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FIRST EPISODE PSYCHOSIS: TWO CASES TO ILLUSTRATE THE ROLE OF COGNITIVE BEHAVIOUR THERAPY IN MAKING SENSE OF UNUSUAL EXPERIENCES

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Abstract. This paper describes two cases involving the use of cognitive behavioural therapy (CBT) to treat the positive symptoms of schizophrenia. In both cases the individuals were experiencing acute psychotic symptoms during their first admission to hospital. Each case illustrates how CBT was used to tackle a particular issue pertinent to the delivery of treatment at this early stage in the development of an individual's experiences of psychotic symptoms. Case one describes therapy with a young person of 17 where developmental issues are pertinent; case two describes the use of therapy to engage a person whose symptoms have ostensibly remitted. In both cases the promotion of understanding of the origin of their experiences was vital to the conduct of therapy. The implications of these issues to conducting therapy with this client group and the methods used to overcome them are discussed with reference to the future developments of cognitive behavioural therapy for use with this client group.

Keywords: Acute psychosis, first episode psychosis, cognitive behaviour therapy, therapeutic alliance, formulation, stress-vulnerability model.

Introduction

The usual first line treatment for acute psychosis is anti-psychotic medication (British Psychological Society, 2000) combined with admission to inpatient or acute day-hospital services for those experiencing the most distress or disruption. It is unusual for people to be offered psychological treatment to reduce the severity of the psychosis during the initial stages of the psychotic illness (Haddock, Morrison, Hopkins, Lewis, & Tarrier, 1998a).

Psychosocial interventions have been found to reduce the distress associated with psychotic experiences and also reduce the intensity and frequency of the experiences themselves (Kuipers et al., 1997; Tarrier et al., 1998a; Sensky et al., 2000). It is increasingly recognized that psychosocial interventions can reduce the probability of relapse. "Relapse rates" can be reduced by as much as 50% by including psychosocial interventions (Hogarty & Ulrich, 1998).

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Four randomized controlled trials have shown that cognitive-behaviour therapy (CBT) can have a beneficial effect on residual positive symptoms in chronic schizophrenia as an adjunct to usual treatment (Tarrier et al., 1993, 1998a; Kuipers et al., 1997; Sensky et al., 2000). An additional benefit was that treatment gains are maintained (Kuipers et al., 1997; Tarrier et al., 1998a) or increased (Sensky et al., 2000) at follow-up.

The studies cited above have all focused on people with chronic residual symptoms rather than acute illness. However, in relation to early schizophrenia, there is a strong treatment effect to traditional (medical and nursing care) treatments, with 80–90% of patients achieving remission by 10–12 weeks (Lieberman et al., 1992). It is clear therefore that a proportion of patients with first episode schizophrenia are going to have an improvement in their symptoms without adding CBT to the treatment regime.

What therefore might be the additional benefit of including psychological interventions at this early stage in the development of psychotic symptoms? The potential advantage of CBT treatment in the acute phase is to speed recovery (Drury, Birchwood, Cochrane, & MacMillan, 1996; Haddock et al., 1998a) or slow down the development and course of the illness and minimize the risk of subsequent episodes and disability (McGlashan, 1996; Drury et al., 1996; Birchwood, McGorry, & Jackson, 1997; Haddock et al., 1998a).

The SoCRATES group conducted a randomized control trial where the "early intervention" has focused on CBT for positive psychotic symptoms actually during the first or second (if within 2 years of the first) acute episode. Lewis et al. (2002) report the acute phase outcome of the SoCRATES trial, which was designed to examine the efficacy of CBT compared to treatment as usual in patients with DSM-4 schizophrenia or related disorders admitted to day- or inpatient care. The sample included only those experiencing acute symptoms for the first (80% of the sample) or second time (if occurring within 2 years of the first). It was discovered that those receiving CBT or supportive counselling (SC) showed faster recovery rates in the Positive and Negative Symptom Scale (PANSS) (Kay, Opler, & Lindenmayer, 1989) total score and the positive symptom subscales compared to routine care alone. CBT showed significantly faster recovery compared to SC when hallucinations were analysed separately.

The positive results of the Drury et al. (1996) and SoCRATES (Lewis et al., 2002) studies indicate that it may be appropriate and beneficial to apply psychological treatment at early stages of a psychotic illness and demonstrate that interventions during an acute episode are not only feasible but may also produce long lasting and significant benefits (Haddock et al., 1998a).

