet they’d bloody take that.
## Psychiatric inpatient admission rates - Auckland

*Wheeler, A. NZ Medical Journal 2005*

<table>
<thead>
<tr>
<th></th>
<th>Inpatients</th>
<th>Community</th>
<th>Risk Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>European</td>
<td>60%</td>
<td>61%</td>
<td>1.0</td>
</tr>
<tr>
<td>Maori</td>
<td>23%</td>
<td>11%</td>
<td>2.1</td>
</tr>
</tbody>
</table>
Psychotic disorder
(eg ‘schizophrenia’)

European 38%
Maori 62%
Pacific Islanders 59%
Asian 59%
Prevalence of Child Abuse in Psychiatric Inpatients

‘Models of Madness’
chapter 16

Average child abuse rates from review of 40 inpatient studies

- **Female inpatients:**
  - Sexual abuse: 50%
  - Physical abuse: 48%
  - Either sexual or physical: 69%

- **Male inpatients:**
  - Sexual abuse: 28%
  - Physical abuse: 51%
  - Either sexual or physical: 60%
More subtle types of childhood maltreatment

Averages from six studies of people diagnosed ‘schizophrenic’

Emotional Abuse ….. 47%

Emotional Neglect … 51%

Physical Neglect …… 41%

(Read et al., 2008, Clinical Schizophrenia)
### Child Abuse and ‘Schizophrenia’ symptoms

<table>
<thead>
<tr>
<th>Hallucinations</th>
<th>Child Abuse</th>
<th>No Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auditory</td>
<td>43%</td>
<td>18%</td>
</tr>
<tr>
<td>Command</td>
<td>13%</td>
<td>2%</td>
</tr>
<tr>
<td>Visual</td>
<td>17%</td>
<td>4%</td>
</tr>
<tr>
<td>Tactile</td>
<td>12%</td>
<td>0%</td>
</tr>
</tbody>
</table>

- *p* < .0005
- *p* < .005
- *p* < .001

Read J, et al. 2003
Dutch general population (n = 4045) free from psychotic symptoms, followed for 3 years (Janssen et al., 2004)

Controlled for: age, sex, education, discrimination, ethnicity, urbanicity, unemployment, marital status, other mental health problems, psychosis in relatives, drug use.:

- Those abused as children 9 times more likely to develop ‘pathology level psychosis’

- Those suffering most severe level of abuse 48 times more likely to develop psychosis
The psychiatric establishment is about to experience an earthquake that will shake its intellectual foundations. When it has absorbed the juddering contents of the latest edition of one of its leading journals, *Acta Psychiatrica Scandinavica*, it will have to rethink many of its most cherished assumptions.

*Newsweek* (12 Dec., 2005):

“the most definitive look at schizophrenia to date”

“The cumulative impact of this research has swayed opinion in the profession's highest echelons”.

---

**The Guardian** (UK) (22 Oct., 2005):

“The psychiatric establishment is about to experience an earthquake that will shake its intellectual foundations. When it has absorbed the juddering contents of the latest edition of one of its leading journals, *Acta Psychiatrica Scandinavica*, it will have to rethink many of its most cherished assumptions.”
People who had experienced three types of trauma (sexual abuse, physical abuse etc.) were 18 times more likely to be psychotic than non-abused people.

People who had experienced five types of trauma were 193 times more likely to be psychotic.
‘Child Maltreatment and Psychosis: A Return to a Genuinely Integrated Bio-Psycho-Social Model’
J Read, et al., 2008, Clinical Schizophrenia

- Ten out of eleven recent general population studies have found, even after controlling for other factors (including family history of psychosis), that child maltreatment is significantly related to psychosis.

- Eight of these studies tested for, and found, a dose-response.

- This paper advocates a return to the original stress-vulnerability model proposed by Zubin and Spring in 1977, in which heightened vulnerability to stress is not necessarily genetically inherited, but can be acquired via adverse life events.
Parental Loss

• Morgan et al., 2007

390 people with a first episode of psychosis, compared to a control group

2.4 times more likely to have been separated from one or both parents before age 16

3.1 times more likely to have had a parent die

12.3 times more likely to have had their mother die
FIRST META-ANALYSIS


‘Childhood adversities increase the risk of psychosis:
A meta-analysis of patient-control, prospective- and cross-sectional cohort studies’.

Schizophrenia Bulletin (2012)

A meta-analysis improves on ordinary literature reviews by adopting rigorous inclusion criteria and allowing for differences in sample sizes and methodologies when conducting analyses.
• Analysing the most rigorous 41 studies ....

• people who had suffered childhood adversity were 2.8 times more likely to develop psychosis than those who had not (p < .001 level).

