

Clinical Section

COGNITIVE THERAPY FOR PREVENTING TRANSITION TO PSYCHOSIS IN HIGH RISK INDIVIDUALS: A CASE SERIES

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Abstract. Early interventions for psychosis have recently received a great deal of interest. This is because research findings have indicated the importance of duration of untreated psychosis (DUP) in influencing future prognosis. Most interventions have so far centered around the early identification of first episode cases in an attempt to minimize the DUP. A further development of the early intervention strategy aims to identify high-risk cases prior to the onset of psychosis. Treatment of this at risk group could potentially prevent the onset of psychosis. In this paper we describe three cases from a randomized controlled trial designed to test the feasibility of a cognitive therapy intervention, to prevent the onset of psychosis. These are presented with formulations based on a recent cognitive model conceptualizing the onset of psychosis. Implications of this approach for future research and clinical practice are also discussed.

Keywords: Psychosis, early intervention, prevention, cognitive therapy.

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Introduction

This case series will provide three examples from a randomized controlled trial of early detection and cognitive therapy for preventing transition to psychosis in individuals at high-risk of becoming psychotic. This study has been designed to identify indicators of risk of transition to psychosis, to examine the effectiveness of cognitive therapy (CT) in reducing the transition rate in high risk individuals, and to determine the effectiveness of a monitoring intervention in reducing the duration of untreated illness should transition occur. It is too early to be able to reach a decision regarding the efficacy of our preventative psychological intervention; however, as early detection and intervention for psychosis are identified in the National Service Framework (DoH, 1999) and the National Plan for the NHS (DoH, 2000), we will present some of our experiences of working with this client group.

Rationale

The length of time between the onset of psychosis and subsequent treatment has been termed the Duration of Untreated Psychosis (DUP). The average length of DUP has been found to be approximately one year (Loebel et al., 1992; Barnes et al., 2000). A number of studies have found that a longer DUP is associated with poorer prognosis (Crow, Macmillan, Johnson, & Johnstone, 1986; Loebel et al., 1992) and one study found it to be the most important predictor of treatment response in a large group of first admission patients (Drake, Haley, Akhtar, & Lewis, 2000). There are concerns that the association between DUP and poor treatment response may merely represent a difference in the illness itself with longer DUP being associated with a more insidious onset and shorter DUP associated with an acute presentation. For a review of the evidence on DUP see Norman and Malla (2001).

The main clinical implication from these findings is that minimizing DUP would be advantageous to the client, their family and the treatment team. However, an average DUP of 52 weeks indicates that there are clear difficulties in being able to identify people who are in the early stages of psychosis. A recent study found that people experiencing their first psychotic episode have a fear about disclosing their symptoms and often become preoccupied with them (Moller & Husby, 2000).

The Duration of Untreated Illness (DUI) combines the initial prodromal period prior to the onset of psychosis and the DUP, with an average DUI being 2 years (Loebel et al., 1992). This period gives a potential window of one year prior to the onset of psychosis during which people actively seek access to some form of help (Johnstone et al., 1986). Researchers in Australia have demonstrated that it is possible to identify a high-risk prodromal group and found that 40% of their sample became psychotic over a period of one-year (Yung et al., 1998). Further work is being undertaken to refine assessment strategies for identifying these high-risk individuals (Miller & McGlashen, 2000) in an effort to further improve the ability to predict the onset of illness.

If it is possible to identify high-risk individuals it may also be possible, as Falloon (1992) has argued, to design interventions at this stage that might result in the primary prevention of psychosis or at least delay the onset. However, to utilize medication as a treatment option for this high-risk group would mean exposing the majority to side effects of neuroleptic medication, despite the fact that they will never go on to develop psychosis. This obviously would have undesirable ethical implications (Bebbington, 2000; Yung & McGorry, 1996).