Working with people with early onset psychosis will identify unique problems. Developmental issues may be pertinent as schizophrenia tends first to be diagnosed in older adolescence/early adulthood (late teenage years and early twenties) (Cooper, 1978). This is a crucial time in many young people's lives as they are trying to find their sense of identity and purpose and learning many "life skills". It is also a time when people are influenced extensively by the world around them, by fashion, friends and family. Due to the early onset individuals may still be living at home under the care of their parents and may have yet to develop a complex understanding of their social environment and the skills that are required to survive independently.

Another complicating factor may be comorbid drug misuse. Drug and alcohol misuse is an increasing problem in adolescents and young adults and people with psychotic symptoms may be using drugs and alcohol (British Psychological Society, 2000). Illegal drugs such as cannabis, ecstasy, LSD, heroin, cocaine and amphetamines can cause symptoms that closely

resemble positive psychotic symptoms in individuals who do not have a mental illness. Although drug misuse is not thought to cause schizophrenia it can worsen the symptoms of the illness (Mueser & Gingerich, 1994), so tackling it early may be beneficial.

Psychosis is a potentially traumatic experience (McGorry et al., 1991), which has the capacity to change a person's usual way of construing themselves, their environment and their future. Isolated experience of the altered thoughts and feelings that constitute the positive psychotic symptoms and a lack of alternative explanation for their occurrence other than what sense the individual makes of it, understandably means that the individual believes that it is the world that has changed, rather than that they have an illness (Fowler, Garety, & Kuipers, 1995). They may be bewildered by their initial contact with mental health services and very sceptical of medical explanations. First contact with mental health services can be a frightening experience in its own right. Individuals may have been brought into hospital against their will and kept there on a section of the Mental Health Act (1983). The wards may contain other patients who are behaving in a bizarre manner. Patients may receive a diagnosis that means nothing to them other than their "lay person's" understanding of "schizophrenia" and the role of psychiatric hospitals and staff, which is largely influenced by media (mis-) representations (British Psychological Society, 2000). People who recover quickly with the aid of medical intervention may want to leave the hospital and mental health services as soon as possible as a way of coping with this traumatic experience. Drury et al. (1996), and Fowler, Garety and Kuipers (1995) suggest that an important part of psychological intervention is the integration of the experience of the disorder with an acceptable explanation to promote understanding of the symptoms of psychosis and protect or recover their sense of self.

The following paper is not aimed at evaluating the efficacy of CBT in early schizophrenia. Instead, by describing two cases in detail, we will illustrate how CBT can be used in practice. The cases we have chosen were selected because they highlight issues not normally found in a chronic population. These issues include working with a younger person and using therapy to engage a person whose symptoms have ostensibly remitted. By using an individual case formulation approach to the treatment of these patients, we were able to deal with these issues.

Method

Two patients were selected to illustrate particular issues from a cohort being evaluated as part of a larger study into the efficacy of CBT for early psychosis (The Socrates Study, see Lewis et al., 2002, for a detailed description of the study). All therapists were mental health professionals trained in CBT for psychosis. Debbie was seen by RS and Bill by KG. All therapists received regular individual supervision on all cases involving listening to the therapy tapes, with appropriate feedback.

Cognitive Behaviour Therapy for psychotic symptoms

The CBT interventions utilized in this study were built on widely accepted models of psychosis and established CBT techniques (Kingdon & Turkington, 1994; Tarrier, Wells, & Haddock, 1998b; Tarrier & Haddock, 2002). The two main aims of treatment were to reduce the frequency and severity of positive psychotic symptoms and to maintain treatment gains and prevent relapse after discharge. In order to achieve these overall aims in therapy, therapists had to spend time pursuing other factors that patients found stressful.

The unique aspect of CBT for this client group was the way in which the therapy was delivered. The pilot for the Socrates study (Haddock et al., 1999a) had shown that an intensive intervention was acceptable and thus the CBT process that had been developed for people with chronic psychosis was modified in key ways:

1. The stage of illness – patients were engaged in therapy within 10 days of their admission to an acute ward enabling intervention at the acute or recent onset stage of positive psychotic symptoms, at a time of high distress for the patient.
2. The delivery – patients received short intense bursts of therapy (2–3 sessions a week) up to a maximum of 20 hours over a 5-week period. This was followed by a further 4 hours of therapy spread over the subsequent 3 months.
3. The location – the therapists were proactive by seeing patients on the acute admission wards or in their own homes once they were discharged from hospital.
4. The engagement strategies – insight into their mental health problem was not a prerequisite. The initial focus of each intervention was on what the patient had identified to be their priority. These differed from those of people with more chronic problems.

