

Implementing cognitive–behavioural therapy for first-episode psychosis

JEAN ADDINGTON and JOHN GLEESON

Summary Significant symptomatic improvement after a first episode of psychosis is not matched by a similar improvement in functional outcome. Thus, increased attention has been given to psychological intervention, in particular cognitive–behavioural therapy (CBT), with the hope of enhancing functional recovery. Outcome trials of CBT for schizophrenia are few, in particular for the first episode, and have been occasionally criticised for their lack of significance compared with supportive therapies. We describe a modular CBT approach for those with a first episode of psychosis that addresses adaptation as well as both functional and symptomatic outcome and one that parallels the theoretical shift in CBT that has occurred in the last decade. Guidelines for integrating CBT into an early psychosis service are presented.

Declaration of interest None.

Treatment for first-episode psychosis has emerged as an important field in psychiatry because of the preventive possibilities (McGorry, 2000). Recovery from psychotic symptoms is common after the first episode, with 75–90% achieving remission from positive symptoms 1 year after treatment (Lieberman *et al*, 1993; Edwards *et al*, 1998; Addington *et al*, 2003a). However, even in the case of ‘best practice’ there are some limitations to biological treatments. Adherence rates to medication are notoriously low in patients with first-episode psychosis (Coldham *et al*, 2002). Some patients are characterised as ‘slow responders’, others are at risk of treatment

resistance even when adherence is addressed and even with ideal biological interventions, relapse rates are very high after the first year of follow-up (Lieberman *et al*, 1993; Robinson *et al*, 1999; Edwards *et al*, 2002). Most importantly, functional recovery (e.g. social, vocational, interpersonal) remains a major challenge. The illness remains disabling and problematic for patients and their families, as symptom improvement is not always matched with functional improvement (Tohen *et al*, 2000; Addington *et al*, 2003b). It is therefore critical that we develop treatment approaches to complement pharmacotherapy to achieve improved functional outcome. In addition, such treatment needs to focus on limiting psychosocial damage by offering sustained treatment during this critical early period when vulnerability is at its peak and ‘we have the best opportunity to provide a degree of damage control’ (McGorry, 2001, p. 156).

CBT FOR PSYCHOSIS: OUTCOME

One particular psychological therapy, cognitive–behavioural therapy (CBT), is gaining recognition as a potentially effective treatment for improving outcome among patients with schizophrenia (Cormac *et al*, 2002). Four separate randomised controlled trials (RCTs) have demonstrated the effectiveness of CBT. In a comparison of CBT *v.* routine care (pharmacotherapy) *v.* supportive therapy significantly more patients in the CBT group demonstrated improvement in positive symptoms (TARRIER *et al*, 1998). There was an advantage for CBT at the 1-year follow-up over routine care, but at the 2-year follow-up both CBT and supportive counselling demonstrated an advantage over routine care (TARRIER *et al*, 1999, 2000). A second trial (GARETY *et al*, 1997; KUIPERS *et al*, 1997) comparing CBT with routine care

demonstrated a greater reduction in symptoms for 21% of the CBT group *v.* 3% of routine care participants. A third study (SENSKY *et al*, 2000) demonstrated that CBT was effective in treating positive as well as negative symptoms in schizophrenia compared with a supportive therapy called ‘befriending’. Both forms of therapy led to significant clinical improvement in symptoms at the end of treatment, but at the 9-month follow-up only the CBT group had sustained improvements. In a fourth study of acutely ill in-patients (DRURY *et al*, 1996, 2000), those receiving CBT demonstrated a significantly greater reduction in positive symptoms over the first 12 weeks, a difference that was maintained at 9 months.

Very few CBT trials have focused on populations with first-episode psychosis. The SoCRATES trial used a large representative sample ($n=315$; 83% first episode) to compare a 5-week treatment package of CBT plus routine care with supportive therapy plus routine care and with routine care alone during the acute phase of the psychotic illness. The aim of the SoCRATES trial (LEWIS *et al*, 2002a) was to determine the impact of CBT during the acute phase of the psychotic illness on accelerating remission from acute symptoms. At 70 days there were trends towards faster improvement of positive symptoms in the CBT group compared with supportive therapy and routine care (LEWIS *et al*, 2002a). At 18 months’ follow-up, CBT demonstrated significant advantages in outcome over routine care and some advantages over supportive therapy (LEWIS *et al*, 2002b).