A solution would be to employ a treatment strategy with little or no side effects and one that targets the problems that are causing concern. A psychological intervention would, therefore, be indicated. Cognitive Therapy (CT) for psychosis has been around for almost 50 years, starting with a single case study (Beck, 1952). The accumulating body of evidence to support this treatment option has now reached the point where randomized controlled trials have demonstrated the efficacy of cognitive therapy for both acute and chronic psychosis (Drury, Birchwood, Cochrane, & Macmillan, 1996; Kuipers et al., 1997; Tarrrier et al., 1998; Sensky et al., 2000). Cognitive therapy is also collaborative, educational and time-limited, reducing problems in engaging patients in comparison with pharmacological approaches. The patient and therapist work together on whatever is prioritized on the problem list (this may be, and often is, unrelated to psychosis). Another compelling rationale for the provision of CT to people at high risk of developing psychosis is the predominance of mood-related symptoms in psychotic prodromal states (Birchwood, 1996). CT is an extremely effective treatment for both anxiety disorders (Clark, 1999) and depression (Hollon, DeRubeis, & Evans, 1996). Therefore, CBT would appear the most appropriate treatment strategy to be offered during the initial prodrome in an effort to minimize symptoms and possibly prevent the transition to psychosis.

Identification strategy

In order to identify the high-risk population for this study we have utilized the criteria developed by Yung et al. (1998), who defined two groups who were classified as being at incipient risk of psychosis. Specific state risk factors operationally defined by the presence of either brief, limited intermittent psychotic symptoms (BLIPS) or attenuated (subclinical) psychotic symptoms made up one group. Duration and severity criteria for these symptoms were based on Brief Psychiatric Rating Scale (BPRS; Overall & Gorham, 1962) cut-off scores. Trait plus state risk factors, operationally defined by the presence of an at risk mental state plus either a family history of a first degree relative with a history of any psychotic disorder or a diagnosis of schizotypal personality disorder in the individual, accounted for the second group. In contrast to Yung et al. (1998), we used the Positive and Negative Syndromes Scale (PANSS; Fiszbein, & Opler, 1987) and scores on the BPRS were directly translated into PANSS scores. The PANSS is a clinician administered 30-item semi-structured interview consisting of 7 items assessing positive symptomatology (e.g. hallucinations, delusions, conceptual disorganization), 7 items assessing negative symptomatology (e.g. blunted affect, passive/apathetic social avoidance) and 16 items assessing global psychopathology (e.g. depression, anxiety, lack of insight, guilt). All items are scored between 1 (not present) and 7 (severe). In the following section, cases that represent the different routes into the study have been selected for discussion.

Although the lifetime prevalence of psychosis is approximately 3 : 100, the annual incidence is actually quite rare. Our identification strategy therefore required that we accessed as many potential sources of referral as possible. Agencies who have contact with young people experiencing distress associated with our identified symptom profiles were contacted. These include health settings such as primary care psychology, community mental health teams, drug and alcohol teams, and accident and emergency departments. We also liaised with local children's hospitals, University counselling services, colleges and voluntary youth organizations, and social services departments providing support for children in care. Regu-

lar liaison meetings and communication with these agencies have been maintained throughout the study.

A cognitive model describing the onset of psychosis

Recent psychological models of psychosis have tended to focus on symptoms as advocated by Bentall (1990). There are various examples of these models (Bentall, Kinderman, & Kaney, 1994; Morrison, Haddock, & Tarrier, 1995; Morrison, 1998), which have served to expand our theoretical knowledge of specific symptomatology and subsequently guide clinical interventions. However, most of these models have had little to say about the development of psychosis. Patients in a high-risk population may not have experienced well-formed psychotic symptoms. One of the guiding principles of cognitive therapy is that the disorder being treated should have a cognitive model that explains the onset and maintenance of symptoms and guides the treatment of these symptoms.

Recently, there have been models (Garety, Kuipers, Fowler, Freeman, & Bebbington, 2001; Morrison, 2001) developed that enable us to conceptualize the onset and development of psychotic symptoms. The model developed by Morrison (2001) focuses upon the interpretation of intrusions and specifically implicates the cultural unacceptability of the interpretation of the intrusion in determining whether someone is deemed to be psychotic. This suggests that similar processes are involved in the development of psychotic and non-psychotic disorders. Wells and Matthews' (1994) SREF model of emotional dysfunction specifically implicates faulty self and social knowledge, including metacognition and declarative and procedural beliefs. Initial onset of psychotic symptoms often seems to be related to an inability to generate alternative (culturally acceptable) explanations, frequently due to a lack of trusting or supportive social relationships that would facilitate the normalization of such interpretations (French, Morrison, Walford, Knight, & Bentall, 2001). The lack of such relationships is likely to contribute to faulty self and social knowledge (this may help to explain the short-term benefits derived from befriending interventions; Sensky et al., 2000). Our interventions are based on idiosyncratic case formulations derived from Morrison's (2001) model, incorporating patients' life experiences, self and social knowledge, intrusions and their interpretations of intrusions, and their emotional, behavioural, cognitive and physiological responses. This also facilitates the use of specific models of emotional disorders (e.g. Clark, 1999; Salkovskis, 1996; Wells & Matthews, 1994) where relevant.

