Psychological Interventions

Why, How and When to use in Early Psychosis

Orygen
The National Centre of Excellence in Youth Mental Health

EPPIC
Early Psychosis Prevention and Intervention Centre

Special thanks are extended to the clinicians from Orygen Youth Health Clinical Program (OYHCP) who made themselves available to contribute to this resource. OYHCP is the specialist youth mental health service located on the Orygen campus in Melbourne. For more than two decades, OYHCP has been a pioneer in the field of early intervention for emerging and severe mental illness. In that time it has become a world-leader in the development and provision of best-practice mental health care for young people: care founded on clinical expertise and the latest evidence. The integration of OYHCP's wealth of skills, experience and knowledge with Orygen's comprehensive range of research, clinical and knowledge transfer services enables Orygen to sustain a comprehensive academic health sciences centre at the forefront of innovation in youth mental health care.

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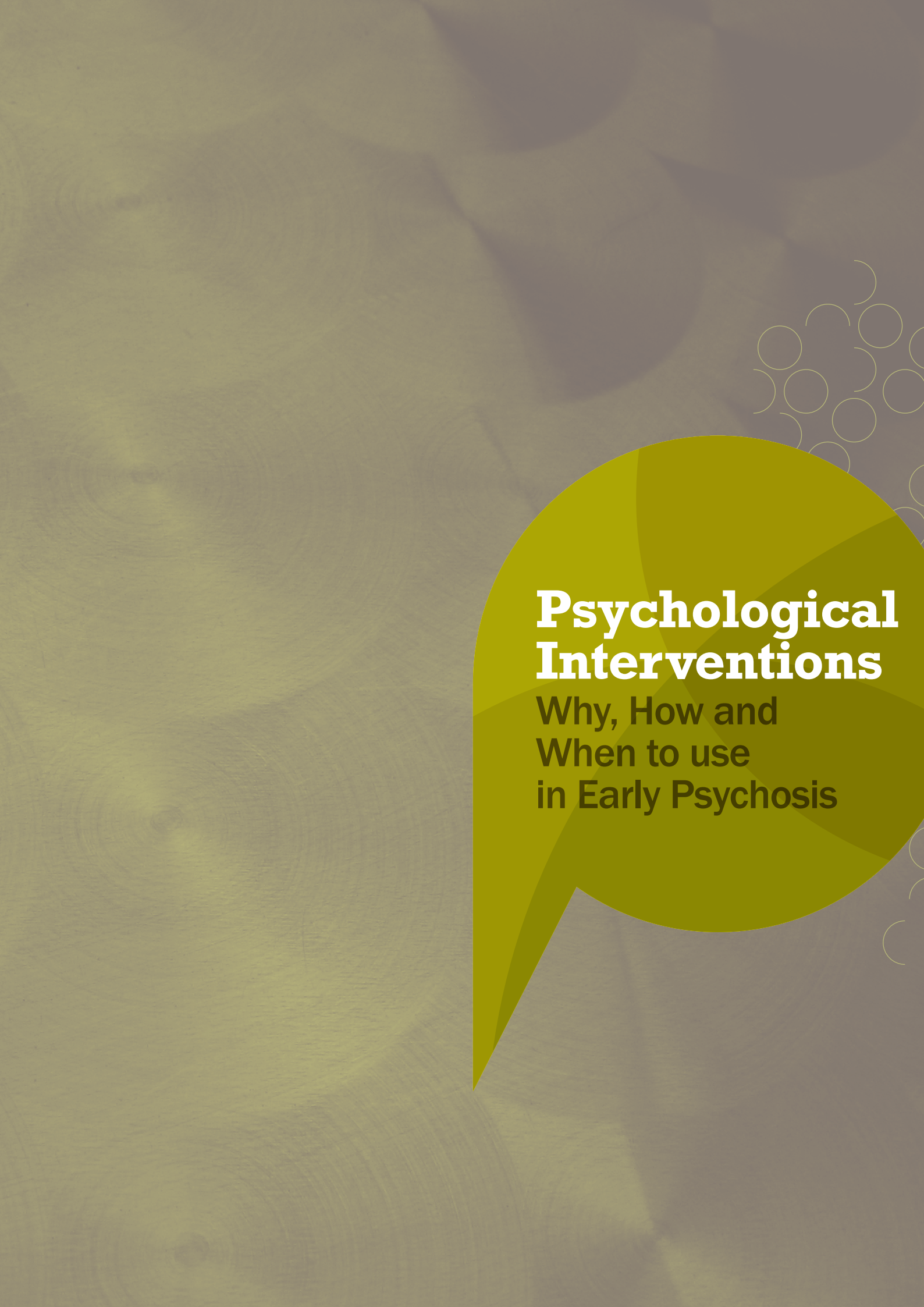

