Psychological Interventions in Early Psychosis

A TREATMENT HANDBOOK

Edited by

JOHN F.M. GLEESON AND PATRICK D. McGORRY

The University of Melbourne, Australia

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John F.M. Gleeson is currently Associate Professor in the Department of Psychology, The University of Melbourne and the Northwestern Mental Health Program (a program of Melbourne Health). His major research interests include secondary prevention in psychotic disorders, and he is currently the Chief Investigator of a randomized trial at EPPIC, examining the effectiveness of a multi-modal relapse prevention intervention. He was previously Acting Director of Clinical Programs and Senior Psychologist at ORYGEN Youth Health, which incorporates the EPPIC Program. He has previously held a range of senior clinical and teaching roles at EPPIC since 1994. In 1998 he developed a Graduate Diploma in Young People's Mental Health, and has lectured extensively, nationally and internationally, on psychosocial treatments in first-episode psychosis.

Patrick D. McGorry is currently Professor/Director of ORYGEN Youth Health, which is linked to The University of Melbourne and the Northwestern Mental Health Program in Melbourne, Australia. He has contributed significantly to research in the area of early psychosis over the past 16 years. Over that time he has played an integral role in the development of service structures and treatments specifically targeting the needs of young people with emerging or first-episode psychosis. More recently there has been a broadening of his focus to cover the full spectrum of mental disorders in young people. In the last 2 years he has published over 50 journal articles and chapters in many well-respected international journals such as the *American Journal of Psychiatry*, *Schizophrenia Research* and *Archives of General Psychiatry*. He is currently the President of the International Early Psychosis Association and an Executive Board Member of the International Society for the Psychological Treatments of the Schizophrenias and other Related Psychoses. He is also a member of the Organizing Committee of the World Psychiatric Association Section on Schizophrenia, the Advisory Board of UCLA Center for the Assessment and Prevention of Prodromal States (CAPPS) and a member of the Editorial Board of *Schizophrenia Research*.

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Foreword

From its origins in Melbourne over a decade ago, the idea of creating specialized services for early intervention in psychosis has grown to encircle the globe. It is an idea that has been actualized in the creation of new service configurations, new psychotherapies and psychotherapeutic perspectives, and a new and growing body of knowledge to inform clinical care. The idea that new onset psychosis and even pre-illness onset prodromal states might best be managed in specialized settings and by specially trained teams may in time rank along with the deconstruction of the asylum as a major turning point in our thinking about the management of serious mental illness. How has this new therapeutic movement taken hold so quickly? What are its essential elements?

Two critical observations derived from longitudinal research set the stage for the current focus on early psychosis. First was the observation that in all societies where investigators looked, substantial time (12 to 18 months) typically elapsed between the onset of psychotic symptoms and the time a person found their way to a clinician who could institute appropriate treatment. Furthermore, many studies seemed to indicate that patients with the longest *duration of untreated psychosis* responded more slowly and less completely once treatment was begun.

Second, modern first-episode psychosis studies established the fact that once patients with a first psychotic episode were identified and treated, most had a rapid and robust initial treatment response. Among the most demoralizing findings, however, was the additional observation that given available treatments and treatment systems, within a year or two the vast majority of patients went on to suffer a relapse. After the first relapse, once again, most or nearly all went on to have one or more subsequent relapses. With each turn of this cycle, the quickness and completeness of treatment response was truncated leaving clinicians treating these individuals feeling powerless to turn back the tide of what could sometimes seem like an inexorable march towards chronicity. Based on watching far too many young persons transformed over the span of a few years into 'chronic patients', some hypothesized that repeated or prolonged periods of psychosis itself heralded a deteriorative neurobiological process that proceeded irreversibly in only one direction. While research has not, on balance, upheld a 'biological toxicity' hypothesis of prolonged psychosis, it is clear that by whatever mechanism, prolonged and repeated episodes inflict suffering and dismantle lives.

Together, duration of untreated psychosis and first episode studies point to an inescapable conclusion: our health systems fail to get patients with a first episode of psychosis into treatment and in most instances fail to prevent recurrences and deterioration. It is from the imperative to do better that early psychosis research and service development derive their momentum.

As this volume makes clear, psychosocial interventions are at the center of the array of services that must be developed to create a comprehensive system of care for persons who have suffered a first episode of psychosis. The treatment approaches described are both

illness phase-specific, for example focusing on the pre-psychotic phase, first episode, and first-relapse and *individual problem-specific*, addressing problems such as co-occurring substance abuse, suicidality, negative symptoms and treatment-resistance. Common elements of these approaches include a focus on relationship-building and engagement, the flexible adaptation of techniques to meet individual needs and preferences, the mobilization of families as allies in the treatment effort, and the integration of person-oriented approaches with current biological understanding of psychosis. Unlike earlier generations of psychological therapies that rested on endorsement from authorities, the approaches outlined here have been developed within a framework of evaluation research and evidence-based practice. While the data are not all in yet, over the next several years we can look forward to the results of rigorous evaluations or randomized trials to further clarify the utility of these approaches and guide their refinement and dissemination.