The CBT was formulation driven and the specific techniques used in these two cases included: education, understanding symptoms in terms of a normalizing rationale (Kingdon & Turkington, 1994), ongoing monitoring of symptoms and risk, using guided discovery to aid belief modification (examining/collecting evidence, examining alternative explanations in a collaborative manner), hypothesis/reality testing, developing rational responses to beliefs, examining beliefs that cause distress that underlie psychotic symptoms, medication compliance and staying well action plans, which identified the role of stressors in relapse as well as monitoring symptoms (relapse prevention).

Measures

Each case was assessed by an independent rater pre and post intervention and at 9- and 18-months follow-up. The measures reported in this paper are the Positive And Negative Symptom Scale (PANSS: Kay et al., 1989) and the Psychotic Symptom Rating Scales (PSYRATS) Haddock, McCarron, Tarrier, & Faragher (1999b). The PSYRATS is made up of two scales, one to measure the dimensions of auditory hallucinations (HS) and one that measures the dimensions of delusions (DS). Though other measures were taken (Lewis et al., 2002), they were not critical to the understanding of this paper and have therefore been omitted for clarity. The measures we have reported are for interest only as the main aim of the paper is to describe the therapy.

Case studies

Case study one – Debbie. Debbie was a 17-year-old white female who lived with her parents and attended college. She was admitted briefly to an acute psychiatric ward with a diagnosis of schizophrenia following a psychotic episode while on an exchange visit to Germany. She was experiencing auditory hallucinations, persecutory delusional ideas and thought disorder. There had been an earlier psychotic episode of delusions and hallucinations following the break-up of a romantic relationship, though Debbie had not previously disclosed this. The salient points in this case, in addition to positive psychotic symptoms,

were:

1. Developmental issues and how to conduct the therapy;
2. Stressful developmental issues and how these were incorporated into an understanding of the onset of her symptoms;
3. The accessibility of environmental and personality factors contributing to stress.
4. The very recent onset of depression/negative symptoms.

Developmental issues and how to conduct the therapy. Debbie was on the borderline between childhood and adulthood and one of the problems in engagement in therapy for Debbie was around her worries about what therapy would entail. This was overcome by encouraging her to decide what she would need to help her feel less anxious. Because of her young age and living circumstances this involved the close proximity of her parents and allowing her to be in control of the pace of therapy. She was asked to decide upon the parameters of therapy e.g. option of the presence of a parent in the session (which she declined), breaks during the sessions etc. Her parents were extremely concerned and supportive and it was necessary to find ways to involve them without actually including them in the therapy. Debbie was encouraged to discuss the content of the session with her mother, and perhaps to play all, or parts of the audiotape of the session. It was hoped that this would help consolidate knowledge gained in the session and facilitate the completion of homework tasks. It actually had the beneficial effect of broaching difficult subjects with her parents and enabling Debbie to ask for particular forms of help from her parents.

Stressful developmental issues and how these were incorporated into an understanding of the onset of her symptoms. Engagement was enhanced by collaboratively agreeing the initial goal of therapy, which was to help her understand the development and maintenance of her problems. The particular stressors identified in the build up of her psychotic symptoms are typical of someone of her developmental stage. Debbie had concerns about her performance at school and was expected by her parents to perform exceptionally well in examinations. She was also concerned about the wellbeing of her friends, had doubts about her boyfriend's fidelity and also the health consequences of her naval piercing (a fear of infection). Since her admission to hospital she had become worried about what her peers would think of her on her re-introduction to college and whether she would cope with the studying.

To reduce her anxiety about her experiences it was agreed that trying to understand what had been happening in her life would be an appropriate focus of therapy. The chronology of events and her thoughts about them were explored. Debbie believed that a critical incident in the build-up of her current symptoms was being on an exchange visit and the need to communicate in a foreign language. At this time she was also concerned about her forthcoming language examination, and was worried about getting an infection from a recent piercing of her naval. She experienced extremely distressing recurrent visual images that she attributed to the stress of these factors. These images served to exacerbate the stress, and she started to have auditory hallucinations in the form of words from her deceased uncle, which she attributed to telepathic messages. Examination of her stressors and experience with reference to the vulnerability-stress model (Zubin & Spring, 1977) helped Debbie to understand how stress may have contributed to how her psychotic experiences may have arisen, which helped "normalize" them, making them more understandable and therefore less frightening (Kingdon & Turkington, 1994).