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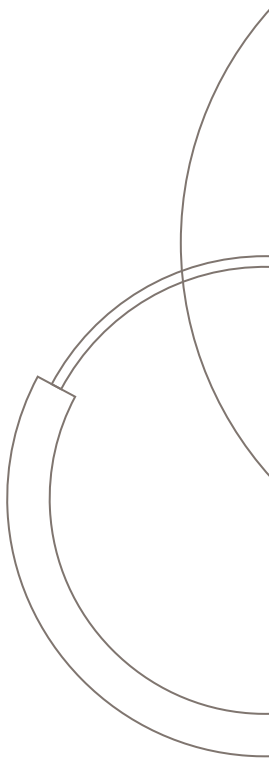

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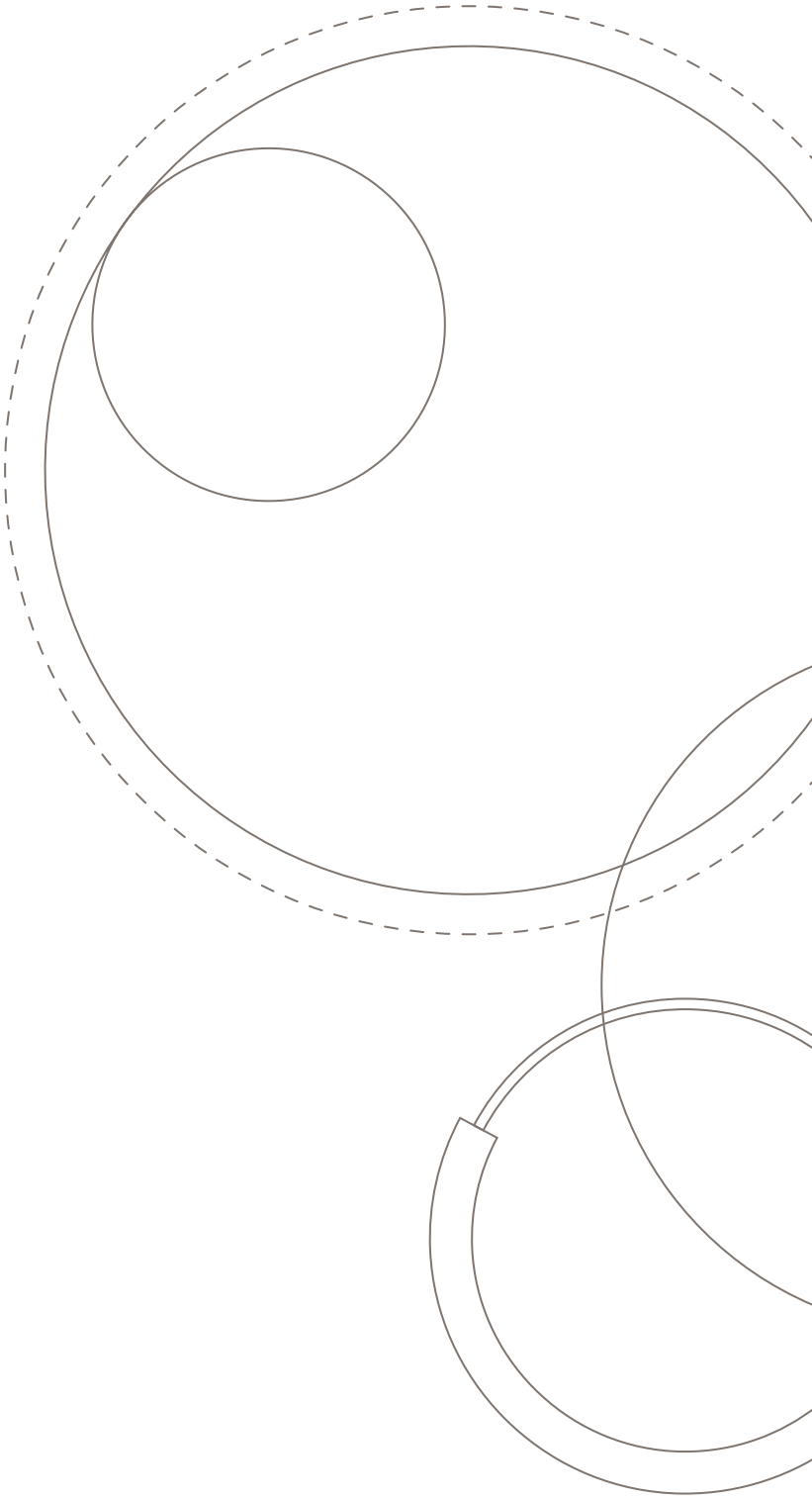