This volume describes work in progress. As a status report from those on the leading edge of creating and evaluating specialized early psychosis programs, it represents the best current thinking regarding treatments and treatment systems for young people balanced on the edge of catastrophe. From theory to practice to evaluation and reformulation of practice it may be a blueprint for saving lives.

Wayne S. Fenton, M.D.
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Preface

Every clinician knows that the human relationship with the person diagnosed with a psychotic disorder and particularly schizophrenia is the cornerstone of effective therapy and the foundation for recovery. This was one of the major tenets of an earlier generation of psychotherapeutic effort in schizophrenia and related psychoses but had drifted out of focus during the 1980s with the rise of an excessively narrow biological psychiatry and the decline of the traditional psychoanalytic approach. The lack of a blueprint or body of knowledge and skills for working with psychotic patients meant that many of their most salient needs were ignored. Fortunately this situation is changing for the better.

Since the publication of Carlo Perris' eclectic and seminal text in 1989, *Cognitive Therapy with Schizophrenic Patients*, there has been a steady growth in the application and evaluation of cognitive, cognitive-behavioural, and integrated need-adapted psychodynamic treatments for schizophrenia and psychosis. Over the past 5 years these developments have been reflected in the publication of a number of treatment handbooks for the clinician based in the mental health setting. The majority of these treatment handbooks have presented the innovative cognitive-behavioural methods of UK-based clinical and experimental psychologists, and have reflected their contributions to the treatment of psychotic symptoms and relapse prevention. The principal aim of these texts has been to add to the repertoire of trained cognitive-behavioural therapists in their work with patients with established (and often treatment-resistant) forms of psychotic disorders. Somewhat less attention has been paid to the earlier application of psychological interventions for first-episode patients whose clinical, personal and broader developmental needs often differ from patients with longer-term illnesses.

In parallel with this psychological renaissance, international interest in intensive early intervention in psychosis has grown exponentially. This paradigm shift is reflected in major research growth in early psychosis and a raft of service and policy reforms that have extended throughout Europe, Scandinavia, Canada, the USA, Australia and the Asia-Pacific region, in addition to the establishment of the International Early Psychosis Association, and the publication of several texts with a focus on early psychosis. The International Society for the Psychological Treatments of the Schizophrenias and Other Psychoses similarly has expanded and given unequivocal support for the early use of psychological interventions in psychotic illness and for early intervention itself. Given these developments at the international and local service system level, we were motivated to bring together the range of psychological treatments for early psychosis. This text aims to equip clinicians to address the psychological needs of first-episode patients across specific early stages of treatment.

Psychological Interventions in Early Psychosis is envisaged as a practical treatment handbook for the clinician with previous training in a range of psychotherapies, and for the postgraduate student undertaking training. The text is organized according to phases of illness commencing with the prepsychotic *at-risk* phase and extending to protracted recovery from psychotic symptoms. In addition, the collection of contributions includes cognitive and

cognitive-behavioural interventions which have not previously been described in available psychosis-related texts—namely suicide prevention and treatment of comorbid cannabis abuse.

The introductory chapter, by Patrick McGorry, outlines the imperative for psychological intervention in early psychosis to be integrated with biological treatments—an argument that is placed within the historical context of psychotherapies for schizophrenia. Chapter 2 outlines the preventive rationale for cognitive therapy with patients presenting with features of 'at-risk mental state' for the development of acute psychosis. The clinical implications from research undertaken at PACE (a research-based clinic in Melbourne for young people at heightened risk for psychosis) are detailed, an approach that has been taken up enthusiastically in the UK EDIE project. Chapter 3, contributed by Ron Siddle and Gillian Haddock, introduces the reader to the clinical lessons from the SoCRATES study in the UK, with a detailed description of psychological interventions for the acute phase of early psychosis.

The phases of cognitively orientated therapy for early psychosis (COPE), which was developed at EPPIC as a short-term focal therapy, is described by Lisa Henry in Chapter 4. The intervention aims to ameliorate the risk of the 'self' being overwhelmed by the stigma of diagnosis and the impact of entry into treatment, and to treat secondary morbidity. Our Scandinavian colleagues, Johan Cullberg and Jan-Olav Johannessen, are ideally placed to outline, as they do in Chapter 5, the place of brief, adapted psychodynamic therapies in the early stages of recovery from the acute episode. Chapter 6 outlines the specific needs of the family members of first-episode patients in dealing with the uncertainty, grief and trauma surrounding the experience in caring for the young person. The approach, described by Jean Addington and Peter Burnett, details family work undertaken at EPPIC, in Melbourne, Australia, and Calgary, Canada. A second key Canadian contribution is included in Chapter 7, by Ashok Malla, Terry McClean, and Ross Norman, in which the opportunities for recovery from acute psychosis, which can be provided within the group context, are expertly explored.

Chapter 8 introduces the reader to a treatment strategy recently trialled at EPPIC for comorbid cannabis abuse—a significant variable in relapse and prolonged recovery following the initial episode. Kathryn Elkins, Mark Hinton and Jane Edwards outline the scope of the problem and describe specific clinical interventions with illustrative case vignettes. Chapter 9 by John Gleeson focuses upon the first psychotic relapse. Starting from a critical understanding of the construct of relapse as applied to the first-episode group, the chapter provides guidelines for understanding and formulating the risk for psychotic relapse. The prime interventions for relapse prevention are included, with reference to two contrasting case vignettes.

