
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.

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 transference 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).

To enhance coping and adaptation

Once again recognition of the degree of difficulty in surviving and adjusting to this typically overwhelming crisis and challenge is the key. The illness and its treatment occur during a phase of life in which not only are coping capacities and personal identity still immature, but parental attachment and peer relationships are also in flux and more tenuous. The development of COPE therapy (Jackson et al., 1996, 1998) was focused on these aspects of recovery.

To improve cognitive functioning

Cognitive impairment has been recognized as another dimension that is critically important to functional recovery. Psychological interventions aimed at enhancing cognitive functioning have been developed in recent years with variable success (Pilling et al., 2002a, 2002b; Wykes & van der Gaaz, 2001) but have not yet been systematically applied in early psychosis.

To improve interpersonal relationships that may have been a problem in any case as a result of risk factors independent to the psychosis, and may have worsened or been disrupted by the effects of illness

Here the framework of cognitive analytic therapy or CAT (Ryle & Kerr, 2002) may be particularly useful as a generic intervention which aims to improve distress and interpersonal functioning. The capacity for individual formulation and a strongly collaborative approach based on mutually agreed issues is particularly appealing for this age group and should help with engagement. The CAT model is being adapted for several more severe forms of mental disorder, including borderline personality disorder (Ryle, 1997) and, currently, psychotic disorders (Ryle & Kerr, 2002).

To provide support and assistance to family members

Family interventions are the most strongly evidence-based of all the psychosocial interventions in psychotic disorders. The needs of family members in early psychosis are not only intense but also phase specific; however, they have not yet been adequately addressed in research or routine clinical practice. Crisis intervention, emotional support, stigma management and education are obvious strategies. This is another vital focus for psychological interventions in the future.

To promote vocational recovery

Vocational rehabilitation has proved to be promising as an intervention even in late phases of disorder in very disabled patients (Drake et al., 1999; Lehman et al., 2002). There is an obvious opportunity to develop more preventively oriented vocational interventions during early psychosis to enable young people to resume their vocational trajectories as soon as possible in the recovery process and to limit the secondary collateral damage wrought by the illness. This will require quite a different approach and has the potential to result in major cost-effectiveness advantages since such interventions are likely to be much more effective earlier in the course of illness. Better quality of life, less poverty and marginalization for patients, and a reduction in the massive indirect costs of the illness are probable benefits. This should be a priority area.

To reduce the risk of suicide and aggression

Suicide is the main cause of premature mortality in schizophrenia and other psychotic disorders (Power et al., 2003). Typically this occurs during the early years of illness when the disorder is at its most virulent and the adaptational task is most overwhelming for patients and families. Clinical services generally are tenuously involved with many patients during this phase, and though there is a crucial need for highly assertive treatment, they have not offered proactive psychological interventions designed to reduce demoralization and suicide risk. There is preliminary evidence that such a focus may be helpful for the subgroup at especially high risk (Power et al., 2003). Antidepressants are similarly underutilized in schizophrenia, and clozapine, which has been shown recently to reduce suicide risk in schizophrenia (Meltzer et al., 2003), is withheld from many patients until much later in the course of their illness.

Similarly, although aggression is a frequent clinical problem—particularly during the acute phase of illness for a subset of patients—there have been very few studies of how psychological interventions could improve this situation. The adolescent and young adult period, especially in males, is the peak phase of life for offending behaviour (Rutter & Smith, 1995), yet there has been little study of, or preventive intervention for, ‘comorbid’ psychosis and offending behaviour.

To prevent relapse

The early years of illness, especially the first 2–5 years post-entry to treatment, are the peak period for experiencing a relapse of the disorder (Birchwood & Spencer, 2001; Gleeson, 2001; Linszen et al., 1994; Robinson et al., 1999). While medication adherence is the most powerful factor reducing the risk of relapse, psychosocial interventions also have much to offer and warrant greater research and clinical interest.

To reduce harm from comorbid substance use

While comorbid substance use is a common clinical problem in early psychosis, there is little evidence that intervention is effective. Barrowclough et al. (2001) show some benefit in more established illness, however studies of intervention with early psychosis patients are still in progress (Edwards et al., 2002a; Kavanagh et al., 2002).