Cognitively Orientated Psychotherapy for Early Psychosis (COPE; JACKSON *et al*, 1999) aims to facilitate adjustment after a first episode of psychosis. In an open trial those receiving COPE demonstrated improved illness adaptation as assessed by an integration and sealing-over scale (McGLASHAN *et al*, 1977) compared with those who had not participated (JACKSON *et al*, 2001). It has been demonstrated (THOMPSON *et al*, 2003) that sealing-over/integration is an important factor related to recovery which is malleable over time.

In the RCTs that compared CBT with varied forms of supportive therapy, the positive impact of CBT was inconsistently diminished relative to the supportive therapy, although *never outperformed* (LEWIS *et al*, 2002a,b; TARRIER *et al*, 1999; SENSKY *et al*, 2002). In a comprehensive review, PENN *et al* (2004) consider the potential mechanisms

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behind this reported effectiveness of supportive therapy and conclude that there is an important role for ‘meaningful social contact’ with others. The clear implication from the review is that CBT should target social needs and goals, placing a greater emphasis on the interpersonal context and social consequences of relationships, including the therapeutic relationship.

CBT IN EARLY PSYCHOSIS PROGRAMMES

The results from clinical trials of CBT for psychosis and the need to develop psychosocial interventions for patients with first-episode psychosis make CBT a compelling treatment to consider as an integral part of early psychosis services. Comprehensive early intervention programmes are being developed throughout the world (Edwards & McGorry, 2002). Despite diversity in services that usually reflects the need for congruency with local settings, services usually offer similar components in order to integrate biological, psychological and social aspects of treatment. These typically are ongoing optimal pharmacotherapy and psychiatric case management, plus a range of psychosocial treatments that may include psychoeducation, individual CBT, phase-of-illness-specific groups, vocational services and a family component (Addington & Addington, 2001; Addington & Burnett, 2004). In implementing a CBT component for an early psychosis service several issues must be addressed: (a) the theoretical model on which the CBT component is based; (b) goals of CBT for early psychosis; (c) a clearly defined outline of the approach; and (d) a plan for training and delivery of CBT.

THEORETICAL BASIS OF CBT FOR EARLY PSYCHOSIS

Cognitive models of psychopathology have demonstrated the effectiveness of well-described interventions and of training models that include methodologies for assessing therapist adherence and competence (Vallis, 1998). Furthermore, since the early work of Beck *et al* (1979) a ‘second generation’ of models of cognitive therapy has developed giving attention to constructs, such as affect, early development, attachment, interpersonal processes and the therapeutic relationship (Guidano & Liotto, 1983; Safran *et al*, 1986; Greenberg & Safran, 1987; Safran & Segal,

1990; Ryle & Kerr, 2002). These ‘second-generation’ models have been incorporated into a meta-model of CBT (Howes & Parrott, 1991; Howes & Vallis, 1996), which places five major models of CBT on a dimension from rationalism to constructivism. These different models focus specifically on: (a) automatic thoughts; (b) faulty processing styles and dysfunctional assumptions regarding the self; (c) core cognitions or self-schema; (d) emotional and cognitive development; and (e) interpersonal and interactional factors in addition to cognitions. They are well described elsewhere (Beck *et al*, 1979; Guidano & Liotto, 1983; Safran *et al*, 1986; Greenberg & Safran, 1987; Safran & Segal, 1990; Howes & Parrott, 1991; Howes & Vallis, 1996; Ryle & Kerr, 2002). With the exception of Beck (Beck & Rector, 2000) and Perris & McGorry (1998), theorists of cognitive therapy do not address psychosis.