Although others have described the importance of understanding demoralization following a first episode of psychosis, Chapter 10 by Paddy Power introduces the reader to a manualized cognitive-behavioural therapy (CBT) intervention for first-episode patients with suicidal ideation. The chapter reviews the data pertaining to the huge but understudied issue of suicide and self-harm in the psychotic population, before describing the 'LifeSPAN' intervention which was evaluated within a randomized-controlled trial of CBT at EPPIC.

Chapter 11, contributed by Jane Edwards, Darryl Wade, Tanya Herrmann-Doig and Donna Gee, describes CBT for 'prolonged recovery' from the first episode. The ramifications of delayed recovery from positive psychotic symptoms after the first episode are outlined, together with the rationale for individual symptom-based CBT interventions for this patient group. Drawing upon the EPPIC 'STOPP' (Systematic Treatment of Persistent

Psychosis) model, interventions for hallucinations and delusions are detailed with illustrative case material. In Chapter 12, Max Birchwood, Zaffer Iqbal, Chris Jackson and Kate Hardy argue cogently for an increased focus upon interventions for emotional distress associated with psychosis in both research trials and in clinical practice. Chapter 13 addresses the difficult area of negative symptoms—a much neglected issue in psychological literature for early psychosis. While the use of low-dose antipsychotic medications and in particular atypical agents has reduced the extent and severity of this clinical syndrome, it remains a tenacious clinical challenge. Paul Falzer, David Stayner and Larry Davidson review the relevant literature on negative symptoms and posit five principles, derived from research and clinical experience, for working with first-episode patients with negative symptoms.

The subjective experience of psychosis and principles from the recovery model are integrated in Chapter 14, contributed by Rufus May, who brings a unique dual perspective from his experience as both consumer and clinical psychologist. This is essential reading for all clinicians and consumers.

Finally, Chapter 15 attempts to answer the frequently asked question: 'How can services undertake highly specialized psychosocial interventions in a contemporary mental health setting with limited resources and high caseloads?' While acknowledging these apparently formidable constraints, this chapter highlights some of the strategies successfully adopted within the West Midlands Region in the UK via a range of comprehensive training programmes. Their experience is mirrored around the world in an increasing number of settings.

We hope that this handbook will stimulate clinicians and researchers alike to continue to innovate and evaluate novel interventions for first-episode patients and their families, with the aim of improving outcomes. We would like to thank all our colleagues for their generous efforts in contributing to this work. In addition, we would like to acknowledge all of the consumers and their families who contributed to these ideas and applications. Finally, thank-you to our own families for enduring our preoccupation with this project, and special thanks to Theresa Cheng for her tireless and essential administrative efforts in preparing this manuscript.

John Gleeson and Patrick McGorry
Parkville, Australia
August 2003

1 An Overview of the Background and Scope for Psychological Interventions in Early Psychosis

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In recent years there has been a renaissance of interest in psychological interventions in psychosis. This revival has been catalysed by a number of forces, notably a welcome growth in therapeutic optimism, the advent of novel drug therapies, the reform and community embedding of mental health services, the rise of consumerism in mental health care and the steady extension of cognitive therapies across the full spectrum of psychiatric disorder with an accompanying evidence base. Naturally, people experiencing early psychosis are in a particularly good position to benefit from effective forms of psychological intervention. They have many currently unmet psychological needs, extensive comorbidity, and at this phase of illness the task of recovery is challenging but potentially more achievable. While drug therapies are essential for the vast majority of people with psychotic disorder, optimal recovery in a psychological and functional sense is rarely achieved without skilled psychological assistance. This chapter reviews the origins and vicissitudes of the psychological approach to psychosis during past eras and the basis for future evolution and extension with a particular focus on early psychosis.

HISTORY

The modern origins of psychological interventions in psychosis can be traced back to the French Revolution and the emergence of so-called moral treatment in the late eighteenth and early nineteenth centuries. Pinel in France, and the York Retreat and later John Conolly in England were the pioneers of this change in approach (Jones, 1983). The harsh custodial methods used to respond to madness began to be leavened by a more humane approach which reflected the more liberal thinking of the period. Some patients began to be cared for in smaller facilities characterized by a lack of physical restraint, greater freedom and humane attitudes, and early forms of behavioural management. However, whatever the symbolic significance of such models, they failed to generalize or prosper, and were largely swept aside by the growth of the asylums during the latter half of the nineteenth century and first half of the twentieth.

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Edited by J.F.M. Gleeson and P.D. McGorry.

