Psychosocial Treatments for Clinical High Risk Individuals

Jean Addington and Mark van der Gaag

McFarlane and colleagues present an integrated approach to pre-psychosis and first episode psychosis patients. It is critical to distinguish between these 2 groups and to establish evidence-based treatments. This commentary focuses on clinical high risk (CHR) in the pre-psychosis time frame.

• The goal of treatment for those at CHR is not just on preventing conversion to psychosis but ameliorating the wide range of problems with which these young people present. The majority of these CHR individuals are indeed clinical cases. Not only are they troubled by the attenuated psychotic symptoms which define their “at risk state” but the majority have comorbid diagnoses in particular depression and anxiety. Substance use, in particular cannabis and alcohol use, is not uncommon and there is well-supported evidence of their poor social skills and difficulty with relationships that continue even when there is an improvement in the attenuated psychotic symptoms.

• At this early stage anti-psychotic medication may have a poor risk/benefit profile and currently psychosocial treatments are the treatments of choice. Already several reviews and/or meta-analyses of RCTs support the benefits of psychosocial treatments. Cognitive behavior therapy (CBT), the most often studied therapy, may prevent the transition to psychosis (1) in that it can enhance non-psychotic explanations for the odd experiences of those at CHR. It has demonstrated improvement in attenuated psychotic symptoms, and could be helpful for anxiety and depression. CBT thus has become an evidence-based treatment option in recent years and meta-analysis showed in 676 patients that conversions to psychosis can be reduced in about 50%.

• There is a need for more work in psychosocial treatments to help the CHR individual with social relations and maintaining strong family connection/support. Withdrawal and loneliness prevent the testing of ideas and hypotheses about other people and may contribute to the development of psychosis. Reality is in the end a social construction. To stay in touch with reality is to stay in touch with other people. The MacFarlane study demonstrates the importance of family members to stay involved with CHR youth and to keep them on track in a shared reality. Although the evidence is indirect and not as convincing as the results of a randomized controlled design, the findings hint to outreach to families, schools, and workplaces to prevent social exclusion in the CHR population. The only RCT specifically with family interventions confirmed that improving family relationships may have prophylactic efficacy in individuals at high risk for psychosis.

• The next steps should be in defining treatments that meet the specific needs of CHR youth; in particular efforts to prevent social withdrawal; that is from friends, school, or workplace. One treatment does not fit all; thus treatments need to fit the needs of the individual, their presenting problems, and their unique level of risk of developing a psychotic illness as well as different resiliency factors that may need to be supported.

References