• Nine of the ten studies that tested for a dose-response found it.
FIRST META-ANALYSIS

odds ratios for each type of adversity:

<table>
<thead>
<tr>
<th>Type of Adversity</th>
<th>Odds Ratio</th>
<th>Number of Studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>sexual abuse</td>
<td>2.4</td>
<td>20</td>
</tr>
<tr>
<td>physical abuse</td>
<td>2.9</td>
<td>13</td>
</tr>
<tr>
<td>emotional abuse</td>
<td>3.4</td>
<td>6</td>
</tr>
<tr>
<td>neglect</td>
<td>2.9</td>
<td>7</td>
</tr>
<tr>
<td>bullying</td>
<td>2.4</td>
<td>6</td>
</tr>
<tr>
<td>parental death</td>
<td>1.7</td>
<td>8</td>
</tr>
</tbody>
</table>
Theories about HOW child abuse/neglect leads to psychosis

• COGNITIVE

• PSYCHODYNAMIC

• DISSOCIATION

• ‘TRAUMAGENIC NEURODEVELOPMENTAL’

• ATTACHMENT
UNDERSTANDING HEARING VOICES

• About 10-15% of us hear voices at some point in our lives (Beavan, Read & Cartwright, 2011, Journal of Mental Health)

• About 80% of over 60 year olds who have lost their life partner hear or see their partner within 12 months of their death

• When people are hearing voices their voice muscles are moving and the speech area of the brain lights up

• So ‘voices’ are internal events projected out onto the world

• COGNITIVE: Impaired ‘source monitoring’

• PSYCHODYNAMIC: Projection of frightening intrusive memories
Hearing Voices

Response to first experiences of voice-hearing crucial:

Who is in control – me or the voices? Does it mean I am mad/bad?

Level of distress largely predicts who becomes psychotic

Distress largely determined by explanation

(Delusions are sometimes attempts to explain hallucinations)
Psychological processes that have been implicated in paranoia

Jumping to conclusions (e.g. Garety et al. 2001): Patients with delusions tend to ‘jump to conclusions’ (make a decision about uncertain events) on the basis of little information

Theory of mind (e.g. Corcoran & Frith, 1996): Paranoid patients have difficulty in understanding other people’s thoughts and feelings

Attributions (e.g. Kaney & Bentall, 1989): Paranoid beliefs are related to abnormal styles of reasoning about the causes of events
Paranoid patients make excessively stable and global attributions for negative events. More importantly, they blame people more than situations.

* High scores mean self-blaming, low scores mean the cause is something to do with other people or circumstances.
The Contribution of Early Traumatic Events to Schizophrenia in Some Patients: A Traumagenic Neurodevelopmental Model

John Read, Bruce D. Perry, Andrew Moskowitz, and Jan Connolly

The current diathesis-stress model of schizophrenia proposes that a genetic deficit creates a predisposing vulnerability in the form of oversensitivity to stress. This model positions all psychosocial events on the stress side of the diathesis-stress equation. As an example of hypotheses that emerge when consideration is given to repositioning adverse life events as potential contributors to the diathesis, this article examines one possible explanation for the high prevalence of child abuse found in adults diagnosed schizophrenic. A traumagenic neurodevelopmental (TN) model of schizophrenia is presented, documenting the similarities between the effects of traumatic events on the developing brain and the biological abnormalities found in persons diagnosed with schizophrenia, including overreactivity of the hypothalamic-pituitary-adrenal (HPA) axis; dopamine, norepinephrine, and serotonin abnormalities; and structural changes to the brain such as hippocampal damage, cerebral atrophy, ventricular enlargement, and reversed cerebral asymmetry. The TN model offers potential explanations for other findings in schizophrenia research beyond oversensitivity to stress, including cognitive impairment, pathways to positive and negative symptoms, and the relationship between psychotic and dissociative symptomatology. It is recommended that clinicians and researchers explore the presence of early adverse life events in adults with psychotic symptoms in order to ensure comprehensive formulations and appropriate treatment plans, and to further investigate the hypotheses generated by the TN model.