Case studies

In this section we will present three cases to highlight our experience of working with this client group. They have been chosen to represent different routes into the study and also some of the difficulties we have experienced in undertaking this kind of work. All patients have given informed consent to their cases being written up although some details have been altered in order to maintain anonymity.

John (BLIPS route)

John, a 22-year-old man, was referred to the project by a local casualty department that he attended at the persuasion of his friends and relatives, who felt that he had become anxious,

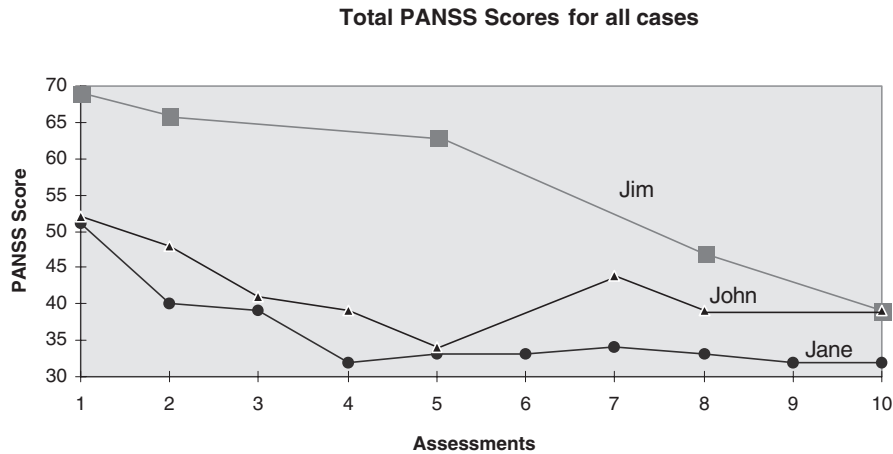


Figure 1. Title total PANSS scores for all three cases presented

unpredictable and was extremely angry at times. At casualty, the staff were uncertain about his presentation, although they felt that he might meet the criteria for our project. He was subsequently referred to the study and also for an out-patient appointment with a consultant psychiatrist. He was seen with members of his family a few days after the referral but, after the initial assessment, declined to become involved with the project (PANSS score can be seen in Figure 1). His family, however, maintained telephone contact with the project team and were concerned that he should receive some kind of help.

A week later, John attempted to borrow some money from one of his relatives, as he had spent a considerable amount when he was “unwell”. A member of his family telephoned the team for advice about whether they should give the money or not. They were keen to prevent any further episodes, which they felt would be inevitable if he was left untreated. The family independently decided to lend the money if John agreed to see a member of the team and John consented somewhat reluctantly to this. The initial meetings were spent engaging John in therapy, using a range of techniques. The time and location of meetings was negotiated, a shared language was utilized, whilst the therapist demonstrated a willingness to listen and understand. During the first few sessions, a guided discovery questioning style was used to enable John to think about the development of his difficulties. John acknowledged that something had been wrong and that he had been severely stressed, but also that he wanted to forget about his problems. He therefore displayed evidence of the sealing over coping style described by McGlashan (1987).

John was eventually seen for 14 treatment sessions. The therapist attempted to develop a shared problem list, in order to allow John to prioritize the things that he could work on. However, the only two items on this list were: 1. Wanting more money; 2. Wanting a job. A list of stressful life events, which had preceded John’s symptoms, was also developed. This led to a simple stress-vulnerability formulation of his difficulties. A full formulation can be seen in Figure 2. John’s father was keen to understand the process of therapy and John was happy for this to take place. Therefore, a session was arranged in which his father was seen in order to outline the rationale for the intervention and gather information.