To reduce the risk of transition to psychosis from prodromal or ‘ultra high risk’

Psychological interventions to reduce symptoms and risk of transition in prodromal or ultra high-risk states are being actively developed and evaluated (Morrison et al., 2002; Phillips et al., 2002). Such approaches are likely to be very appealing if effective.

**KEY PRINCIPLES FOR PSYCHOLOGICAL INTERVENTION
IN EARLY PSYCHOSIS**

Psychological interventions in early psychosis should be developed and delivered according to several general principles:

- Psychological interventions should be based on clinically testable theories in individuals and groups of patients.
- Psychological interventions should be highly compatible with biological models of vulnerability and of disorder.
- Psychological interventions should be pragmatic in terms of length and depth of intervention.
- Psychological interventions should be offered as part of a multi-modal treatment approach.
- Given the extensive and variable needs of patients and families, a broad range of interventions should be available.
- Interventions should be sequenced according to phase of illness, because the pattern of needs and, hence, opportunity for psychological intervention varies according to phase.

The latter two principles will be briefly elaborated.

The Optimal Range of Psychological Intervention

Schizophrenia is an illness that happens to a person with a unique psychological makeup.
(Gabbard, 1994)

While the foundation for all interventions and for recovery is a healthy and stable relationship with the patient, a range of approaches is necessary to achieve this and to move beyond it. Many young people will find it very difficult to develop such a trusting relationship with a clinician because of their developmental stage, their previous experience of relationships with older people, a lack of experience and comfort with health and mental health services, and the disorganizing effects of the illness. Knowledge and training in a range of approaches is indispensable to the clinician. Crisis intervention, psychodynamic knowledge, cognitive-behavioural techniques, coping enhancement strategies, communication and educational strategies and group and family intervention skills are all part of the required repertoire. The use of these techniques and approaches should be directly linked to a careful assessment of needs and perceived needs of the patient and his or her family members at any given point in time. These needs evolve with time and the phases of the illness, and are affected by the response of the underlying disorder to drug therapies. The notion of a hierarchy of needs and capacities of the patient is helpful. The most urgent items—such as finding food, shelter, emotional support and a stable and secure environment—must be dealt with first (EPPIC, 2001). Unless these needs are met, the task of addressing other key needs, even central ones such as medication adherence, will be undermined (Hogarty et al., 1997a). Even when the basic human needs are less stark, working alongside the patient in an advocacy and case management mode to tackle real-life problems demonstrates a commitment to the patient and family which builds trust and opens the door to more ambitious recovery goals. This sort of trust is vital if there is to be a chance of overcoming stigma, denial, tendencies to act out destructively, especially via substance abuse and an understandable failure to cope. An active therapeutic role which should move beyond the confines of office-based intervention can be provided without raising expectations too high or risking ‘over-involvement’ if the therapist is confident, energetic, well-trained and supervised. In most settings, the much greater risk is one of under-involvement and low expectations which harm the patient and increase the risk of demoralization.

How far one can go in moving on to address other internal and interpersonal problems in the person's life depends on the resources and capacities of the patient. For most patients, a return to pre-illness capacity and potential would be a successful outcome. For some others, taking a broader view of additional comorbidity and mental health needs may give the patient an opportunity to tackle other problems in his or her life. Psychodynamic understanding can be useful here provided it is mobilized within an active and antiregressive structure, such as has been developed in cognitive-analytic therapy. Elsewhere I have outlined a simple three-level model to grade the complexity of interventions in early psychosis (McGorry, 2000). Levels 1 and 2 include psychoeducation, crisis support, supportive psychotherapy, and relapse prevention strategies, and should be available to all patients. Level 3 includes CBT for early treatment resistance, suicide risk reduction and substance abuse, and should be offered to subgroups on a needs basis.