Introduction

Schizophrenia is considered to be one of the most biologically based of the mental disorders (Chua and Murray 1996; McGuffin, Asherson, Owen, and Farmer 1994; Walker and DiForio 1997). However, the methodological rigor of the evidence for this proposition is often described as less than adequate (Bentall 1990; Boyle 1990; Karon 1999; Rose 2001; Ross and Pam 1995). This article explores the possibility that for some adults diagnosed as schizophrenic, adverse life events or significant losses and deprivations cannot only "trigger" schizophrenic symptoms but may also, if they occur early enough or are sufficiently...
Evidence that schizophrenia is a brain disease

- Overactivity of hypothalamic-pituitary-adrenal (HPA) axis
- Abnormalities in neurotransmitter systems (especially dopamine)
- Hippocampal damage
- Cerebral atrophy
- Reversed Cerebral Asymmetry
The effects of early childhood trauma on the developing brain

- Overactivity of hypothalamic-pituitary-adrenal (HPA) axis
- Abnormalities in neurotransmitter systems (especially dopamine)
- Hippocampal damage
- Cerebral atrophy
- Reversed Cerebral Asymmetry
I don't think that abuse itself is a strong cause for psychosis. It hurts, but it is rather simple.

I think that the threat and the betrayal that come with it feed psychosis. The betrayal of the family that says, “you must have asked for it,” instead of standing up for you. That excuses the offender and accuses the victim. And forces the child to accept the reality of the adults. That forces the child to say that the air is green, while she sees clearly it is not green but blue.

That is a distortion of reality that is very hard to deal with when you're a child. You are forced to betray yourself. That is what causes the twilight zone. What makes you vulnerable for psychosis.
Assessment and Treatment

Asking and Listening
Psycho-social History

- Early childhood, including birth
- School – academic and peer relationships
- Family/whanau environment during childhood
- Adolescence – friends and school, sexuality
- Abuse history
- Past and current safety issue (harm to/from self/others)
- Mental health history (including helpful and unhelpful contact with mental health professionals)
- Legal issues
- Substance abuse
- Medical history (including brain injury)
- Employment history (including unpaid)
- Interests/hobbies – past and present
- Major relationships in adolescence/adulthood
- Support history – who has/does client talk to about personal difficulties
- Spiritual, religious and other beliefs
- Current relationships/family
Rates of Abuse Inquiry

Chart review of 100 inpatients

• Even when an abuse section was included in the admission form, 68% of the psychiatrists skipped that section

• Abuse prevalences when asked, and not asked, at initial assessment:

  CHILD SEXUAL ABUSE:
  If asked: 47%
  If not asked: 6%

  ANY ABUSE, LIFETIME:
  If asked: 82%
  If not asked: 8%
Adequacy of Response -

Chart review of 200 outpatients

Percentage of childhood and adulthood abuse cases (n = 92) responded to with:

- Documenting previous disclosure or treatment: 33%
- Mention in Summary Formulation: 37%
- Mention in Treatment Plan: 33%
- Abuse counselling: 22%
- Reported to legal or protection agencies: 0%

None of 144 abuse cases (inpatient & outpatients combined) reported to legal or protection agencies
‘WHY, WHEN AND HOW TO ASK ABOUT CHILD ABUSE’
Read J, et al., Advances in Psychiatric Treatment (2007)
New Zealand training programme described for Royal College of Psychiatry (UK) journal

2008 NHS Guidelines – all clients must be asked and staff must be trained
Principles of Abuse Inquiry

• Ask all clients

• As part of initial assessment (with some exceptions)

• Funnel towards abuse questions with general questions about childhood

• Do not ask “Were you abused?” Instead, use specific examples
Reliability of disclosures of ‘psychiatric patients’

- Corroborating evidence for reports of child sexual abuse [CSA] by psychiatric patients has been found in
  - 74%  [HERMAN J, SCHATZOW E. 1987]
  - 82%  [READ J, et al. 2003]

- One study found that “The problem of incorrect allegations of sexual assaults was no different for schizophrenics than the general population”

- 2009 British study – disclosures of CSA, CPA and neglect were stable (over 7 years), valid, and not associated with current severity of psychotic symptoms
  [FISHER et al., 2009]
Principles of Response to Abuse Disclosures

- **Not** necessary to gather all details

- AFFIRM that it was positive to tell

- **ASK** if they have ever told someone- and how did that go?

- SUPPORT – **offer** information, resources, counselling (so have them available !)

- SAFETY – of clients, of others
“There was an assumption that I had a mental illness and because I wasn’t saying anything about my abuse no one knew”

“There was so many doctors and nurses and social workers in your life asking you about the same thing, mental, mental, mental, but not asking you why”

“I just wish they would have said ‘What happened to you?’ ‘What happened?’ But they didn’t.”
Implications for treatment

• Give people an opportunity to talk about their understanding of their problems

• Drugs are not enough

• Be guided by ethical principle of informed choice of treatment modality

• NICE Guidelines (UK – 2009): Medical and psychological treatments equally important
Public also prefer talking therapies to medication for schizophrenia in:

Australia
Austria
Canada
China
England
Germany
Hong Kong
India
Italy
Japan
Russia
Slovakia
South Africa
Switzerland
Turkey
Cochrane review of Risperidone

(Rattehalli, Jayaram, & Smith, 2010).

