Early Intervention: How Early and With What?

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As noted recently in the Washington Post,1 a report by McFarlane et al in this Issue2 was controversial as soon as it was published online. There is substantial interest in moving the time of detection and treatment of mental disorders with psychoses to earlier in the development of psychopathology. But how early, how to identify those who merit clinical attention, and how to intervene are hotly debated issues. The consideration of creating Attenuated Psychosis Syndrome as a new DSM 5 disorder was the most controversial subject addressed by the Psychosis Work Group.3 Reviews of studies to date document the presence of psychopathology in clinical high-risk persons, a range of validating variables distinguish these cohorts from non-ill control cohorts and reveal a very substantial rate of transition to a full psychosis illness.4-5 The primary issues at present are whether to create a new disorder vs using existing categories, and whether therapeutic interventions are evidence-based. These and other related issues have been addressed in a recent comprehensive review6 and argument pro and con for creating a new disorder has been summarized.7-8

The McFarlane et al report2 provides new data evaluating a predefined therapeutic intervention relevant to people who are at substantial risk of progression to full psychosis or early in the experience of their first psychotic episode. An unusual methodology and statistical analysis was used as an alternative to a more stringent clinical trial design creating limitations and controversy on the interpretation of study results. Nonetheless, substantial new data is presented bearing on the practicality and effectiveness of early intervention. We published this report to generate a discussion of key issues as the field moves clinical services in the direction of diagnosis and treatment of clinical high-risk persons not yet, and perhaps never, manifesting a psychotic illness. Towards this end, we have also published go-with commentaries to give emphasis to several views on the relevance of the present results (see commentaries, this issue). The scientific evaluation of the timing and nature of therapeutic interventions for clinical high-risk cases is in its infancy and data, while encouraging, is limited.9-10 However, throughout the history of medicine, clinicians have had to treat patients and address issues of “what is wrong” and “what can be done to help” without solid evidence-based guidelines. In the present consideration of early detection/intervention for potentially severe mental disorders, what is the clinician to do? Assuming the patient has symptoms of psychopathology and experiences distress, disability, and/or dysfunction, the clinician has a responsibility to provide clinical care. Much can be done in the absence of methodologically sound evidence for efficacy and effectiveness, including:

- Clinicians can provide structure and a safe environment, in the context of a clinical relationship, that facilitates exploration and understanding;
- Supportive psychotherapy and education can be provided to:
  ◦ support relatedness with family members and others;
  ◦ reduce misunderstanding, anger, and frustration;
  ◦ identify and support personal strengths;
  ◦ identify sources of stress and develop stress reduction techniques.
- Cognitive behavioral therapy can be implemented to address negative anticipation and other adverse cognitive coping strategies;
- Clinicians can monitor symptoms to facilitate the detection of symptomatic exacerbations and earlier intervention and reduction of the duration of untreated psychosis;
- Clinicians can address problems with sleep/wake cycle, anxiety, depression, and social withdrawal;
- Antipsychotic drugs may be prudently used if psychotic-like symptoms are exacerbating into full psychosis.

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The list could be longer, and randomized controlled trials to date offer some guidance, especially with respect to cognitive behavioral therapy.9 But, clinicians regularly have to use general clinical knowledge and skills and adapt them to a person’s current circumstance in advance of clear guidelines.

The field needs a new disorder class to focus science on therapeutic discovery and to translate findings from expert centers into clinical practice and service delivery systems. Several terms and somewhat different ascertain-ment criteria have been successfully used to establish the field of clinical high-risk research,11,12 and the proposed Attenuated Psychosis Syndrome in Section 3 of DSM-5 provides explicit criteria for future study.3,13 In the meantime, it is hoped that the McFarlane et al report2 stimulates discussion that advances the goal of early detection and intervention to offer hope for clinical interventions that can be beneficial to all and life course changing for those vulnerable to chronic psychotic illness.

Acknowledgment

The authors have declared that there are no conflicts of interest in relation to the subject of this study.

References