Introduction

Young people with early psychosis can experience distressing symptoms and a range of co-occurring difficulties (these can be biological, psychological and social in nature) that affect wellbeing and functioning for each individual.

The treatment options available to young people with early psychosis are broad and involve a comprehensive and complementary range of biopsychosocial interventions. This manual focuses specifically on psychological interventions for use in early psychosis.

Psychological interventions are an essential element in the treatment of young people experiencing early psychosis. These interventions are informed by the identified goals, values and problems for each young person and their family, and assist with reducing symptoms and related distress, support adaptation to the experience of psychosis, and help promote functional recovery.

It is essential that clinicians working in this field keep in mind the key aims of any form of intervention and ensure they are not drawn into a narrow focus on symptom reduction to the detriment of the young person's personal wellbeing and social and occupational recovery. Interventions will be most effective when they relate to what is most important to the young person and aim to assist the young person to regain their usual developmental trajectory. Genuine engagement and collaboration are more likely when clinicians display openness to the preferences, ambitions and values of each young person and are empathetic and flexible when addressing these elements in treatment.

About this manual

Psychological interventions: why, how and when to use in early psychosis is one of a series of manuals produced as part of the EPPIC National Support Program (ENSP) to support the implementation of the Early Psychosis Prevention and Intervention Centre (EPPIC) Model in early psychosis services. The EPPIC Model is a model of specialised early intervention in psychosis that aims to provide early detection and developmentally appropriate, effective and evidence-based care for young people (aged 12–25 years) at risk of, or experiencing, a first episode of psychosis. The EPPIC Model has been developed from many years of experience within the clinical program at Orygen Youth Health and is further informed by the National Advisory Council on Mental Health's Early Psychosis Feasibility Study, which sought international consensus from early psychosis experts from around the world.[1] The provision of evidence-based psychological interventions to young people with early psychosis is one of the 16 core components that make up the EPPIC Model.

How to use this manual

This manual is intended as a guide for allied health clinicians who are working in an integrated case-management/therapist role employing psychological interventions to treat young people with early psychosis.

It is divided into seven parts:

Part 1: Background and rationale

Part 2: Theoretical models of psychological interventions for psychosis

Part 3: Psychological assessment, formulation and treatment planning

Part 4: Psychological interventions for early psychosis

Part 5: Cognitive–behavioural interventions for co-occurring symptoms or conditions

Part 6: Relapse planning and prevention

Part 7: Challenges and considerations for using psychological interventions in early psychosis.

This manual outlines a range of cognitive–behavioural and other psychological interventions that are effective when working with a range of common goals or difficulties experienced by young people with early psychosis.

Clinicians should select interventions based on a comprehensive case formulation and collaborative identification of treatment goals with the young person. Given the varied nature of psychosis, this manual is not intended as a prescriptive step-by-step guide, and young people may benefit from combinations of the different interventions described here.