Psychological treatments for schizophrenia and other psychoses were almost totally neglected during much of this period for two reasons. Firstly, psychoses, particularly schizophrenia, were seen as severe and degenerative neuropsychiatric diseases for which there was no effective treatment. The Kraepelinian model meant that a diagnosis of, in particular, schizophrenia or dementia praecox created profound therapeutic nihilism—an effect which largely persists to this day, despite the subsequent development of effective treatments and demonstration that the course is not in fact one of deterioration (Harrison et al., 2001). Ironically, Kraepelin personally believed that a supportive psychotherapeutic approach was often helpful to the patient (Nagel, 1991). Custodial care was the only practical option during much of the asylum era, and although it was originally inspired partly by humanitarian ideals, it resulted in reality in much suffering and iatrogenic harm. Secondly, despite the rise of new psychological treatments within the psychoanalytic paradigm, people with psychoses, again especially schizophrenia, were initially believed to be unable to benefit from such treatments. Freud in particular stated that such patients were unable to form a relationship—especially a transferential one—with the therapist, and hence could not be treated with psychoanalysis. According to Federn (1952), Freud regarded patients with schizophrenic-type psychotic disorders as a 'nuisance to psychoanalysis'.

The Neo-Freudians however, specifically the interpersonal school led by Harry Stack Sullivan, began to seriously question this view from the 1920s. They regarded the organic disease model for schizophrenia to be a mistaken concept, believing that the syndrome was largely an adaptational problem based on earlier experiences and, perhaps, some constitutional predisposition. Having much more faith in the patient's capacity to relate, they developed a new type of psychotherapy aimed at a mutual doctor–patient understanding of the patient's development and of the unconscious conflicts that created the symptoms. Sullivan, who quite rightly perceived the person with schizophrenia as 'much more simply human than otherwise' (Sullivan, 1947), not only developed a theory of schizophrenia which attempted to explain the disorder on an interpersonal basis, but his modified form of psychoanalytic psychotherapy was more reality oriented, active and flexible (Sullivan, 1947). He was also acutely aware of the possibilities for prevention and early intervention in schizophrenia and wrote some seminal papers on this topic (Sullivan, 1927). His successors, notably Frieda Fromm-Reichmann at Chestnut Lodge, extended his work greatly even as biological treatments were emerging. Fromm-Reichmann also projected an optimistic approach to the patient which resonates well with the thinking of the current early psychosis paradigm:

> I am thinking especially of the diagnosis of schizophrenia as being connected in the minds of many lay people and unfortunately also in the judgement of many psychiatrists with the connotation of psychotherapeutic inaccessibility. They believe that only shock treatments and psychosurgery can help to relieve the suffering of these patients, even though they realise that this may be accomplished at the expense of the emotional integrity and further development of the patients' personalities. The diagnosis "schizophrenia" given by a psychiatrist of my school of psychiatric thinking is coupled with the knowledge that he and the patient are heading for hard work, but it is by no means offered in the spirit of prognostic discouragement. (Fromm-Reichmann, 1960, p. 61)

In many settings, prior to the advent of antipsychotic medication, psychoanalysis became the treatment of choice for schizophrenia. In many parts of the world, particularly in the USA for a time, psychoses were regarded as disorders with a psychological basis rather than neuropsychiatric diseases. Despite this, however, even in the heyday of psychoanalytic

treatment, most patients were institutionalized with no access to these time-consuming and arcane interventions. During the 1940s many were exposed to the widespread use of electroconvulsive therapy (ECT) and psychosurgery. While Arieti (1974) evolved the interpersonal approach further, presciently moving it in a cognitive direction and integrating it with biological therapies, the times were changing. The discovery of antipsychotic medication in the early 1950s, the associated slow decline of the asylum model, and the rise of biological psychiatry, ultimately changed the landscape of treatment for people with psychotic disorders. The perspective slowly changed from psychological reductionism to biological reductionism. The rationale and technique enabling clinicians to work psychologically with patients evaporated, resulting in greatly reduced therapeutic contact with patients who, despite being more psychologically accessible due to effective antipsychotic therapy, became increasingly ignored as human beings. For many the excessive doses of only partially effective medicines did indeed relieve suffering, but only 'at the expense of the emotional integrity and further development of the patients' personalities'. They often led impoverished lonely lives in community settings, graduating to a new state of neglect. This trend has continued inexorably until the present day, and while it has affected psychiatry as a whole, it has particularly affected psychotic disorders. Very few patients with psychotic illness currently receive modern evidence-based psychosocial interventions (Jablensky et al., 1999). The specially adapted forms of psychoanalytic psychotherapy gradually became discredited in the treatment of schizophrenia, partly because they were based on a reductionistic and speculative theoretical stance, but mainly because it had proved difficult to find evidence for their efficacy either as a sole treatment or even as an adjunct to drug therapy (Gunderson et al., 1984; Malmberg & Fenton, 2003; May, 1968). While this view was later challenged (Gottdiener & Haslam, 2003), during the 1980s it became clear that psychoses were associated with a range of central nervous system (CNS) abnormalities that more definitively supported a disease model. The zeitgeist crystallized around this model, and schizophrenia was now seen exclusively as a disorder of the CNS structure and function. Only in the past decade, catalysed by the seminal work of Carlo Perris (1989), has there been some rebalancing and there is at last the potential to go beyond both forms of reductionism and move towards true integration of biological and psychosocial treatments in psychosis.