Indeed, as Perris & McGorry (1998) suggest, when developing cognitive interventions for psychosis it is clearly an advantage to expand other theoretical ideas to broaden and deepen the approach. In fact, Perris & McGorry go as far as anticipating the challenge as not only integrating different models of CBT but integrating the meta-theories underpinning CBT with theories of cognitive neuropsychology and another neuroscientific aspect of psychosis, such as the neuroimaging paradigms.

What is important for the development of CBT interventions in early psychosis is that this meta-perspective allows the CBT therapist to maintain both a conceptual and theoretical fidelity and yet blend models to maximise flexibility and pragmatism to address a range of problems in a range of cases (Howes & Parrott, 1992; Howes & Vallis, 1996). A further rationale for this broader approach is aptly stated by John Strauss:

‘What we are dealing with is not some stereotyped disease process stamped onto some shadowy “every person” but processes of the disorder that interact with a very important and differentiated person – a person that is goal directed, a person whose feelings and interpretations influence actions that in turn affect phases of the disorder or recovery’ (1989, p. 185).

Thus, CBT for early psychosis must address functional outcome and not just psychotic symptoms. Adopting only one model of CBT is too narrow and is deficient in addressing both the range of difficulties following the first episode as well as the heterogeneity of psychosis. Alternatively,

without this meta-perspective the different models of CBT could become so eclectic as to develop into an amalgam of techniques and strategies that appear cognitive or behavioural in nature and which are adopted and used without any real understanding of their implications. Thus, CBT for early psychosis can and should be based on sound theoretical models of cognitive therapy and psychopathology that lend themselves to further refinement and testing.

GOALS OF CBT IN EARLY PSYCHOSIS

The goals of CBT need to take into account not only the symptoms of the illness, but the impact of the illness on an individual. This includes isolation from families and friends, damage to social and working relationships, depression and demoralisation and an increased risk of self-harm, aggression and substance misuse. Persistent symptoms that remain after the early recovery phase are an additional problem and add to the already disrupted developmental trajectory. The goals for CBT are to increase the understanding of psychotic disorders, to promote adaptation to the disorder, to increase self-esteem, coping and adaptive functioning, to reduce emotional disturbance and secondary morbidity and to prevent relapse. When used as a treatment for delusions and hallucinations CBT aims to reduce the distress that these symptoms can cause and to provide the person with strategies and skills to manage residual symptoms in everyday life. The overall goal of CBT in early psychosis is to enhance both symptomatic and functional recovery and as such should be available to every one in an early psychosis programme.

MODULAR APPROACH TO CBT FOR EARLY PSYCHOSIS

We describe a modular approach of CBT for first-episode psychosis. These modules include: engagement, education, addressing adaptation, treating coexisting anxiety or depression, coping strategies, relapse prevention, and treating positive and negative symptoms, and have been guided by a wide range of texts and manuals of empirically supported treatment models that offer both unique and complementary perspectives of CBT for psychosis.

Three texts offer both a theoretical basis for and a systematic guide to the therapy (Kingdon & Turkington, 1994; Fowler *et*

al, 1995; Chadwick *et al*, 1996); Nelson offers a detailed description of CBT for symptoms as a practice manual (Nelson, 1997); and others offer a range of useful case studies (Kingdon & Turkington, 2002; Morrison, 2002). Drawing from the work of several of the above texts, *Systematic Treatment of Persistent Psychosis* (STOPP; Hermann-Doig *et al*, 2003) is the only manual that has a specific focus on CBT for first-episode psychosis. Additional works address the individualised formulation (Fowler, 2000), adaptation to the illness (Jackson *et al*, 1999), coping strategy enhancement (Tarrier, 1992), strategies for hallucinations (Haddock & Slade, 1996), relapse prevention strategies (Birchwood & Spencer, 2001; Gumley *et al*, 2003; Gleeson, 2004) and CBT strategies to enhance adaptive functioning (Penn *et al*, 2004).