This manual does not address more advanced or complex interventions. Such interventions include those used for the treatment of persistent positive psychotic symptoms, specific interventions for the treatment of comorbid substance use and early psychosis, and interventions for working with young people with comorbid borderline personality disorder and early psychosis. These topics and others will be addressed in other ENSP resources.

This manual presents case scenarios and anecdotes from young people who have received treatment in the EPPIC service through the Orygen Youth Health Clinical Program to provide real-world context.

Throughout this manual, the term 'early psychosis' is used to refer to the early course of a psychotic disorder. It encompasses the period from emergence of the at-risk mental state (ARMS) (where a young person is considered to be at ultra-high risk [UHR] of psychosis) through the first full-threshold psychotic episode, to the 'critical period' of up to 5 years after entry into treatment for the first psychotic episode.[2] Psychological interventions have demonstrated benefits across all phases of early psychosis.[3]

The interventions presented in this manual apply across all phases of early psychosis; however, for a comprehensive overview of interventions for the UHR group, please also refer to the ENSP manual *A stitch in time: interventions for young people at ultra high risk of psychosis*.[4]

Other complementary ENSP resources are *Get on board: engaging young people and their families in early psychosis*,[5] and online learning modules 'Introduction to cognitive behavioural therapy' and 'Case formulation in early psychosis'. Additional reading and resources that provide greater background and depth for specific psychological interventions are referred to throughout this manual.

It is recognised that clinicians working in early psychosis services will have varying levels of formal training and experience in delivering psychological interventions. Therefore, the interventions outlined in this manual should be used in conjunction with ongoing training and supervision, which are essential for the safe and effective use of psychological interventions.

Psychological interventions and the EPPIC Model

Psychological interventions form one of the 16 core components of the EPPIC Model.[6] They are likely to be used to varying degrees by all clinicians in an early psychosis service. Interventions include engagement, providing psychoeducation to young people and their families, stress management, strategies to support adaptation to psychosis, coping with psychotic symptoms, relapse-prevention and cognitive–behavioural strategies to address co-occurring or secondary morbidity issues.

Psychological interventions within the EPPIC Model are mainly delivered as part of continuing case management. Case managers from all disciplinary backgrounds are expected to use psychological interventions – predominantly those informed by cognitive–behavioural therapy (CBT) – as part of their usual case-management role. There is also provision within the EPPIC Model for referral to a senior clinical psychologist within the team when case complexity requires a more experienced or specialised therapist.

Early psychosis services are required to provide all clinicians who use psychological interventions with access to training, education and key resources (e.g. clinical manuals) to ensure quality and safe practice. Clinicians also require access to clinical supervision from senior clinicians with experience and qualifications in providing psychological interventions. It is important that there is a senior clinical psychologist employed within the service to ensure and oversee the delivery of support to clinicians regarding psychological interventions.[6]

In the EPPIC Model, the case manager is required to provide psychological interventions in addition to being the coordinator of all aspects of care for the young person. To fulfil these roles, the case manager must have a sound understanding of the model of care, and the confidence and skills to deliver the psychological interventions. Ensuring that case managers have such attributes can be achieved by clearly stating expectations within their position description and providing access to appropriate training and clinical supervision. Further, embedding a clinical culture that emphasises the psychological aspects of recovery from early psychosis is fundamental to the EPPIC Model.

PART 1

Background and rationale

Background and rationale

What is early psychosis?