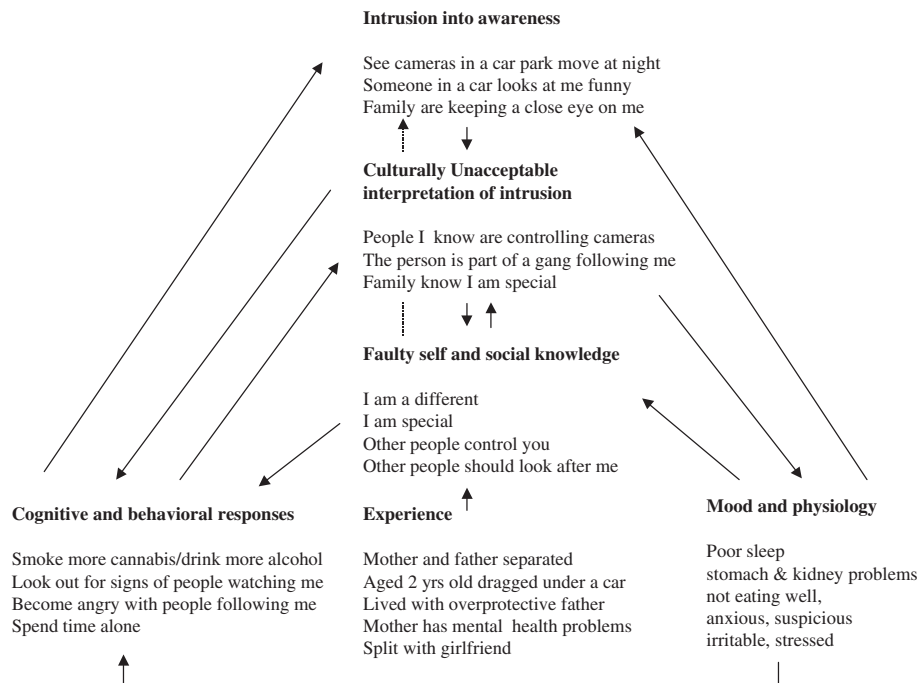


Figure 2. Case formulation for John

John also saw the psychiatrist around this time and there were still attenuated psychotic symptoms at this point. Following the appointment, John and his father felt there had been little opportunity to discuss matters and he was subsequently discharged from psychiatric care. Significantly, John had been adamant that he did not wish to take medication as a treatment option, but was content with a psychological intervention strategy.

John seemed reasonably convinced that people were following him at the point that he was having his ‘break down’. John had developed this belief after seeing a camera move, appearing to following his movements late one night in a car park (an intrusion into awareness). He had then begun to believe that people he knew were controlling the cameras and watching over him (a culturally unacceptable interpretation of intrusion). This belief was then maintained, because friends and relatives really did start to keep an eye on John because of his erratic behaviour. These events were obviously picked up by John through selective attention and monitoring the speech and behaviour of other people (cognitive and behavioural response) until he became convinced that people were following him. The therapist spent time examining evidence in relation to specific situations, attempting to discriminate between factual evidence and unsubstantiated conclusions. A critical incident was identified, which had occurred when he had driven to a friend’s house some distance away. On the way, he had felt that a large number of people driving on the motorway had been keeping an eye on him and they had been instructed to do so by a specific person. His evidence supporting this interpretation was that people had looked at him whilst he was driving on the motorway. Questions such as the number of people required for this conspir-

acy to succeed, the difficulty of organizing them, and the costs involved were carefully explored. John had not previously considered the specifics of his belief in this way, and quickly began to consider alternative explanations for his experiences (correcting faulty self and social knowledge). Other experiences were similarly explored.

Later sessions were spent working on John's problem of wanting to become active and obtaining a job. Initially, he was unsuccessful and when he did secure a job, it paid significantly less than his previous one prior to his illness. We discussed rehabilitation in the context of a physical illness and how this may be pertinent to him. However, despite this it became apparent that experiences of rejection had caused him some concern, and had led to depressive thoughts. John also disclosed that he experienced suicidal thoughts that were highly intrusive, as they were involuntary and unwanted. He said that he had no desire to end his life, but worried that, if he had these thoughts for long enough, he would be bound to act on them. The therapist discussed with him the nature of intrusive thoughts, and normalizing information based on the paper by Rachman and De Silva (1978) was provided. This appeared to be successful in challenging John's catastrophic interpretations of his suicidal thoughts and his thoughts about suicide reduced in frequency and duration with a subsequent reduction in distress and preoccupation regarding these thoughts.

Towards the end of his treatment, the death of a close relative caused John considerable distress. Whilst drinking in a local pub with friends who knew the deceased, he started to have a panic attack. Subsequently, he again started to believe that he was "going mad". This led to him avoiding people and isolating himself in case they recognized what was happening to him. His sleep pattern deteriorated, and he spent long periods of time awake at night worrying. In the session following this, he was clearly having difficulty communicating and his speech was slowed and vague.