The accessibility of environmental and personality factors contributing to stress. The intervention included a large element of education about symptoms of psychosis and anxiety. Debbie benefited greatly from a session focusing on panic attacks using a vicious circle approach, including education and guided discovery about the role of misattribution of symptoms of anxiety (Clark & Ehlers, 1993). Debbie recognized that having a need for control, and a tendency towards perfectionism were important in the way she lived her life, and these were discussed in such a way that she was able to consider alternatives to the rigid way that she utilized these core beliefs at the time. Behavioural experiments were used to challenge these core beliefs and Debbie recognized over time that her underlying vulnerability towards a need for perfection and control were diminished slightly.

The very recent onset of depression/negative symptoms. Positive logging of minor and major successes helped Debbie to realize that there were lots of good things in her life and served also to elevate her mood a little. Activity scheduling and other behavioural techniques were utilized to minimize the effects of depression and of negative symptoms, which were contributing to Debbie's difficulties.

Staying well. Medication was discussed at several points over the course of therapy. In each situation a neutral stance was adopted, with Debbie being encouraged to consider both advantages and disadvantages of her medication when she expressed doubts (due to the presence of extra-pyramidal side effects). Towards the end of the course of therapy Debbie was encouraged to identify her own risk times, early warning signs and to develop action plans to cope, to maintain gains and deal with crises.

Outcome. At the end of the booster sessions Debbie was back at college. She was back in touch with her friends and had complied with her medication. She had not experienced any more psychotic symptoms. Helping her to understand her symptoms was considered by Debbie to be the most useful aspect of the therapy and her only criticism was that maybe she needed a longer period of intervention. The PANSS showed a reduction in symptomatology of approximately 50% from pre-treatment to 3 months into the study; this had reduced further by 9 months but had increased a little at 18-month follow-up. A similar pattern was observed with hallucinations and delusions using the PSYRATS DS and HS. Delusions scores reduced from 18 to 4 at 3 months with a further reduction to 0 by 9 months but had increased slightly to 8 at 18 months. Hallucinations appeared to decrease much more quickly than delusions; only one week after inclusion in the study the scores had reduced from 34 to 0. This reduction was maintained at 9 months. At 18 months there was an increase in hallucinations to 23, still lower than pre-treatment levels. Figure 1a shows the results of the PANSS total score and Figure 1b shows the results of the PSYRATS DS and HS data.

Case study two – Bill

Bill was a 29-year-old white male admitted for the first time to an acute psychiatric ward on a Section 2 of the Mental Health Act (1983) with Schizophreniform disorder. His positive symptoms included delusional ideas and bizarre behaviour. These experiences had resulted in him drawing pictures and writing on the walls of his flat and avoiding other people. This

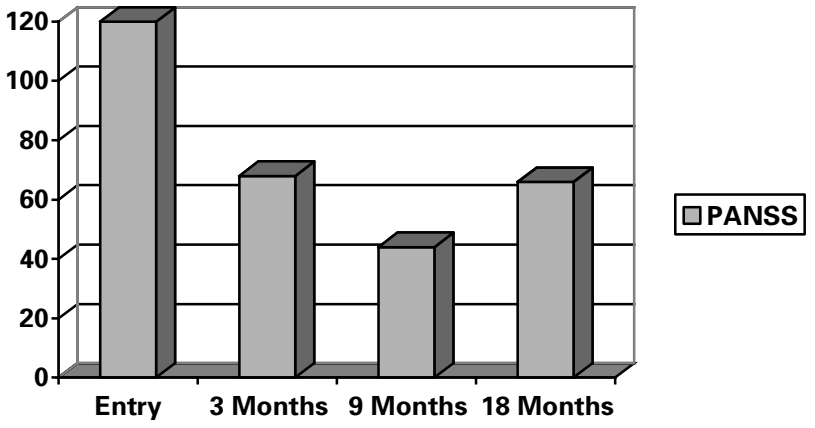

Figure 1a. Frequency graph showing PANSS total score over the 18-month follow-up period for Debbie