The term 'psychosis' broadly covers a heterogeneous group of symptoms that occur across a range of psychiatric disorders. Such symptoms include positive symptoms such as perceptual disturbances (e.g. illusions and hallucinations), odd or unusual beliefs (e.g. delusions), and thought and language disturbances (e.g. formal thought disorder).[7] Many people also experience negative symptoms such as avolition, anhedonia and amotivation, which are often associated with functional difficulties across a number of domains (e.g. social and occupational).[8] A person may meet the criteria for the diagnosis of a psychotic disorder without exhibiting all these symptoms. In fact, it is possible for two people to meet threshold criteria for the same psychotic disorder (e.g. schizophrenia) without sharing a common set of symptoms.[9]

Diagnostic uncertainty and instability are particularly prevalent in early psychosis, when symptoms have developed recently, fluctuate markedly, and their longer term course is not yet known.[10] As such, the term 'psychosis' is preferred during the early stages of illness. The phase-based model of psychosis applied in the EPPIC Model conceptualises the course of a psychotic episode as passing through distinct phases (see Figure 1). These phases are ARMS, acute, early recovery, late recovery and ongoing or incomplete recovery. Not everyone who is identified as ARMS will transition to a first episode of psychosis. Those who do transition to a first episode of psychosis will have either a complete or an incomplete recovery.[4] Treatments must be matched to both the phase of psychosis and the specific individual needs of the young person.

A clinical staging model has also been applied to psychosis to provide a framework for grading the stage of the psychotic disorder and the most appropriate treatments for that stage of illness (Table 1).[3,11] As such, appropriately phased and less invasive evidence-based treatments (e.g. CBT) can be provided for people at UHR for psychosis, while medications associated with more adverse effects are reserved for later stages (e.g. clozapine for treatment-resistant psychosis).