The therapist spent time isolating cognitions associated with the panic attack, the key catastrophic misinterpretation being "I am going mad". The therapist also discussed John's safety behaviours, which he believed prevented others from observing his onset of madness, for example slow, considered speech and avoiding people. A formulation of these behaviours and experiences was presented to John. He made a fairly speedy recovery from this episode and, at the following appointment, had significantly reduced his safety behaviours and was much more active. His sleep pattern and concentration had improved as a consequence, and he no longer believed that he was going mad.

John has obtained a job similar to the one he had prior to his BLIP. All suicidal thoughts, ceased, he was no longer paranoid, and he recognized the links between his thoughts, feelings and behaviour. He was provided with an early warning sign package and also a blueprint (a summary of therapy with major points included such as formulations, experiments, and challenges using evidence for and against thoughts) of therapy on audiotape, as this is the medium he preferred.

Jane (attenuated symptoms route)

Jane, a 22-year-old woman, was referred by her GP. He had seen a leaflet that briefly described the project, which had been sent to all of the GPs in the area. Jane was referred to the study because she felt that people were talking about her. This had arisen after she had begun to experience intrusive thoughts about harming her young child. Jane felt that people might be able to read her mind and that they might be able to see what a bad mother

she was. She avoided going out as a consequence and was unable to continue her work as a dinner lady. Jane was assessed by one of our team and her PANSS scores are presented in Figure 1. She entered the study via the attenuated symptom route. Jane was randomized to the treatment condition and seen for a total of 11 sessions over a period of 4 months. A final booster was offered but was not felt to be necessary by Jane.

The initial session focused upon engagement and assessment. At Jane's request all sessions took place at her GP's surgery and at times that were convenient and negotiated. This enabled Jane to feel that she had some control over, and was contributing to, the therapy process. At the initial assessment Jane was encouraged to describe her problems. She was clearly frightened but was able to disclose that she was having unwanted thoughts about harming her daughter. She was very clear that she had no intention of acting on these thoughts but was terrified that, if she thought something then there was a possibility of it happening (thought-action fusion, as described by Rachman, 1993). She was also concerned that other people may be able to read her thoughts and that they might arrange to have her daughter taken away from her. To avoid this happening, she was isolating herself and finding it difficult to take her daughter to the playgroup, which she normally attended. Finally, Jane felt that she must be a bad or evil person for being unable to control her thoughts.

She had not disclosed these fears in such detail to anyone previously and had concerns that the therapist would act upon what she had said and have her daughter taken away from her. One aspect of CT is to try and achieve an early success experience, as this can alleviate distress for the patient, give hope and also enhance engagement. Merely allowing time for Jane to disclose her symptoms, being interested in hearing about her thoughts and wanting to understand what was happening was an important strategy for engagement. The assessment clearly indicated that her thoughts were intrusive in nature, and it was her fear of acting on her thoughts and the belief that others may read her thoughts that drove the distress. The therapist's apparent lack of fear for her daughter's safety was a significant comfort to her.

The main intervention in the session was to test the belief Jane held about the need to control her thoughts. Jane did not disclose these intrusions and concerns about people reading her thoughts because of her fears about the consequences, which served to maintain her faulty self and social knowledge. In common with many people with obsessional difficulties, when Jane experienced a problematic intrusive thought she attempted to force it out of her mind using thought suppression (Salkovskis, Forrester, Richards, & Morrison, 1998). Jane felt that this strategy should be effective, and therefore agreed to test out how effective it was. She was asked not to think of a pink rabbit for 30 seconds, as suggested by Salkovskis and Kirk (1989). The result was that she immediately began to think of and picture in her mind a pink rabbit (the paradoxical effect of thought suppression – see Wegner, Schneider, Carter, & White, 1987), which served to enable normalization of her experiences. It also served to indicate that her strategy may not be the most effective and in fact may well increase the intrusions in terms of frequency, duration and intensity. The homework task from this session was to listen to the audiotape of the session and also to consider what happens when she experiences one of her intrusive thoughts.

At the second treatment session Jane said that she had experienced a significant reduction in her intrusive thoughts in terms of frequency, duration and subsequent distress. Since the last session she had thought of the experiment with the pink rabbit; whenever she experienced an intrusive thought, this changed her affect from one of fear to one of amusement.