EARLY PSYCHOSIS: A NEW PARADIGM IN MENTAL HEALTH

Over the past decade, a growing sense of optimism about the prospects for better outcomes for schizophrenia and related psychoses has created substantial reform, and there is momentum in clinical practice in many countries to develop early intervention strategies. Clinicians and policy makers are enthusiastic about reform based on the early intervention idea because of the sound logic behind it, the unacceptably poor access and quality of care previously available to young people with early psychosis, and the increasing evidence that better outcomes can be achieved.

The growth of this paradigm is more broadly based than the earlier, unsuccessful psychotherapeutic endeavours. Some of the current optimism has flowed from the development of a new generation of antipsychotic medications with greater efficacy and fewer toxic side-effects, but a second major factor has been the belated recognition that a special focus on the early phases of illness could result in a substantial reduction in morbidity and better quality of life for patients and their families. This is not a new idea, having been formulated

during the preneuroleptic era by Sullivan in particular, and others subsequently (Meares, 1959; Sullivan, 1927). However, due initially to a lack of effective treatment and subsequently to tenacious therapeutic nihilism, it remained dormant for decades. A revival of interest has come from several origins. From the psychotherapeutic perspective, Ugelstad (1979) proposed a secondary prevention effort focusing on intensive supportive psychotherapeutic intervention for first-episode schizophrenia in Scandinavia. Recognising that young first-onset patients were at maximum risk for poorer outcomes, and that the incidence of such cases was relatively small in any given catchment or sector, he outlined a practical way of focusing psychological expertise on the needs of such patients, who presented at a manageable rate for clinical services. This model gave rise to the Nordic Investigation of Psychotherapeutically-orientated treatment for new Schizophrenia (NIPS) project, an ambitious undertaking, the results of which were unfortunately inconclusive (Alanen et al., 1994). Interest in early intervention gradually re-emerged within mainstream psychiatry during the 1980s as a result of some key research studies (Crow et al., 1986; Falloon, 1992; Lieberman, Matthews & Kirch, 1992), and grew exponentially during the 1990s (Birchwood, Fowler & Jackson, 2000; Edwards & McGorry, 2002; McGorry & Jackson, 1999). This revival and its sustainability will depend on a stable recognition of the need for an integrative biopsychosocial approach to aetiology and treatment.

The first-episode research focus rapidly revealed the special clinical needs of young people at this phase of illness, the iatrogenic effects of standard care and an encouraging range of secondary preventive opportunities. This was especially clear when the clinical care of the first-episode and recent onset patients was streamed separately from chronic patients, something that is still difficult to engineer (McGorry & Yung, 2003). The key failures in care are: prolonged delays in accessing effective treatment, which consequently usually occurs in the context of a severe behavioural crisis; crude and typically traumatic and alienating initial treatment strategies; and subsequent poor continuity of care and engagement of the patient with treatment. Young people have to demonstrate severe risk to themselves or others to gain access, and a relapsing and chronically disabling pattern of illness to qualify for assured ongoing care. These features are still highly prevalent in most systems of mental health care, and even in developed countries with reasonable levels of spending in mental health (Garety & Rigg, 2001).

The increasing devolution of mental health care into community settings has provided further momentum, as has a genuine renaissance in biological and psychological treatments for psychosis. An exponential growth in interest in neuroscientific research in schizophrenia has injected further optimism into the field with a new generation of clinician-researchers coming to the fore. Several countries have developed national mental health strategies or frameworks that catalyse and guide major reform and mandate a preventive mindset and linked reform. Around the world an increasingly large number of groups have established clinical programmes and research initiatives focusing on early psychosis and it now constitutes a growth point in clinical care as well as research (Edwards & McGorry, 2002). This blend of science and sociology has the potential to lead to a sea change in the way these illnesses are conceived and managed.

While primary prevention is still out of reach, secondary prevention or 'early intervention' is an excellent interim option. This includes early detection of new cases, shortening delays in effective treatment, optimal and sustained treatment in the early 'critical period' of the first few years of illness, and may eventually include the capacity to identify a proportion of cases in the prepsychotic period. Reducing the impact and burden of psychotic

disorders in society as a whole is an achievable and important objective. It may also be possible to reduce the prevalence by shortening the duration of illness by delaying onset, reducing the period of time spent living with the symptoms and disability, or accelerating recovery. However, none of this has yet occurred despite the development of highly effective treatments, because we have failed to translate recent advances to the real world in a timely manner. Even with existing knowledge, substantial reductions in prevalence and improved quality of life are possible for patients provided that societies are prepared to mandate and pay for it (Andrews et al., in press). Early intervention, with its promise of more efficient treatment through a proactive and enhanced focus on the early phases of illness, is an additional prevalence reduction strategy which is now available to be more seriously tested and, if found cost-effective (Carr et al., 2003; Mihalopoulos, McGorry & Carter, 1999), to be widely implemented. At least two randomized-controlled trials are in progress evaluating models of this type.