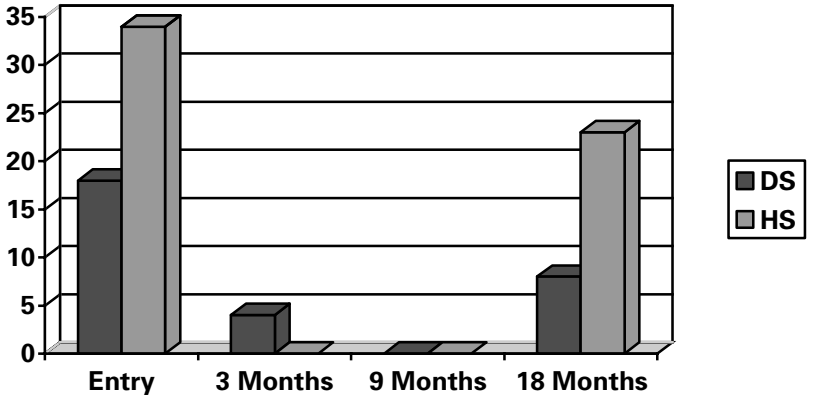

Figure 1b. Frequency graph showing the scores of the PSYRATS Delusion and Hallucination scales over the 18-month follow-up period for Debbie

was his first contact with mental health services. The salient points in this case in addition to positive psychotic symptoms were:

1. The patient's symptoms had (ostensibly) remitted and he believed that talking about them would bring them back.
2. High levels of subjective arousal and fear about the whole experience meant that he wanted to leave hospital as soon as possible and distance himself from everyone that he associated with the experience, particularly Mental Health Services. In terms of therapy, this required a specific focus on providing a model by which to understand the onset and possible recurrence of his symptoms.

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3. The acuteness of his symptoms allowed full exploration of the content of his psychotic symptoms and underlying beliefs and concerns about how he should be conducting his life.

The patient's symptoms had (ostensibly) remitted and he believed that talking about them would bring them back. The majority of Bill's positive symptoms had subsided in the 10 days before he saw a therapist, believing only his delusions of reference. He denied that these were a problem to him and did not think it would be useful to discuss them in therapy. It was only once the reason for his reluctance was discovered, i.e. that he thought talking about the symptoms would make them more likely to return, that this issue could be tackled. An element of education about the nature of psychotic symptoms was used very early on in therapy to try and reduce this belief and engage Bill in therapy. Engagement (or therapeutic alliance) developed further as a sympathetic, non-medical approach was taken to understanding the client's experiences. The client was more willing then to discuss his current symptoms, perhaps because his fear of them had reduced.

High levels of subjective arousal and fear about the whole experience required a specific focus on providing a model by which to understand the onset and possible recurrence of his symptoms. Bill was extremely distressed by being in hospital and the fact that his family had played an active part in his admission. Once Bill had agreed to participate in therapy a problem list, which addressed the patient's concerns at the time, was produced collaboratively. It was agreed that the goal of therapy was to understand what brought him into hospital (psychotic symptoms) and why they might have occurred (formulation for precipitating and maintaining factors). This involved exploring exactly what he had been doing and thinking that had warranted his family to worry so much and to try to help both him and the therapist understand why he had come into hospital.

A large amount of information was obtained about the events leading up to his admission and the associated thoughts, feelings, behaviours and meaning. These were interpreted in terms of "stressors", drawing on the vulnerability-stress model (Zubin & Spring, 1977) and put into context using a normalizing rationale (Kingdon & Turkington, 1994), which helped Bill to understand how his problems may have arisen.

His symptoms occurred against a background of life events that were important in terms of how Bill viewed his life. Six years prior to his admission to hospital Bill and his friends had been involved in taking illegal drugs, which had lead to the break-up of his relationship with his girlfriend and a fight through the courts for contact with his daughter Kim. His ex-girlfriend then committed suicide by burning herself, and her family and his stepdaughter Sally blamed Bill for her death. His best friend Steve then died of a drug overdose but Bill continued to make money by selling prescription tranquillisers and taking a concoction of illegal and prescription drugs himself. In the year leading up to his admission Bill was beginning to realize the futility of his lifestyle and how it did not match his long term goals, which were to be a respectable person and good father. He thought that his situation was "hopeless" that he would never "get his act together". He found this incredibly stressful as he searched for a solution. He was comparing himself to others in a detrimental way and thought that the only solution was to stop all his drug taking abruptly, which he managed to do 6 months before admission. It was hypothesized that this lead to physical symptoms of withdrawal, lack of sleep, and not looking after himself properly. In order to achieve his short-term goal of staying drug free, he began to

isolate himself and lost contact with friends. He subsequently developed positive symptoms of psychosis: delusional ideas, and bizarre behaviour. Writing things on the wall such as "Heaven and Hell", "Drugs are Evil", "Climbing the Ladder to Success". His family, to whom he was very close, were concerned due to his lack of contact with them and his unusual behaviour, so they called out his GP, who involved a psychiatrist and an approved social worker and Bill was brought into hospital.