One of the advantages of offering a modular approach is that there is a range of interventions to meet many of the needs of clients with first-episode psychosis and thus there is less need for 'exclusion criteria'. Phases of illness include acute in-patient, acute out-patient, in recovery, in remission and in prolonged recovery. It is recommended that CBT be introduced to patients with first-episode psychosis once medication, stabilisation and symptom remission has begun, in order to enhance the goal and expectation of optimal recovery. Typically, the length of treatment is approximately 20 sessions over 6 months. This allows strategies to be offered to those who may be experiencing a prolonged symptomatic recovery. Only a brief description of the modules is possible.

Engagement, assessment and formulation phase

The engagement phase includes the formation and development of the therapeutic alliance. Engagement occurs not only between therapist and client but between client and therapy. The range and extent of assessments can vary and routine instruments may have already been completed as part of the service. Instruments specifically relevant to the focus of the therapy can be used here. Assessment helps these individuals to realise that their experiences are understood.

Developing an individualised formulation begins at the first session of CBT and through several sessions in order to identify problem areas and to develop a sound understanding of the key elements leading to the psychotic disorder and of the factors

that maintain the problem areas. An assessment of the background to psychosis gives the psychotic episode a specific biological, psychological and social context. The therapist outlines his or her understanding of the aetiology, development and maintenance of the problem and supplies a rationale for the intervention and length and frequency of sessions. Developing a consensus about treatment goals facilitates an atmosphere of trust. The ultimate goal of the formulation is to help the individual make sense of the current situation and to establish a specific rationale for the direction the therapy might take. Further elaboration and refinement of the formulation occurs as more information is obtained during the course of therapy as well as in the context of more general psychiatric assessment.

Psychoeducation

There are many aspects of psychosis that patients need to understand. These include symptoms, diagnoses, theories of psychosis, individual explanatory models of psychosis, impact of substance misuse, medications, warning signs, nature of recovery, and agencies and personnel involved in treatment. In an integrated early psychosis programme such education may occur elsewhere, for example, as part of a group programme. Regardless, before embarking further with CBT for psychosis it is important that the individual has some understanding of the concept of psychosis and what it means for them, rather than just providing facts and information. This may occur at different times and even in different contexts depending on the individual's coping style and readiness to absorb the information.

Adaptation to psychosis

In this model, the approach focuses on the individual and addresses his or her understanding of the disorder, the disorder's impact on the self, the adaptation to the psychosis and self-esteem. These individuals need to realise their potential. They can 'take stock' of themselves by identifying strengths and limitations, expand coping skills, and make realistic plans for new directions. Learning how to distance oneself from the negative aspects of the environment and focusing on accomplishments can only serve to enhance self-esteem. Work at this point can include challenging social fears, increasing competence and improving self-esteem. Finally, addressing

adaptation can help patients engage in constructive activities to implement change and improve their functioning. The realisation that the changes they make reflect their own capabilities and that this contributes to their own recovery is powerful.

Treatment of secondary morbidity

Secondary morbidity is the result of a failure to adapt and includes depression, anxiety and substance misuse. In this phase individuals learn about the nature of the secondary condition. There may be a focus on cognitive challenging where underlying beliefs and assumptions are examined, challenged and replaced with more appropriate and rational beliefs and assumptions. This can be supplemented by group-based interventions for anxiety management or substance misuse.

Coping strategies

Coping strategies are designed to help with positive and negative symptoms and with the functional and emotional problems that arise from the symptoms. Target positive symptoms need to be identified. Available strategies include coping strategy enhancement (Tarrier, 1992) and distraction and focusing techniques for voices. Interventions for negative symptoms typically include behavioural self-monitoring, paced activity scheduling, assertiveness training and diary recording of mastery and pleasure. Specific behavioural and cognitive strategies are available to help patients work towards improved functional outcome despite symptoms.

Relapse prevention

Relapse prevention is experienced by 80–95% of patients over the first 2–5 years after the commencement of treatment (Robinson *et al*, 1999). A range of interventions and general principles, derived from CBT, have been described to address relapse prevention. These include monitoring for and intervening with early warning signs of relapse and cognitive restructuring of enduring self-schema which may be associated with elevated risk of relapse.