A FRAMEWORK FOR CLINICAL INTERVENTIONS IN EARLY PSYCHOSIS

The pattern and style of intervention in early psychosis differs from that required in later stages of these disorders. A staging approach is used here to summarize the key elements currently believed to be appropriate. Knowledge and evidence are accumulating steadily and the range and sequence of interventions is expected to evolve further. A fundamental principle is that careful integration of drug and psychosocial interventions is always essential.

Prepsychotic or Prodromal Phase

In most patients a prolonged period of symptoms and increasing disability, commonly termed the 'prodrome', occurs before the onset of severe and persistent positive psychotic symptoms sufficient to allow the diagnosis of schizophrenia or first-episode psychosis (Agerbo et al., 2003; Häfner et al., 1995). Such psychosocial damage is usually extremely difficult to reverse. Recently it has also been shown that active neurobiological change may occur during this period (Pantelis et al., 2003). The prepsychotic phase is an active focus of research (McGorry et al., 2002) and this is leading to better understanding of the process of onset as well as the treatment needs and options. It is already clear that psychological interventions are likely to benefit patients at this phase and may have preventive or ameliorative effects on the onset process. The following points reflect an acceptable clinical approach to such patients at the present time.

- The possibility of psychotic disorder should be considered in any young person who is becoming more socially withdrawn, performing more poorly for a sustained period of time at school or at work, behaving in an unusual manner, or becoming more distressed or agitated yet unable to explain why.
- Subthreshold psychotic features combined with the onset of disability (Yung et al., 2003) indicate very high risk. The young person and the family should be actively engaged in assessment and regular monitoring of mental state and safety. This should be carried out in a home, primary care or non-psychiatric setting if possible, to reduce stigma.

- Concurrent syndromes such as depression and substance abuse, and problem areas such as interpersonal, vocational and family stress, should be appropriately managed.
- Information about the level of risk of progression to psychosis should be carefully provided, conveying a sense of therapeutic optimism. It should emphasize that current problems can be alleviated, that progression to psychosis is not inevitable, and if psychosis or schizophrenia does occur then effective and well-tolerated treatments are readily available. Engagement at this early stage will help to reduce any subsequent delay in accessing treatment for first-episode psychosis and hence shorten the duration of untreated psychosis.
- The use of antipsychotic medication during the prodrome is the subject of current research (Bechdolf, Wagner & Hambrecht, 2002; Cornblatt et al., 2002; McGlashan et al., 2003; McGorry et al., 2002; Miller et al., 2003; Woods et al., in press). At present, it should be reserved for patients who are clearly and persistently psychotic.

First-Episode Psychosis (FEP)

Two key issues in FEP are the *timing* of intervention (and thus the duration of untreated psychosis (DUP), (McGlashan, 1999)) and its *quality* (the sustained provision of comprehensive phase-specific treatment) (Birchwood, 2000; Edwards & McGorry, 2002; McGorry & Jackson, 1999; National Collaboration Centre for Mental Health, 2002; National Service Framework, 1999; Zipursky & Schulz, 2002).

There are often prolonged delays in initiating effective treatment for first-episode psychosis. Prolonged DUP is associated with poorer response and outcome (Harrigan, McGorry & Krstev, 2003; McGlashan, 1999; Norman & Malla, 2001). Early identification of people in the earliest phases of psychotic disorders combined with optimal treatment is very likely to reduce the burden of disease while it is active (Malla & Norman, 2002). Any improvements in long-term outcome should be seen as a bonus, rather than as a prerequisite for improving clinical standards during early illness (Lieberman & Fenton, 2000).

FEP tends to be more responsive to treatment than subsequent episodes and later phases of illness, but it can be more demanding because of the range of clinical issues to be addressed. Syndromes, and hence diagnoses, tend to be unstable and may evolve over time. The umbrella term 'psychosis' allows this syndromal flux and comorbidity to be accommodated, and treatment commenced for all prominent syndromes, before a stable diagnosis such as schizophrenia or bipolar disorder needs to be applied. Whether or not core 'schizophrenia' can be securely diagnosed or not is not crucial for effective treatment in first-episode psychosis. Treatment-relevant syndromes are positive psychosis, mania, depression, substance abuse and the negative syndrome. Some of the main principles of treatment of FEP are as follows.

- Strategies to improve access to treatment for FEP include better mental health literacy, more informed primary care, and greater responsiveness of public and private psychiatry to possible cases. Community-wide education systems should be developed to improve understanding of how psychotic disorders emerge in a hitherto healthy person and how to seek and obtain effective advice, treatment and support (Johannessen et al., 2001; Larsen et al., 2001). Above all, a high index of suspicion and a low threshold for expert assessment should be set for FEP.