• “Risperidone appears to have a marginal benefit in terms of clinical improvement compared with placebo in the first few weeks of treatment but the margin of improvement may not be clinically meaningful.

• Global effects suggests that there is no clear difference between risperidone and placebo

• Risperidone causes many adverse effects and, these effects are important and common.

• People with schizophrenia or their advocates may want to lobby regulatory authorities to insist on better studies being available before wide release of a compound with the subsequent beguiling advertising.”
Adverse effects of anti-psychotic drugs

- **First-generation:**
  - tardive dyskinesia (30-50%)
  - neuroleptic malignant syndrome (1%)

- **Second-generation (‘atypicals’)**
  - reduced sexual function
  - agranulocytosis
  - rapid weight gain
  - diabetes
  - heart disease
  - neurodegeneration
  - reduced life span
Antidepressants
Kirsch et al. (2008)

Meta-analysis of all available studies, including those previously unpublished by the drug companies:

Drug–placebo differences:

• Virtually no difference at moderate levels of initial depression

• Small difference for patients with very severe depression . . .

• . . . reaching ‘clinical significance’ only for patients at the upper end of the very severely depressed category.

{This is less than 10% of people receiving the drugs}
Drug company influence

• Research Funding

• Scientific journals

• Educational/training institutes

• Training for doctors

• Drug licensing bodies

• Lobbying governments

• More recently, the internet…..
Drug Companies and the Internet

Significant Bio-Genetic -Bias in Drug Company funded websites

<table>
<thead>
<tr>
<th>(%D-C Funded)</th>
<th>Causes</th>
<th>Treatments</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia (58%)</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>(Read 2007)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression (42%)</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>(de Wattignar &amp; Read, 2008)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PTSD (42%)</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>(Mansell &amp; Read, 2008)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADHD (37%)</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>(Mitchell &amp; Read, in prep.)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Erectile Disorder (44%)</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>(Mati &amp; Read, in prep.)</td>
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</tbody>
</table>
Financial incentives have contributed to the notion of a ‘quick fix’ by taking a pill and reducing the emphasis on psychotherapy and psychosocial treatments.

If we are seen as mere pill pushers and employees of the pharmaceutical industry, our credibility as a profession is compromised.

As we address these Big Pharma issues, we must examine the fact that as a profession, we have allowed the bio-psycho-social model to become the bio-bio-bio model.”
“I cannot be the only person to be sickened by the sight of parties of psychiatrists standing at the airport desk with so many gifts with them that they might as well have the name of the drug company tattooed across their foreheads”.
PART III Models of Madness:
Social and psychological approaches to responding to madness

20 Prevention of psychosis: creating societies where more people flourish

21 The work of experience-based experts

22 Cognitive therapy for people with psychosis

23 Psychodynamic psychotherapy for psychosis: empirical evidence

24 The development of early intervention services

25 Non-hospital, non-medication interventions in first episode psychosis

26 Family therapy and psychosis: replacing ideology with openness
Cognitive Therapy for Psychosis

The primary aims of CT for psychosis are:

1. to reduce the distress experienced by people with psychosis
2. to improve their quality of life.

The aim of CT is not necessarily to reduce the frequency of psychotic symptoms, but rather to help patients to achieve the specific goals that they have set in relation to the problems that they have identified.

Focusing on generating less distressing explanations for psychotic experiences, rather than attempting to eliminate these experiences.

CT should recognise that psychotic experiences may well serve a function for the person.
Cognitive therapy for hallucinations and delusions

1. Focus on stated needs
2. Focus on one ‘symptom’
3. Assess frequency, intensity, conviction, distress etc
4. Use cognitive approach to gently explore alternative interpretations for delusions
5. Help client understand hallucinations are internal events
6. Stay focused on:
   a. the relationship
   b. self-esteem
   c. the relationship!
CBT or the relationship?

- CBT has strong evidence to support its efficacy for psychosis.
- But best predictor of positive outcome – for any treatment – is the quality of the therapeutic relationship!
IMPLICATIONS FOR PRIMARY PREVENTION

The 2012 meta-analysis calculated that the ‘estimated population attributable risk’ was 33%.

This means that if the six childhood adversities reviewed were eliminated the number of people with psychosis would be reduced by a third! (Varese, Smeets et al. 2012).
“Psychologists must join with persons who reject racism, sexism, colonialism, and exploitation and must find ways to redistribute social power and to increase social justice.

Primary prevention research inevitably will make clear the relationship between social pathology and psychopathology and then will work to change social and political structures in the interests of social justice.

It is as simple and as difficult as that!”