This was discussed using a simple formulation indicating links between intrusions, interpretations of intrusions, emotions, and behavioural and cognitive responses (including thought control strategies). The main agenda item in this session was her thoughts regarding harm to her son. During this session the research paper on normal and abnormal obsessions (Rachman & De Silva, 1978) was discussed (as in the previous case), further normalizing her intrusions. The homework task from this session was for Jane to take the article away and look at it, as the therapist wanted to hear her comments at the next session. A formulation of the case can be seen in Figure 3.

The next few sessions were quite short because Jane had difficulties organizing childcare and brought her young child along. These sessions built on the work of understanding intrusions and the development of strategies to deal with them by focusing upon recent specific incidents that Jane had experienced. Jane was encouraged to have thoughts about harming the therapist whilst holding some scissors (as recommended by Salkovskis et al., 1998). Jane was unable to do this as she felt that having those kind of thoughts was “not right”, consistent with work on metacognition by Wells and Matthews (1994). Despite this, Jane recognized the important link between having thoughts and subsequent actions. The aim was to modify her cognitive and behavioural responses to culturally unacceptable intrusions, to challenge aspects of her faulty self and social knowledge, and to measure changes in mood and physiology. The frequency, duration and severity of her intrusions continued to reduce over this period.

The focus of the next few sessions was on Jane’s concerns about hypochondriacal ideas, which appeared to have played an important part in the onset of her current symptoms. She

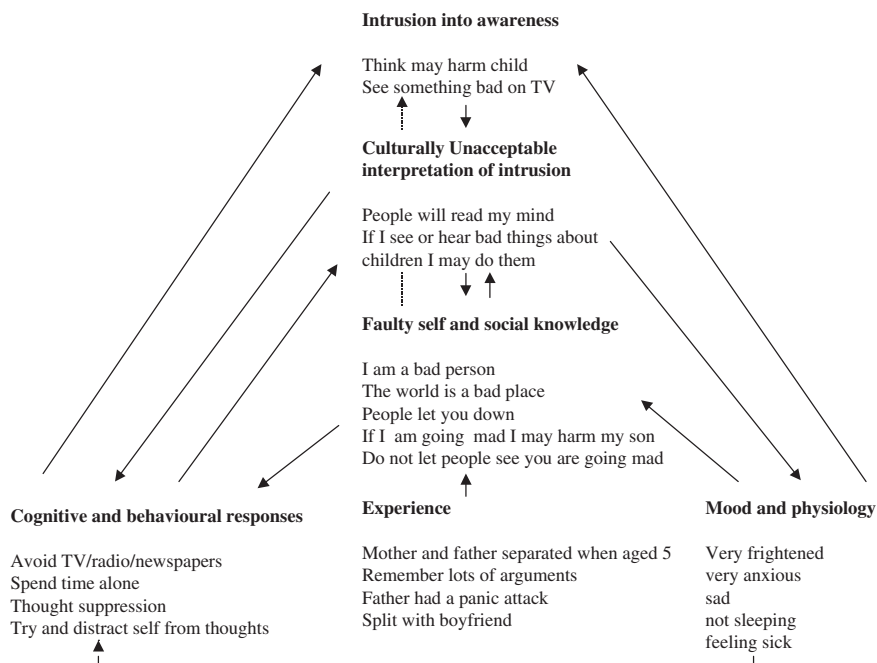


Figure 3. Case formulation for Jane

explained that she had experienced these for some time and that her mother also experienced these kinds of thoughts but was ambivalent about working on them despite frequent visits to her GP in the past because of these thoughts. It also transpired that her hypochondriacal ideas had played a part in the development of her sub clinical psychotic symptoms. Jane explained that in the early stages she had begun to worry about her own health, which quickly escalated to her own mortality. From this she started to worry about what would happen to her daughter if she died suddenly and from there started to worry about her daughter's health. At this point she began to worry that having these thoughts were tantamount to wishing it upon her daughter and she may well have wished her dead, leading to intrusive thoughts about her harming her. As implicated by the model, it was the interpretation of these intrusions that changed. Despite Jane's doubts about their importance, some time was therefore spent focusing not primarily on her hypochondriacal thoughts but her interpretation of what they meant. At this point Jane felt significantly improved and stated that further sessions were not required. Her improvement was reflected in her PANSS scores, which can be seen in Figure 1.