Techniques to address delusions and beliefs about voices

Specific techniques are well described for addressing positive symptoms. For auditory hallucinations, collaborative critical analysis of beliefs about the origin and nature

of the voice(s) is followed by the use of voice diaries, reattribution of the cause of the voices and generation of possible coping strategies. Interventions for delusions can include identifying precipitating and maintenance factors, modifying distressing appraisal of the symptoms and generating alternative hypotheses for abnormal beliefs.

DELIVERY OF AND SUPERVISION IN CBT

There are several options for delivery of CBT in an early psychosis service (Herrmann-Doig *et al*, 2003). First, the overall configuration of services needs to be considered in determining where in the process of treatment the CBT occurs. Cognitive-behavioural therapy can be offered by individual therapists as well as the case manager. This allows case management to continue independently but runs the risk that patients may become overwhelmed by multiple contacts with a range of service providers. Alternatively, CBT can be incorporated into the role of the case manager (cf. Turkington & Kingdon, 2000). This may be practical provided that there are adequate resources. The case managers can offer some CBT with the option of more intensive CBT, if required, being offered by a more experienced therapist. In this context, case managers require adequate supervision from an experienced CBT clinician.

To enhance the delivery of CBT in an early psychosis programme, there needs to be clarification of the different roles of those providing ongoing treatment as well as communication and agreement among team members about treatment plans. Second, clinicians offering CBT need to have access to quality training and quality ongoing supervision which focus on both general therapist skills as well as skills specific to CBT. Third, the service not only requires adequate resources to support the implementation of CBT but must have a clearly stated philosophy and operational policy consistent with the CBT that is being delivered.

DISCUSSION

Offering a specifically designed therapy as described here is based on the fact that the needs of patients with first-episode psychosis are not the same as those with more established forms of schizophrenia and the belief that individually tailored

therapeutic input in the early years may have an important long-term impact. Here, we have suggested a theoretically driven modular approach to CBT that places more emphasis than some of the earlier described models on the interpersonal and social context and the social consequences of symptoms than on symptoms of the illness (Penn *et al*, 2004).

There is a risk as early intervention programmes develop that having a CBT component is seen as desirable and may develop atheoretically out of a pragmatic need to offer some of the well-described interventions. First, an early psychosis service needs to carefully consider the nature and philosophy of their programme and how CBT will best fit in terms of treatment delivery, training and supervision. The CBT component then needs to be based on firm theoretical grounds to optimally offer the course of treatment most needed by these individuals.

Considerably more research both conceptual and empirical is required to evaluate the effectiveness of CBT in the treatment of psychotic disorders at this early stage. Despite recent criticism of CBT for psychosis (Turkington & McKenna, 2003), the very few quality RCTs that have been completed (only one with patients with first-episode psychosis) have, in fact, paved the way for future endeavours in CBT. They have demonstrated effectiveness not only for CBT in both chronic and early stages of psychotic disorders but also for intervention in the interpersonal context. The fact that the 'supportive therapies' demonstrated effectiveness, although never outperforming the CBT (Tarrier *et al*, 1999; Sensky *et al*, 2000; Lewis *et al*, 2002a,b), is a valuable addition to our knowledge in attempts to develop the best treatments for these individuals. Schizophrenia and other psychotic disorders remain disorders of interpersonal functioning more so than other psychiatric disorders and it makes sense to add the interpersonal focus as in the development of CBT for other disorders. We have a lot more to learn about the phase of illness at which to intervene most effectively (Lewis *et al*, 2002a).

Thus, before CBT is 'consigned...to history' (McKenna in Turkington & McKenna, 2003, p.478) there is a need for future research to determine the effectiveness of CBT in early psychosis services by including an interpersonal component, examining optimal timing of delivering interventions and considering a wider range

of clinical and functional outcomes. Our goal is to find the most effective strategies to help these individuals and we need to learn from these early trials to advance and develop our psychological treatments (Penn *et al*, 2004) and then to test their effectiveness.

