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Call for Research: Ethnography, Psychosis and At-Risk Groups

2010-11-11 20:09:00

By Neely Myers

An article this week in Nature highlights new issues surrounding the intersections of psychosis, clinical risk, and adolescence. Psychosis is now thought to lie along a “continuum” in the population from “at-risk” groups who have “psychotic-like experiences” (PLEs) (e.g., hallucinations and delusions that are transient or do not disrupt social functioning) (Meehl 1962; Polanczyk, Moffitt et al. 2010) to people who experience a full-blown “first-episode psychosis” (FEP) who may then go on to develop multiple-episode “psychotic disorders” like schizophrenia (Kelleher and Cannon 2010). Recent estimates find that 5-8% of the general population experience PLEs or “subclinical” psychotic symptoms and may be at-risk for FEP (Yung and McGorry 1996; Norman, Scholten et al. 2005; Van Os, Linscott et al. 2009), but this does not mean that all people with PLEs will develop FEP or schizophrenia. In fact, a recent study of an “ultra high-risk” group with PLEs and cognitive deficits over 18 months had only 19% of participants transition to psychosis (Ruhrmann, Schultze-Lutter et al. 2010).

Great debate (Dobbs 2010) has arisen over when and how to treat people with PLEs in order to try and prevent FEPs with some arguing that treatment before the development of FEP is good, “evidence-based care” (Bosanac, Patton et al. ; Frances 2009; McGorry, Nelson et al. 2009; McGorry, Johanessen et al. 2010). Preventive care is promoted because the duration of untreated psychosis may predict, for some, the social, psychological and biological impact of FEP (Keshavan, Haas et al. 2003; Iyer, Boekestyn et al. 2008). Others argue that the duration of untreated psychosis does not prevent future psychotic episodes (Norman and Malla 2001), and prescribing antipsychotics to people “falsely identified” and “medicalized” (Conrad 2007) as pre-psychotic who will never go on to develop FEP exposes people who may never become ill, particularly teenagers, to the known risks of taking “antipsychotic” medications (e.g., a shortened life span, stigma, debilitating side effects, and difficulties securing health insurance (Bosanac, Patton et al. ; Corcoran, Malaspina et al. 2005; Frances 2009)). These issues deserve careful consideration as western society struggles to determine what constitutes “evidence-based treatment” for psychoses and where the boundary between people who

may or may not need clinical treatment along the psychosis continuum lies.

The primacy of “objective” scientific descriptions have yet to produce an overall understanding of the ways people develop disordered reactions to mental distress, and the ways we might best help them mitigate that distress (Castillo 2006; Frazzetto and Gross 2007; Abbott 2008; Abbott 2008, and this week’s article in Nature). Alternatively, anthropological and sociological literature at times elicits the ways people develop rituals, beliefs, relationships and practices both inside and outside of clinical settings that seem to help them adapt and flourish in spite of mental distress (Hahn and Kleinman 1983; Dow 1986; Fischer 2007; Larsen and Larsen 2007; Rose 2007; Luhrmann 2008; Biehl and Locke 2010). Anthropological research on whether or not at-risk people who present in clinics go on to develop first-episode psychosis could contribute to longstanding debates about the relevance of phenomenological heuristics for understanding and addressing psychiatric disorder (Corin 1990; Estroff 2004; Larsen 2004; Biehl 2005; Jenkins, Strauss et al. 2005; Luhrmann 2010) and the overall importance of “subjective” evidence in “evidence-based” medicine (Greenhalgh 1999; Hunink and Glasziou 2001). This research may also produce hypotheses about the possible ways that clinical (e.g., enrollment in first-episode psychosis treatment programs) and complementary approaches meant to help people cope with PLEs may or may not prevent full-blown psychosis. Such hypotheses may inform current debates about whether or not people who experience PLEs (e.g., as an “at risk” or “high risk” group) should be “medicalized” (Conrad 2007) and classified in the DSM-V or ICD-11 (expected revisions of the two current diagnostic manuals for psychiatrists) and “preventively” treated with antipsychotic medication (Bosanac, Patton et al. ; Kihlstrom 2002; Banzato 2004; Middleton 2008; Frances 2009; McGorry, Johanessen et al. 2010).

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Myers N. Call for Research: Ethnography, Psychosis and At-Risk Groups. *Somatosphere*. 2010. Available at: http://somatosphere.net/2010/11/call-for-research-ethnography-psychosis.html. Accessed October 5, 2011.

APA citation
Myers, Neely. (2010). *Call for Research: Ethnography, Psychosis and At-Risk Groups*. Retrieved October 5, 2011, from Somatosphere Web site: http://somatosphere.net/2010/11/call-for-research-ethnography-psychosis.html

Chicago citation
Myers, Neely. 2010. Call for Research: Ethnography, Psychosis and At-Risk Groups. Somatosphere. http://somatosphere.net/2010/11/call-for-research-ethnography-psychosis.html (accessed October 5, 2011).

Harvard citation
Myers, N 2010, *Call for Research: Ethnography, Psychosis and At-Risk Groups*, Somatosphere. Retrieved October 5, 2011, from <http://somatosphere.net/2010/11/call-for-research-ethnography-psychosis.html>

MLA citation

Myers, Neely. "Call for Research: Ethnography, Psychosis and At-Risk Groups." 11 Nov. 2010. Somatosphere. Accessed 5 Oct. 2011.<http://somatosphere.net/2010/11/call-for-research-ethnography-psychosis.html>