Jim (family route)

Jim was referred to the project by a social worker who was involved with another member of his family. Jim's mother had expressed concern about his behaviour and felt that he needed assistance. An appointment was arranged for assessment with Jim and his mother. He reported minimal psychotic symptoms (PANSS scores can be seen in Figure 1), that he was feeling depressed and anxious, and that he was not functioning as well as he had in the past. It was estimated that he had dropped 30 points on the Global Assessment of Functioning, GAF (APA, 1994) which is a simple 100-point measure of psychological, social and occupational ability designed to be concordant with DSMIV (APA, 1994). His biological father had a diagnosis of paranoid schizophrenia. He was therefore suitable for the study and was randomized to the treatment group.

Initially, Jim appeared somewhat guarded. When talking to the therapist, he would hesitate for long periods before responding to questions, explaining that he wanted to ensure that he gave correct answers. His main concerns were about wanting to obtain a good job or career, and his wish to have more money. He had recently stopped seeing the majority of his friends, because he had applied to join the army and was anticipating blood tests for cannabis. The majority of his friends smoked cannabis and he felt that, in order to stop doing so himself, he would have to avoid them. As a consequence, he spent much more time at his mother's house. This isolated him away from the environment in which he felt most comfortable and relaxed and left him in an environment in which he felt uncomfortable and frequently criticized.

His mother explained that Jim had started to behave in "odd ways". For example, he was spending increasing amounts of time in the bathroom, was spitting for no apparent reason, and sometimes rubbed his genitals when in the presence of his family. He had also been talking a lot about a neighbour who lived opposite in the apparent belief that he was having a relationship with her. He had asked her to go out for a drink but she had refused.

During the early stages of treatment, Jim disclosed that he had been hearing the voice of his neighbour and this had been going on for some time. In fact, he actively sought this experience as it made him feel happy and left him feeling that there was a possibility of

them having a relationship at some point. Jim would spend long periods of time staring from his bedroom window across at the house where his neighbour lived, listening out for her voice. He would also listen out for her voice when he was away from the house and feeling alone. At this point Jim had obvious positive beliefs about the voice, and allocated attention to listening out for it. Jim could not explain how he could hear the voice of his neighbour despite being some distance from her. He assumed that most people in love would have this experience.

The fact that these psychotic experiences had been occurring for some time suggested that Jim was actually psychotic prior to entering the trial, but had kept this secret because he was worried about what other people would think and how they would react. (We have since adjusted our assessment strategy in order to try and prevent acutely psychotic individuals from entering the study.)

The main items on Jim’s problem list included wanting more money, a new job, and a girlfriend, and these served as the focus of therapy sessions. As sessions continued Jim reported that he was spending increasing amounts of time actively listening for the voice of his neighbour. His mother was beginning to worry that his behaviour represented the earliest stages of the illness that had affected her ex-husband. The possible use of medication was discussed with Jim and his family, using a cost benefit analysis. Jim agreed to visit his GP if the therapist would recommend an appropriate medication and dosage (a low dose atypical was recommended). A case formulation is presented in Figure 4.

Jim became increasingly upset by the voices as both the content and interpretation of