REFERENCES

- Addington, J. & Addington, D. (2001)** Early intervention for psychosis: the Calgary early psychosis treatment and prevention program. *Bulletin of the Canadian Journal of Psychiatry*, **33**, 11–16.
- Addington, J. & Burnett, P. (2004)** Working with families in the early stages of psychosis. In *Psychological Interventions in Early Psychosis: A Treatment Book* (eds P. D. McGorry & J. F. Gleeson), pp. 99–116. Chichester: John Wiley.
- Addington, J., Leriger, E. & Addington, D. (2003a)** Symptom outcome one year after admission to an early psychosis program. *Canadian Journal of Psychiatry*, **48**, 204–207.
- Addington, J., Young, J. & Addington, D. (2003b)** Social outcome in early psychosis. *Psychological Medicine*, **33**, 1119–1124.
- Beck, A. T. & Rector, N. A. (2000)** Cognitive therapy of schizophrenia: a new therapy for the new millennium. *American Journal of Psychotherapy*, **54**, 291–300.
- Beck, A. T., Rush, A. J., Shaw, B. F., et al (1979)** *Cognitive Therapy of Depression*. New York: Guilford Press.
- Birchwood, M. & Spencer, E. (2001)** Early intervention in psychotic relapse. *Clinical Psychology Review*, **21**, 1211–1226.
- Chadwick, P., Birchwood, M. & Trower, P. (1996)** *Cognitive Therapy for Delusions, Voices and Paranoia*. New York: John Wiley.
- Coldham, E. L., Addington, J. & Addington, D. (2002)** Medication adherence of individuals with a first episode of psychosis. *Acta Psychiatrica Scandinavica*, **106**, 296–290.
- Cormac, I., Jones, C. & Campbell, C. (2002)** Cognitive behavior therapy for schizophrenia. *Cochrane Database of Systematic Reviews*, **2**, 1–46.
- Drury, V. M., Birchwood, M., Cochrane, R., et al (1996)** Cognitive therapy and recovery from acute psychosis: a controlled trial: II. Impact on recovery time. *British Journal of Psychiatry*, **169**, 602–607.
- Drury, V., Birchwood, M., Cochrane, R., et al (2000)** Cognitive therapy and recovery from acute psychosis: a controlled trial: 3. Five-year follow-up. *British Journal of Psychiatry*, **177**, 8–14.
- Edwards, J. & McGorry, P. D. (2002)** *Implementing Early Intervention in Psychosis*. London: Martin Dunitz.
- Edwards, J., Maude, D., McGorry, P. D., et al (1998)** Prolonged recovery in first-episode psychosis. *British Journal of Psychiatry*, **172** (suppl. 33), 107–116.
- Edwards, J., Maude, D., Herrmann-Doig, T., et al (2002)** A service response to prolonged recovery in psychosis. *Psychiatric Services*, **50**, 1067–1069.
- Fowler, D. (2000)** Psychological formulation of early episodes of psychosis: a cognitive model. In *Early Intervention in Psychosis* (eds M. Birchwood, D. Flower & C. Jackson). New York: John Wiley.
- Fowler, D., Garety, P. & Kuipers, E. (1995)** *Cognitive Behavior Therapy for Psychosis*. Chichester: John Wiley.

Garety, P., Fowler, D., Kuipers, E., et al (1997) London—East Anglia randomised controlled trial of cognitive—behavioural therapy for psychosis. II. Predictors of outcome. *British Journal of Psychiatry*, **171**, 420–426.

Gleeson, J. F. (2004) The first psychotic relapse: understanding the risks, and the opportunities for prevention. In *Psychological Interventions in Early Psychosis: A Treatment Handbook* (eds J. F. Gleeson & P. D. McGorry), pp. 157–174. Chichester: John Wiley.

Greenberg, L. & Safran, J. (1987) *Emotions in Psychotherapy*. New York: Guilford Press.

Guidano, V. F. & Liotto, G. (1983) *Cognitive Processes and Emotional Disorder: A Structural Approach to Psychotherapy*. New York: Guilford Press.

Gumley, A., O'Grady, M., McNay, L., et al (2003) Early intervention for relapse in schizophrenia: Results of a 12-month randomized controlled trial of cognitive behavioural therapy. *Psychological Medicine*, **33**, 419–431.