Uncovering the events leading up to his admission allowed Bill to see how the particular events combined with his beliefs about how he should be living his life resulted in thoughts such as: "Am I to blame for my girlfriend's suicide?" "Am I ever going to be a respectable person?" "Am I a fit father figure?" These thoughts were interpreted as internal stressors and the physical effects of the abrupt cessation of illegal substances as environmental and physiological stressors. Their contribution to his "breakdown" was explored according to the stress-vulnerability model of psychotic symptoms (Zubin & Spring, 1977).

The patient and therapist discussed in detail how his perceptual experiences had changed recently, perhaps due to the abrupt cessation of the illegal drugs and the effect this had had on his behaviour and the concerns of others. Later interventions focused on delusional ideas directly. Delusions of reference were tackled during therapy by outlining recent examples, identifying what evidence he had to support his conclusion, discussing other likely explanations, and finding ways that he could check this out.

Staying well. Medication compliance work involved evaluating realistically the contribution medication had had on reducing the symptoms he was experiencing since his admission to hospital as he had originally denied that the medication had helped at all. Staying well was a vital issue that addressed the role of the previously identified stressors in his "breakdown" and future susceptibility. Potential stressors were identified through guided discovery of current worries and concerns for example money; bringing up his daughter, the relationship with his ex-girlfriend's family and his step-daughter, being a respectable person. Constructive approaches were taken to overcome current and future stressors and practical steps taken to rebuild his life, such as how to initiate contact with his daughter, challenging self-defeating beliefs about gaining employment etc.

The impact of illicit drugs, especially cannabis, was discussed, evaluating the advantages and disadvantages of their use.

Outcome. By the end of therapy Bill's delusional ideas had subsided and he had been discharged from hospital. He had got a job as a cleaner and re-established contact with his daughter whom he was looking after every Saturday. Bill worked hard in therapy and made several positive changes in his life to enable him to become what he considered a more "respectable" person and a better father to his daughter. Later on in the follow-up period he gave up his job as he was unable to see his daughter as often as he liked; however, this led to financial difficulties and stress.

The PANSS showed a reduction in symptomatology of approximately 50% from pre-treatment to 3 months into the study; this was maintained at 9 months but had increased a little at 18-month follow-up. A similar pattern was observed with delusions using the PSYRATS DS. Delusions scores reduced from 14 to 0 at 3 and 9 months but had increased to 11 at 18 months. Bill did not report any hallucinations pre-treatment and this remained unchanged. Figure 2a shows the results of the PANSS total scores and Figure 2b shows the PSYRATS DS data.

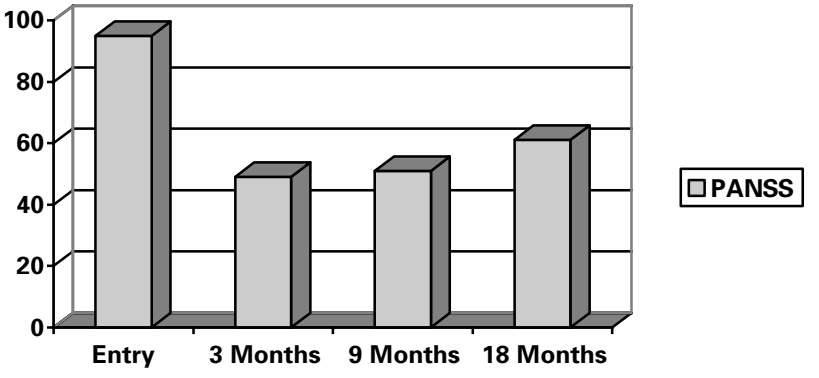

Figure 2a. Frequency graph of PANSS total score over 18-month follow-up period for Bill

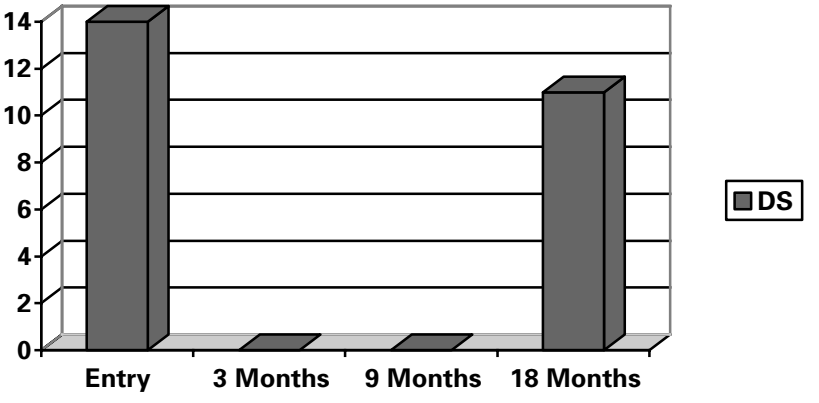

Figure 2b. Frequency graph showing the scores of the PSYRATS Delusion scale over the 18-month follow-up period for Bill