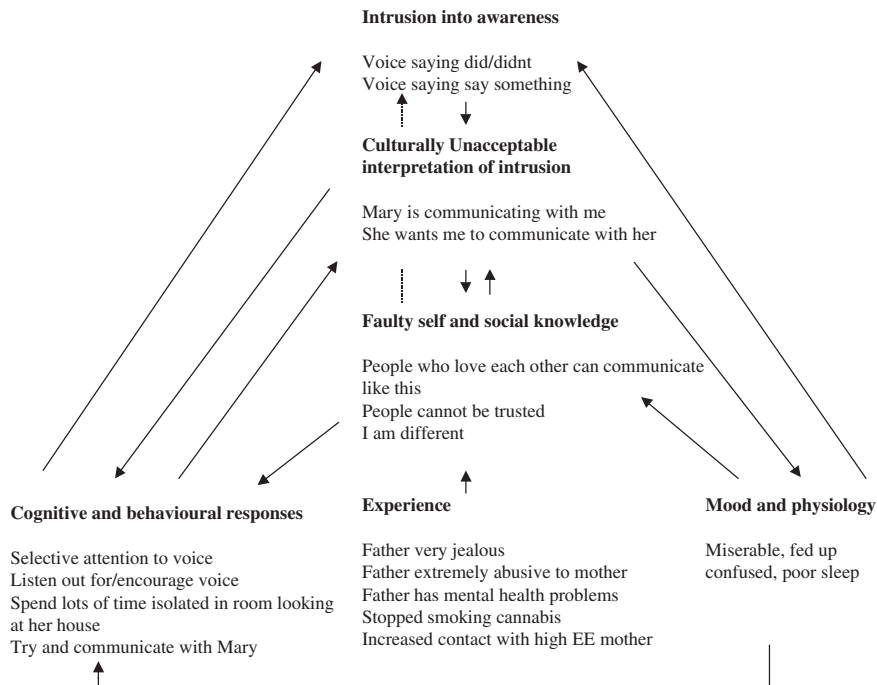


Figure 4. Case formulation for John

them became more negative. The voice became abusive on a few occasions (for example, calling him a “dickhead”). This changed his interpretation of the voices, which he now regarded as the efforts of his neighbour to humiliate him. Unfortunately, he threw a brick through the window of his neighbour’s house. Following this incident Jim was admitted to the local psychiatric unit on an informal basis.

Therapies from the team continued and family interventions were also initiated. The therapist also visited the family of the neighbour at their request, along with a social worker. They were understandably angry and were considering legal action to prevent Jim from coming near their house. This meeting enabled them to contribute to an action plan in case they suspected Jim was becoming ill in the future, thereby reducing tension between the two families. This was collaboratively arrived at with everyone involved as part of a wider early warning signs package.

Jim was discharged back to his own flat and is currently symptom free. However, he experienced transient voices for a while after his discharge and was worried about this, as it seemed to indicate that he might be vulnerable to relapse. Therefore, some time was spent discussing his voices in terms of intrusions, and this proved to be a useful strategy for eradicating any distress he experienced regarding them. It also served to significantly reduce the frequency of the voice.

Although the project failed to avert psychosis in Jim’s case, the team was able to ensure that his contact with services was a positive one and that he was able to get access to a wide range of treatments. His DUP was also reduced because the team engaged with him and advocated treatment at the earliest possible moment.

Summary of cases

These three cases represent potential routes into the development of psychosis. They highlight the fact that this high-risk group is not homogenous in terms of specific symptomatology. For this reason, identification strategies have to rely upon a range of entry criteria. All three cases indicate the importance of engagement and some of the difficulties in this process. However, once engaged these clients have collaborated effectively in the process of treatment. The model described directs treatment strongly towards metacognitive beliefs, selective attention strategies, and the manipulation of safety behaviours. Significantly, in the case that went on to develop psychosis there was a strong positive belief about the psychotic symptoms in the early stages, which again has implications for future treatment protocols. This is supported by evidence from Morrison, Wells and Nothard (2000) who found that positive beliefs about unusual perceptual experiences were the best predictor of predisposition to hallucinations in normal subjects, whilst negative beliefs about hallucinations may be associated with unhelpful coping strategies. Therefore, negative beliefs regarding the appraisal of the voice as being dangerous or uncontrollable may give rise to transition to psychosis. These factors need further research and may help in developing specific cognitive interventions to treat this group of ultra high-risk clients. This kind of intervention is particularly challenging for clinicians, as it fully incorporates the normalization strategies described by Kingdon and Turkington (1994).

Conclusions

In order to provide treatment for individuals at high risk of developing psychosis a clear strategy for identifying cases is required. The identification strategy discussed here is a

pragmatic approach, which relies upon help-seeking behaviours to initiate the process. We have found that engaging these clients is feasible when a problem-orientated approach is adopted. Significantly, the cases presented here have preferred a psychological approach to their problems over a medical one that requires pharmacological intervention. The representative nature of this high-risk group compared to individuals with established psychosis could be questioned. Pathways into psychosis, however, are complex and the issues raised by this group do appear to have strong similarities to people with established psychosis. We have attempted to describe some of the challenges and benefits of providing cognitive therapy for individuals at high-risk of developing psychosis. Tentative models are now being developed to provide clinical guidelines for working with these clients. This is a stimulating though difficult area of work, which strongly challenges the medical model of psychosis, replacing it with a psychological framework for conceptualizing not only the maintenance but also the onset of psychotic symptoms.

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