Haddock, G. & Slade, P. D. (eds) (1996) *Cognitive—Behavioral Interventions with Psychotic Disorders*. New York: Routledge.

Hermann-Doig, T., Maude, D. & Edwards, J. (2003) *Systematic Treatment of Persistent Psychosis (STOPP): A Psychological Approach to Facilitating Recovery in Young People with First-Episode Psychosis*. London: Martin Dunitz.

Howes, J. L. & Parrott, C. (1991) Conceptualization and flexibility in cognitive therapy. In *The Challenge of Cognitive Therapy Application to Non-Traditional Populations* (eds T. M. Vallis, J. L. Howes & P. C. Miller), pp. 25–41. New York: Plenum.

Howes, J. L. & Vallis, T. M. (1996) Cognitive therapy with non-traditional populations: applications to personality disorders and post-traumatic stress disorder. In *Advances in Cognitive Behavior Therapy* (eds K. S. Dobson & K. Craig), pp. 237–272. Thousand Oaks, CA: Sage.

Jackson, H., Edwards, J., Hulbert, C., et al (1999) Recovery from psychosis. In *The Recognition and Management of Early Psychosis* (eds P. McGorry & H. J. Jackson), pp. 265–307. Cambridge: Cambridge University Press.

Jackson, H., McGorry, P., Henry, L., et al (2001) Cognitively oriented psychotherapy for early psychosis (COPE): a 1 year follow-up. *British Journal of Clinical Psychology*, **40**, 57–70.

Kingdon, D. G. & Turkington, D. (1994) *Cognitive—Behavioral Therapy of Schizophrenia*. New York: Guilford Press.

Kingdon, D. G. & Turkington, D. (2002) *The Case Study Guide to Cognitive Behavior Therapy of Psychosis*. Chichester: John Wiley.

Kuipers, E., Garety, P., Fowler, D., et al (1997) London—East Anglia randomised controlled trial of cognitive—behavioural therapy for psychosis. I: Effects of the treatment phase. *British Journal of Psychiatry*, **171**, 319–327.

Lewis, S., Tarrier, N., Haddock, G., et al (2002a) Randomised controlled trial of cognitive—behavioural therapy in early schizophrenia: acute-phase outcomes. *British Journal of Psychiatry*, **181** (suppl. 43), s91–s97.

Lewis, S., Tarrier, N., Haddock, G., et al (2002b) Cognitive therapy improves 18-month outcomes but not time to relapse in first episode schizophrenia. *Schizophrenia Research*, **53**, 14.

Lieberman, J., Jody, D., Geisler, S., et al (1993) Time course and biologic correlates of treatment response in first-episode schizophrenia. *Archives of General Psychiatry*, **50**, 369–376.

CLINICAL IMPLICATIONS

- Cognitive—behavioural therapy (CBT) may be valuable for first-episode psychosis.
- CBT is considered as part of a comprehensive programme.
- CBT interventions can be tailored for individual patients.

LIMITATIONS

- There are limited outcome data on the effectiveness of CBT in early psychosis.
- Evaluation of first-episode services is needed.
- There are limited opportunities for training in CBT for psychosis.

JEAN ADDINGTON, PhD, Department of Psychiatry, University of Toronto, Toronto, Ontario, Canada; JOHN GLEESON, PhD, Department of Psychology, University of Melbourne, Melbourne

Correspondence: Dr Jean Addington, Centre for Addiction and Mental Health, 250 College Street, Toronto, Ontario, M5S 2S1, Canada. Tel: +1 416 535 6936; fax: +1 416 979 693; e-mail: jean_addington@camh.net

McGlashan, T. H., Wadson, H. S. & Carpenter, W. T. (1977) Recovery style from psychosis. *Journal of Nervous and Mental Disease*, **164**, 182–190.

McGorry, P. D. (2000) The scope for preventive strategies in early psychosis: logic, evidence and momentum. In *Early Intervention in Psychosis* (eds M. Birchwood, D. Fowler & C. Jackson), pp. 3–27. Chichester: John Wiley.