Discussion and conclusions

CBT has been shown to be an effective treatment for residual psychotic symptoms (Tarrier et al., 1993, 1998a; Kuipers et al., 1997; Sensky et al., 2000); however, the case studies above illustrate the use of CBT to treat acute first episode psychotic symptoms. The delivery and content of the cognitive behavioural therapy differed from that used in working with chronic patients in four important ways: 1) the stage of illness – patients were seen at a time of high distress during an acute episode of positive psychotic symptoms during their first such experience. 2) The engagement strategies – these reflected the different concerns of this acute, recent onset population. 3) The delivery – patients received short intense bursts of therapy. 4) The location – the therapists were proactive by seeing patients on the acute admission wards or in their own homes once they were discharged from hospital.

The early and acute stages of the illness presented particular problems and opportunities. High levels of subjective arousal, agitation and distress were evident in both patients, due to the positive symptoms themselves, but also as a result of their experiences of mental health

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services. Quick resolution of symptoms, or extreme fear at the consequences of expressing their concerns (e.g. admission to psychiatric hospital) may mean patients deny their problems (McGorry & Jackson, 1999). This was evident in the case study of Bill, who was reluctant to engage in therapy, wishing only to be able to leave hospital and "forget about the whole episode".

Another problem is that first episode patients are very unlikely to have been in therapy previously, and may not view talking about their psychotic experiences as either desirable or helpful. In fact, they may perceive the treatment they have received as unhelpful, unnecessary, or exacerbating their "problems" and may be mistrustful of the therapist (McGorry & Jackson, 1999). This was evident in the case study of Bill, who believed that talking about his experiences would be unhelpful, and Debbie who was anxious about the therapeutic process.

Other factors that were pertinent to this early psychosis group were developmental issues common in adolescence such as those illustrated by the case of Debbie, and the wide use of illegal drugs illustrated by the case study of Bill.

The problems associated with the stage of illness and the acuteness of symptoms required particular engagement strategies. The case studies illustrate that to engage this patient group in therapy it was necessary to change the initial emphasis from positive symptom reduction (common in working with people with residual symptoms), to understanding why they were in their current predicament, whether it be their admission to hospital or the unusual experiences they were having. This also provided particular opportunities that may be unique to this patient group.

The opportunity of engaging patients in a dialogue about their symptoms and recent life events leading up to this first admission, when the experiences are so recent and therefore accessible, is beneficial both in terms of the opportunity to:

1. Present a different model, developing an idiosyncratic version of the vulnerability/stress model and therefore promoting a psychosocial model rather than either a purely biological one or the person's own "psychotic" model, which promotes understanding.
2. Develop more realistic attributions of positive psychotic symptomatology.

Engagement in therapy was the first hurdle to conducting therapy. The quality of engagement affects the outcome of treatment for patients with psychotic disorders (Frank & Gunderson, 1990; Sarti & Cournos, 1990). The term "engagement" refers to the development of a helping, working or therapeutic alliance. It is acknowledged to be an integral component of cognitive-behavioural therapies (Beck, Freeman, and Associates, 1990). The therapeutic endeavour in both the case studies therefore initially focused on identifying subject areas that were perceived as useful and important for the patient, thus engaging them in therapy and helping to build a good therapeutic alliance.

Although there was a difference in the actual content and themes of therapy following the priorities set by the patients, there was some element of understanding their experiences that was important to each patient. Initial formulations were based on the stress-vulnerability model of psychotic symptoms (Zubin & Spring, 1977). A normalizing approach (Kingdon & Turkington, 1994) was used in each case to create a sympathetic, understandable picture of why their problems had developed and the relationship between stress, vulnerabilities and psychotic symptoms. Kingdon and Turkington (1994) suggest that "normalizing" the experience reduces the fear associated with positive psychotic experiences. In the case study of Bill and Debbie

this reduction of fear seemed to allow disclosure of more information, which enabled therapy to progress.