FIGURE 1. **THE PHASES MODEL OF PSYCHOSIS**

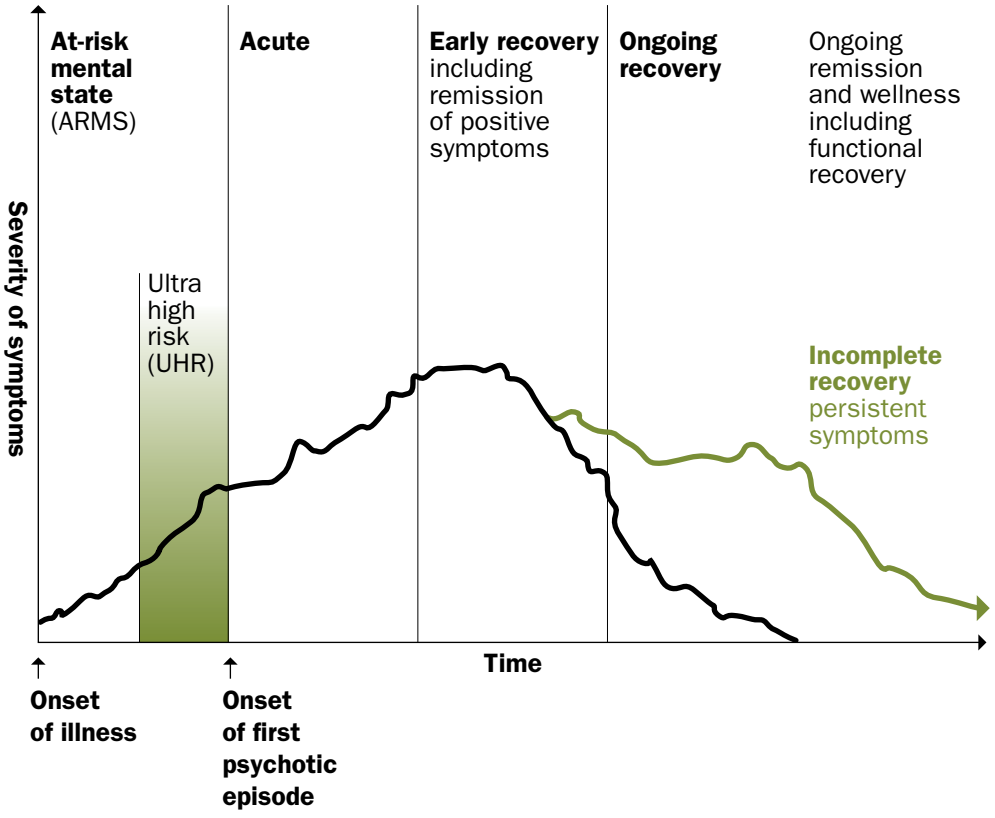


TABLE 1. THE CLINICAL STAGING MODEL OF PSYCHOTIC DISORDERS

STAGE	PSYCHOSIS	TREATMENT
0	Increased risk/no symptoms	Indicated prevention of FEP, e.g.: • improved mental health literacy • family education • drug education
1A	Mild or non-specific symptoms and functional decline	Indicated secondary prevention, e.g.: • formal mental health literacy • family psychoeducation • CBT • actively reduce substance use
1B	UHR – sub-threshold	Indicated secondary prevention, e.g.: • psychoeducation • CBT • substance use work (cessation or harm reduction) • antidepressants
2	FEP – full threshold	Early intervention for FEP, e.g.: • psychoeducation • CBT • substance use work • SGA medication • vocational rehabilitation
3A	Incomplete remission from first episode of care	Early intervention for FEP As for 2, with additional emphasis on medical and psychosocial strategies to achieve remission
3B	Recurrence or relapse stabilised with treatment, but still residual symptoms	Early intervention for FEP As for 3a, with additional emphasis on relapse prevention
3C	Multiple relapses with clinical deterioration	Early intervention for FEP As for 3b, but with emphasis on long-term stabilisation
4	Severe, persistent or unremitting illness as judged by symptoms, neurocognition and disability criteria	As for 3c, but with emphasis on clozapine, other tertiary treatments and social participation despite ongoing disability

CBT: cognitive–behavioural therapy; FEP: first-episode psychosis; SGA: second-generation antipsychotic; UHR: ultra-high risk (of psychosis).
Adapted from the *Australian clinical guidelines for early psychosis*.[12]

Why use psychological interventions in early psychosis?

Treatment for psychosis requires a range of approaches

Although psychotic symptoms will generally respond well to biological treatments, there are limitations to treating young people with medication alone. While around 90% of young people with first-episode psychosis (FEP) who take antipsychotic medication experience remission of symptoms in the first year, 10% will have incomplete recovery from symptoms, and subsequent relapse rates are high (70–80%).[3] Further, the side effects of antipsychotic medication are substantial, and for this and other reasons, many young people experiencing FEP are not fully adherent to medication.[13]

In addition, there are aspects other than remission of symptoms that are important to a young person's recovery. These need to be addressed, and may be targeted by psychological interventions. As such, according to guidelines, treatment for psychosis should include both biological and psychological therapy. Francey et al.[14] and Morrison et al.[15] emphasise the importance of individual choice in treatments for psychotic disorders. They advocate for a careful 'cost–benefit analysis' be undertaken in consultation with every person receiving treatment, particularly young people who are taking antipsychotic medication. As treatments to be considered for early psychosis, psychological interventions must be included as low-risk options that have an established and growing evidence base.

Most international guidelines, including those of The Royal Australian and New Zealand College of Psychiatrists,[16] the United Kingdom's National Institute for Health and Clinical Excellence,[17] and the United States' Schizophrenia Patient Outcomes Research Team,[18] advocate the use of cognitive–behaviourally oriented psychological interventions for people experiencing psychotic disorders. The *Australian Clinical Guidelines for Early Psychosis*[3] advocate for the use of CBT in the UHR phase, pre-onset phase, and acute phase, in addition to assisting with adaptation to psychosis, and planning for and responding to relapse and problematic recovery.

It is important to note that remission of psychotic symptoms is only one aspect of recovery from an episode of psychosis, and in itself does not always lead to functional improvement.[19] Therefore, the aim of treatment is not only to achieve symptom remission, but also to ameliorate the impact a psychotic episode may have on aspects of a young person's life such as their social life, relationships, work or schooling and self-esteem.

A range of psychosocial interventions can be used to address these wider aspects of a young person's recovery. Psychological interventions can help young people to develop strategies to cope with distress, promote adaptation following psychosis, reduce self-stigma and assist with making plans for recovery.[19] They may also be used to support stress management, address co-occurring conditions and other psychosocial factors that are associated with incomplete recovery and relapse, and help with functional recovery. Psychological interventions in early psychosis aim to create sustained change in the young person by encouraging the development of skills and self-knowledge.