The Sequence and Phase-Oriented Delivery of Psychological Intervention

The range of skills referred to above need to be tailored to the phase of illness and influenced by the mental state and level of engagement of the patient. The key phases identified are the prepsychotic phase, the first episode of psychosis, the early recovery period (6 months) and the late recovery period (6 months to 5 years). During the prepsychotic phase it is possible to engage a subgroup of patients who are help-seekers and are at demonstrably increased risk of progressing to a fully fledged psychotic disorder (Phillips et al., 2002; Yung et al., 1996). Psychological interventions may reduce the risk of such progression and may delay or obviate the need for drug therapies, at least in some patients (McGorry et al., 2002; Morrison et al., 2002). The quality and content of such interventions differs from what is required at later stages of illness. Within the first psychotic episode, the sequence of interventions flows from the level of accessibility and engagement of the patient, which in turn depends on mental state, time with the service, and a range of factors intrinsic to the patient, the clinician and the context. The notion of graduating from one level to the next (Hogarty et al., 1997a, 1997b), as well as defining subgroups with special needs, are useful ways to focus specific strategies. Certain needs emerge at predictable time periods, e.g. treatment resistance, psychotic relapse and suicide risk, and hence should be addressed in a timely manner during the phases of recovery. Integration with drug therapies is fundamental and requires close cooperation and joint sessions with the psychiatrist and clinical case manager.

FUTURE

The revival of interest in psychological interventions in schizophrenia and psychotic disorders generally has particular relevance for patients with early psychosis. If these treatments do indeed have a part to play in the optimal recovery of patients with these disorders, then they are likely to be most effective if offered during the early stages. There are certainly many needs identifiable for which psychological interventions are appropriate and necessary and it seems clear that optimal recovery will not occur or will be more difficult to achieve in their absence. It is equally clear that the resources to create, evaluate, translate and fully mandate this element of treatment have not yet been mobilized in a sufficiently substantial way to meet this challenge. The scale of such an undertaking is similar to the international endeavour, which has underpinned the replacement of typical antipsychotic

medications by the atypical agents over the past decade. Even this process is incomplete, despite the massive investment involved. The creation and implementation of evidence-based psychological interventions and a service system to support them will arguably require even greater investment and culture change in most countries.

Many fundamental questions remain unanswered. The timing, content, depth and dose of the currently available therapies has not been explored. Some of the logic and rigour of research designs from pharmacology need to be adapted and applied in psychotherapy research in early psychosis. These include 'dose-finding' studies, studies examining the optimal timing, combining and sequencing of treatments, matching of treatments to subgroups, integration of drug and psychological interventions in multicell designs as has occurred in depression, and cost-effectiveness studies of differing forms and combinations of intervention. The extent and quality of our evidence-base still leaves much to be desired.

One of the major challenges for psychotherapy research generally is to demonstrate the value of special technical content of any kind. Most of the benefit of psychological intervention inevitably flows from so-called 'non-specific' factors such as the therapeutic alliance, trust, hope, optimism and continuity of care. These elements need to be acknowledged and fully exploited in clinical practice, however there is a problem if we find it impossible to show that any additional focus or expertise contributes further benefit. Can CBT really reduce the impact of hallucinations and delusions? Can suicide risk be reduced in patients at high risk through specific technical interventions? Can we reduce the harm resulting from substance abuse? If this is not possible, then the current enthusiasm for psychological interventions will once again dissipate. One of the nails in the coffin of psychoanalytic psychotherapy in schizophrenia was the failure to demonstrate an advantage for insight-oriented psychotherapy over supportive psychotherapy (Gunderson et al., 1984), despite the fact that both forms of intervention were probably helpful to patients. The demise of the one accepted theoretical paradigm supporting psychological intervention in schizophrenia has justified serious personal neglect of patients. While the current situation for CBT in psychosis looks more promising for severe forms of psychosis (Sensky et al., 2000), the results of some research in early psychosis are not yet very compelling (Jackson et al., 1998; Lewis et al., 2002). Better research designs, multicentre studies and integrative designs are needed to clarify and demonstrate the role and complementary value of psychological interventions in early psychosis.

On the positive side, in recent years there has been a significant international effort to tackle these issues and develop a set of psychological and psychosocial interventions for patients and families with early psychosis. Some of this effort is reflected in the pages of this monograph and demonstrates that a beachhead has been established from which further refinement and a stronger evidence base can be constructed. Unlike previous foundations, this one seems to lack the fatal flaw of reductionism and is more securely built on biopsychosocial principles. If this is so, it will not only survive but will benefit from and enhance future advances in drug therapies.

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