Providing alternative psychosocial explanations to their own (delusional) ideas or purely biological models may help the patients integrate the experience into their lives. Drury et al. (1996) and Fowler et al. (1995) suggest that an important part of psychological intervention is the integration of the experience of the disorder with an acceptable explanation to promote understanding of the symptoms of psychosis and protect or recover their sense of self. Thus, understanding reduces the fear associated with the experiences and enables the individual to retain some control. This may prevent first episode patients from falling into the sick role, which is one of the potential drawbacks of a purely medical model of treatment.

The early phase of the illness seemed to provide opportunities to identify the internal and external stressors that occurred prior to the current admission and seemed to precipitate this first episode of psychosis (in these two cases). The trace from "normality" to "psychosis" was fresh and easy to identify. Core beliefs, neurotic symptoms and personality factors were readily available to be identified as internal stressors and were open to discussion as the time period between their occurrence and therapy was a lot shorter (than with chronic patients). The roles of such factors in the build up to psychotic symptoms were elucidated in the case studies of Bill and Debbie. This identification of personal cognitive stressors and their role in psychotic symptoms was vital in helping the individual make sense of their experience and integrate it into their understanding of themselves and hopefully aid relapse prevention.

The early phase of the illness also had important implications for the amelioration of the psychotic symptoms themselves; the relative "freshness" of the positive symptom content meant that alternative explanations/attributions were easier to identify and test out. This was then linked back to the psychosocial model as an overall alternative explanation.

The value of CBT interventions, even when rapid recovery from symptoms has seemingly occurred, was illustrated by Bill's case. Understanding why he had been brought into hospital helped Bill address important issues in his life, which may have reoccurred very quickly on discharge from hospital without identifying and tackling them through therapy.

The above case studies illustrate some of the different challenges that patients with psychosis can pose in therapy and demonstrate that in the early stages of illness and when symptoms are acute, there is a considerable amount that a cognitive behavioural therapy approach can offer. The measures reported illustrate that there were changes in symptomatology for both patients and although there was some increase in symptoms over the follow-up period, neither returned to pre-treatment levels. Within the SoCRATES study, patients varied widely in their response to treatment (Lewis et al., 2002; Tarrier et al., 2004), so in a small case series such as this we use the data out of interest, rather than to make specific claims.

The number and frequency of sessions of CBT may have contributed to the slight increase in symptoms at follow-up, and there may be other ways of delivering the therapy that would prolong the benefits of therapy more effectively. Nonetheless, such cases may help to guide clinicians in some aspects of their work with people with acute early onset psychotic symptoms.

Implications for treatment

We report here on two cases where the patients responded well to the CBT; however, not all the SoCRATES patients did and further evaluation of the SoCRATES data may elucidate which patients are most likely to benefit from CBT. Nonetheless, intensive early intervention is

acceptable, appropriate and worthwhile for some patients. Conducting therapy in an inpatient setting is possible and probably makes attendance at therapy sessions more likely, though it has its own problems and difficulties.

The way the therapist engages with patients is influenced by the fact that patients are newly diagnosed or are awaiting a formal diagnosis. For them, this is a very confusing experience. Problem priorities for inpatients are more likely to be expressed as "getting out of hospital" or "understanding strange experiences" rather than getting rid of voices or delusional ideas. However, incorporating the cause and maintenance of positive symptoms into their agenda in a collaborative manner can be an important aspect of therapy. Medication treatment effects, which can be dramatic, do not preclude CBT interventions. In such instances, however, the emphasis shifts to developing a psychosocial model, in order to understand the onset of symptoms and the role of medication and then onto relapse prevention, concentrating on both stressors and symptom monitoring.

Certain adaptations to therapy were made, which related to the specific needs of this different patient group. The stage in the person's life, the phase of illness, their first contact with mental health services, meant that their needs in terms of psychological intervention differed from a more chronic group.

Working with early schizophrenia is a prime opportunity to present a psychosocial model that can be illustrated idiosyncratically because the trace from "normality" to "psychosis" is fresh and easy to identify and alternative explanations for positive psychotic experience are also easier to identify. Overall, the need to make sense of their whole current experience, not just providing alternative explanations for specific positive symptoms, is important and may be vital to reducing the likelihood of relapse. The vulnerability-stress model, which identifies idiosyncratic stressors, is helpful in providing personal explanations for the individual's experience, which they find helpful.

In order to be successful in therapy with such patients, knowledge of issues relevant to a young age group is vital for the therapist. These issues include: relationships with the opposite sex, drugs, occupation/education, fashions (body piercing, language), illicit drug use, and the possible traumatic effect of psychotic symptoms and the subsequent involvement in mental health services.

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