- Entry and retention within specialist mental health services is often based on a reactive crisis-oriented model in which individuals must reach a threshold of behavioural disturbance, risk, disability or chronicity. This resource-poor model creates unnecessary trauma, demoralization and therapeutic nihilism in patients, families and clinicians. Instead, services should aim for proactive retention of most patients throughout the first 3–5 years of illness, combining developmental (youth) and phase-specific perspectives (Edwards & McGorry, 2002; National Service Framework, 1999).
- Initial treatment should be provided in an outpatient or home setting if possible (Fitzgerald & Kulkarni, 1998). Such an approach can minimize trauma, disruption and anxiety for the patient and family who are usually poorly informed about mental illness and have fears and prejudices about inpatient psychiatric care. Inpatient care is required if there is a significant risk of self-harm or aggression, if the level of support in the community is insufficient, or if the crisis is too great for the family to manage, even with home-based support.
- Inpatient care should be provided in the least restrictive environment. Optimal inpatient units should ideally be streamed by phase of illness and developmental stage, be relatively small in size, and be adequately staffed so that 1 : 1 nursing of highly distressed, suicidal or agitated young people is possible without locking sections of the unit or secluding the patient, unless this is absolutely necessary. The use of traditional psychiatric 'intensive care', a pragmatic intervention which lacks a solid evidence base, is especially traumatic for these patients (McGorry et al., 1991; Meyer et al., 1999; Shaw, McFarlane & Bookless, 1997). Where streaming is not possible, a special section may be created in a general acute unit for young recent-onset patients.
- Pharmacological treatments should be introduced with great care in medication-naïve patients; they should do the least harm while aiming for the maximum benefit. Appropriate strategies include graded introduction, with careful explanation, of low-dose antipsychotic medication (Emsley, 1999; Merlo et al., 2002; Remington, Kapur & Zipursky, 1998) plus antimanic or antidepressant medication where indicated. Skilled nursing care, a safe and supportive environment, and regular and liberal doses of benzodiazepines are essential to relieve distress, insomnia and behavioural disturbances secondary to psychosis, while antipsychotic medication takes effect.
- The first-line use of atypical antipsychotic medication is recommended on the basis of better tolerability and reduced risk of tardive dyskinesia. In the longer term, the risk–benefit ratio may change for some patients, for example if weight gain or sexual side-effects associated with the atypical agents develop. Typical antipsychotic medications may then be one of the options considered (Geddes et al., 2000; Kapur & Remington, 2000; National Collaborating Centre for Mental Health, 2002).
- Of particular relevance here is the principle that psychosocial interventions, especially cognitive-behavioural therapy (CBT), are important components of early treatment, providing a humane basis for continuing care, preventing and resolving secondary consequences of the illness, and promoting recovery (Lewis et al., 2002). During the recovery phase CBT may also be helpful for preserving a stable sense of self, in maintaining self-esteem, for comorbid substance use, mood and anxiety disorders and improving treatment adherence (Jackson et al., 1998).
- Families and, whenever possible and appropriate, other members of the person's social network should be actively supported and progressively educated about the nature of the

problem, the treatment and the expected outcomes. If there are frequent relapses or slow early recovery, a more intensive and prolonged supportive intervention for families is required (Gleeson et al., 1999; Zhang et al., 1994).

- If recovery is slow and remission does not occur despite sustained adherence to two antipsychotic medications (at least one of which is an atypical medication) for 6 weeks each, early use of clozapine and intensive CBT should be seriously considered (Edwards et al., 2002b; National Collaborating Centre for Mental Health, 2002).
- Early use of clozapine should also be considered if suicide risk is prominent or persistent (Meltzer et al., 2003).

Recovery and Relapse: Treating Schizophrenia and Related Psychoses in the Critical Period

Relapses are common during the first 5 years after a first-episode psychosis (Robinson et al., 1999), a phase which has been termed the 'critical period' (Birchwood, Fowler & Jackson, 2000; Birchwood & Macmillan, 1993). Young people naturally find it difficult to accept the lifestyle change of taking daily medication, especially if they have substantially recovered. Poor adherence often contributes to one or more relapses which are risky, disruptive and may confer an increased chance of treatment resistance. Secondary consequences, such as worsening substance abuse, vocational failure, family stress and homelessness, are common during this phase, as the social fabric of the young person's life is put under severe strain.

It is essential that high-quality and intensive biopsychosocial care is provided continuously and assertively during this critical period. In practice, however, patients are rapidly discharged to primary care and must experience acute relapse, a suicide attempt or manifest severe disability and collateral psychosocial damage before further specialist care is provided, often in a reactive 'too little, too late' manner. Services currently tend to disengage at precisely the time when they are most needed and could be of most value. Typically they only become re-involved during increasingly brief acute episodes of care, superimposed on a low base of so-called 'shared care'. This minimalist model is highly inappropriate for the needs of patients during this stormy critical period of illness. Key features of clinical care during this phase are as follows:

- A solid therapeutic relationship and a staged approach to psychosocial intervention is essential (Hogarty et al., 1997a, 1997b). Good adherence to antipsychotic medication and specific psychosocial interventions, particularly family interventions, can reduce the risk of relapse (Pilling et al., 2002a; Schooler et al., 1997). A significant advantage of an atypical antipsychotic over a typical agent in the prevention of relapse has recently been demonstrated (Czernansky, Mahmoud & Brenner, 2002) though it remains unclear whether this is due to better efficacy, better tolerability and hence increased adherence, or both. Poorly engaged and frequently relapsing patients benefit most from intensive case management or assertive community treatment (ACT) models of care (Marshall & Lockwood, 2003). Comorbid substance abuse commonly contributes to relapse, and interventions based on CBT and motivational interviewing are now being developed and show early promise, although this is likely to remain a challenging issue (Barrowclough et al., 2001). Clozapine and CBT are indicated for emergent treatment resistance (Pilling et al., 2002a).