McGorry, P. D. (2001) The detection and optimal management of early psychosis. In *Comprehensive Care of Schizophrenia* (eds J. Lieberman & R. M. Murray), pp. 153–166. London: Martin Dunitz.

Morrison, A. P. (ed.) (2002) *A Casebook of Cognitive Therapy for Psychosis*. New York: Taylor & Francis.

Nelson, H. (1997) *Cognitive Behavioral Therapy with Schizophrenia*. Cheltenham: Nelson Thornes.

Penn, D. L., Mueser, K. T., Tarrier, N., et al (2004) Supportive therapy for schizophrenia: possible mechanisms and implications for adjunctive psychosocial treatments for schizophrenia. *Schizophrenia Bulletin*, **30**, 101–112.

Perris, C. & McGorry, P. D. (eds) (1998) *Cognitive Psychotherapy of Psychotic and Personality Disorders*. Chichester: John Wiley.

Robinson, D., Woerner, M. G., Alvir, J., et al (1999) Predictors of relapse following response from a first episode of schizophrenia or schizoaffective disorder. *Archives of General Psychiatry*, **56**, 241–247.

Ryle, A. & Kerr, I. B. (2002) *Introducing Cognitive Analytic Therapy: Principles and Practice*. Chichester: John Wiley.

Safran, J. D. & Segal, Z. V. (1990) *Cognitive Therapy: An Interpersonal Process Perspective*. New York: Basic Books.

Safran, J. D., Vallis, T. M., Segal, Z. V., et al (1986) Assessment of core cognitive processes in cognitive therapy. *Cognitive Therapy and Research*, **17**, 232–238.

Sensky, T., Turkington, D., Kingdon, D., et al (2000) A randomized controlled trial of cognitive—behavioral therapy for persistent symptoms in schizophrenia resistant to medication. *Archives of General Psychiatry*, **57**, 165–172.

Strauss, J. S. (1989) Subjective experiences of schizophrenia: towards a new dynamic psychiatry: II. *Schizophrenia Bulletin*, **15**, 179–187.

Tarrier, N. (1992) Management and modification of residual psychotic symptoms. In *Innovations in the Psychological Management of Schizophrenia* (eds M. Birchwood & N. Tarrier), pp. 109–131. Chichester: John Wiley.

Tarrier, N., Yusopoff, L., Kinney, C., et al (1998) Randomized controlled trial of intensive cognitive behavior therapy for patients with chronic schizophrenia. *BMJ*, **317**, 303–307.

Tarrier, N., Wittkowski, A., Kinney, C., et al (1999) Durability of the effects of cognitive—behavioural therapy in the treatment of chronic schizophrenia: 12-month follow-up. *British Journal of Psychiatry*, **174**, 500–504.

Tarrier, N., Kinney, C., McCarthy, E., et al (2000) Brief reports: two-year follow-up of cognitive—behavioral therapy and supportive counseling in the treatment of persistent symptoms in chronic schizophrenia. *Journal of Consulting and Clinical Psychology*, **68**, 917–922.

Thompson, K. N., McGorry, P. D. & Harrigan, S. W. (2003) Recovery style and outcome in first-episode psychosis. *Schizophrenia Research*, **62**, 31–36.

Tohen, M., Strakowski, S. M., Zarate, C. A., et al (2000) The McLean—Harvard first-episode project: 6-month symptomatic and functional outcome in affective and nonaffective psychosis. *Biological Psychiatry*, **48**, 467–476.

Turkington, D. & Kingdon, D. (2000) Cognitive—behavioural techniques for general psychiatrists in the management of patients with psychosis. *British Journal of Psychiatry*, **177**, 101–106.

Turkington, D. & McKenna, P. (2003) Is cognitive—behavioural therapy a worthwhile treatment for psychosis? *British Journal of Psychiatry*, **182**, 477–479.

Vallis, T. M. (1998) Treating difficult cases with cognitive therapy. In *Cognitive Psychotherapy of Psychotic and Personality Disorders* (eds C. Perris & P. D. McGorry), pp. 37–62. New York: John Wiley.