- In fully remitted patients, antipsychotic medication should be continued for at least 12 months and then an attempt may be made to withdraw the medication over a period of at least several weeks. Close follow-up should be continued with specialist review for a further period of at least 12 months, and any relapse rapidly identified and treated.
- At least 10–20% of patients fail to fully remit after a trial of two antipsychotic medications. They should be considered as manifesting 'treatment resistance', which means that more active biopsychosocial intervention is urgently required.
- Even in fully remitted patients, a range of psychological, family and vocational issues need to be addressed. Comorbidity, especially substance abuse, depression, post-traumatic stress disorder and social anxiety, is common and should be actively identified and treated.
- Every patient has the right to a safe, secure and agreeable home environment.
- Family support and intervention should be consistently provided during this phase (Lenior et al., 2002).
- Suicide risk must be actively monitored and addressed (Meltzer et al., 2003; Power et al., 2003).
- Vocational recovery interventions should be offered when a stable clinical state has been achieved (Drake et al., 1999; Lehman et al., 2002).
- Most patients should remain principally within specialist mental health care throughout the early years of illness, rather than be discharged to primary care on improvement of acute symptoms. Optimal treatment in this phase is complex, relying heavily on good adherence to medication and an array of psychosocial interventions, which depend on a cohesive team approach. True 'shared care' arrangements, which include primary care clinicians and are driven by clinical rather than cost imperatives, should be actively developed.

WHY PSYCHOLOGICAL TREATMENTS ARE NECESSARY IN EARLY PSYCHOSIS

Modern low-dose drug therapies, while not effective in all cases, are clearly the cornerstone for recovery in early psychosis. Why, therefore, are psychological treatments necessary? In fact drug therapies, while necessary, are not sufficient for full recovery in most patients. More specifically psychological and psychosocial interventions have a role for the following reasons:

To develop a therapeutic alliance

This is a difficult task in this age group and in the face of the obstacles thrown up by the disorder itself. A range of engagement strategies can be utilized (Othmer & Othmer, 1994; Power & McGorry, 1999), however the developmental stage of most patients, combined with the impact of the illness upon relatedness and social cognition, creates special difficulties. Furthermore, a subgroup of patients have experienced developmental neglect or abuse and have even more serious problems with trust and engagement. Most systems of psychiatric care fail to prioritize continuity of care, and even when a stable trusting therapeutic relationship is established it frequently cannot be maintained. If these barriers can be overcome and a good therapeutic alliance established and maintained, then a passport

to recovery and better outcomes and quality of life can be achieved (Frank & Gunderson, 1990).

To provide emotional support in the face of disturbing subjective experiences and stigma

This is a central yet under-appreciated task for psychosocial interventions. The impact of psychotic and related psychopathological experiences is typically disturbing and overwhelming, and patients need accurate empathy for this as well as emotional support and practical help with coping strategies in the early phase of treatment. The experiences can produce trauma (McGorry et al., 1991; Meyer et al., 1999; Shaw, McFarlane & Bookless, 1997) and often the therapeutic environment can add to this rather than alleviate it. The stigma-laden 'recovery' environment represents a further risk factor to patients as they struggle to adjust and recover. Active supportive psychotherapy with strong emotional support is essential in the early stages of treatment for psychosis, though it can be difficult to provide this in a setting where engagement with the patient is undermined by a range of conflicting factors.

To promote understanding of psychosis, active participation in treatment, and adherence to medication

Accepting the need for continuing medication represents a major change in mindset and lifestyle for young people who have developed a psychotic disorder. Despite this there has been very little application of compliance-aiding strategies from other fields of medicine to psychiatry or the exploration of novel strategies. There has been one study in more established schizophrenia that has demonstrated improved compliance (Kemp et al., 1998) but this has not yet been replicated in early psychosis. A range of psychological, motivational and educative strategies are likely to be necessary as well as increasing maturity and personal experience of the persistence of the illness. Psychological interventions will be essential to translate efficacious treatments into real world benefits for patients.

To specifically target individual symptom complexes, comorbidities and maladaptive schemas

Later in the recovery process, there is a role for modified CBT in tackling specific symptom complexes and also longer term maladaptive schemas undermining self-esteem. Positive psychotic symptoms, depression, social anxiety, substance abuse and even negative symptoms are obvious targets for such an approach. Cognitive analytic therapy (see below) may well have a place in addressing longer term and premorbid issues. There has been substantial progress in recent years in developing and evaluating these forms of intervention, many of which are described in this book.

To reduce treatment resistance

While most patients with a first episode of psychosis achieve an initial remission from at least the more florid positive symptoms, the subset of around 10–20% who fail to do so are at serious risk of chronic illness. In addition to clozapine, there is strong face validity and some evidence that CBT will help to improve the degree and quality of remission (Edwards et al., 2002b).