The evidence base of the efficacy of psychological interventions for providing treatment for young people with early psychosis is growing. Over 40 randomised controlled trials (RCTs) have demonstrated that psychological interventions for psychosis:

- improve medication adherence[20]
- reduce severity of symptoms and distress in the acute and recovery phases[21-24]
- reduce positive symptoms in medication-resistant psychosis[25,26]
- reduce transition from UHR to early psychosis[27]
- improve social functioning[28]
- improve negative symptoms and functioning[29]
- improve co-occurring conditions such as depression and anxiety[28]
- reduce relapse rates[30]
- have only a 13% dropout rate.[31]

As such, the evidence in support of the efficacy of psychological interventions in early psychosis is strong.

Understanding psychosis from a psychological perspective

Psychosis is not purely biological

Psychological research into the mechanisms underlying psychosis and its symptoms has increased the understanding of cognitive and social factors involved in psychosis and provided a strong rationale for the place of psychological interventions in the treatment of psychosis. Recently, clinicians and researchers have moved away from understanding psychosis as simply a 'brain disease'[32] or 'chemical imbalance in the brain' for which medication is the primary, and at times, sole treatment. Instead, biopsychosocial aetiological models of psychosis have been advanced such as the stress–vulnerability model (see Box 1).

BOX 1 STRESS–VULNERABILITY MODEL OF PSYCHOSIS

Stress–vulnerability models of the cause of psychosis propose that psychotic symptoms are caused by external factors acting on underlying vulnerabilities in the young person experiencing psychosis. These factors and vulnerabilities may be biological, psychological or social. *Biological factors* include genetics, physiology, biochemistry – in particular neuronal biochemistry – and general physical constitution. *Psychological factors* encompass the legacy of adverse events in early development, and emotional and cognitive responses to interactions with others. *Social factors* include the family and friendship system and the young person's socioeconomic and sociocultural background.

In stress–vulnerability models, psychological processes are thought to play a crucial role in the onset and maintenance of psychosis.[33,34] Research has demonstrated that a range of psychosocial factors are associated with the development of psychotic disorders. Such psychosocial factors include insecure attachment,[35] conflict within the family home,[36,37] experience of trauma and abuse,[38-40] as well as migration and it's correlates of social exclusion, urbanicity and social disadvantage.[41]

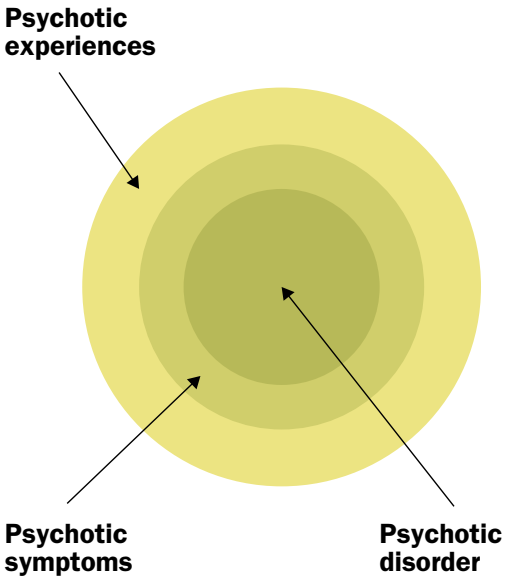
Psychosis as a continuum

A major focus of psychosocial theories of psychosis is the concept that psychotic symptoms are a normal part of human experience and exist on a continuum of severity and acceptability. For many young people the nature of their psychotic symptoms may fluctuate (e.g. from social concern and anxiety to overt paranoia), rather than being qualitatively different with respect to overarching themes (e.g. experiencing thoughts such as 'It's dangerous to be noticed by others').[42] In addition, it is not uncommon that ideas or beliefs that are considered unusual in some cultures (e.g. a belief in witches or ghosts) are accepted as normal in others.[43]

Recent research by Colbert et al.[44] demonstrates that 'delusions' expressed by people with psychotic diagnoses were no more rigid than beliefs held with conviction by members of the general public. Again, this has significant implications given that delusions have historically been defined as fixed and unyielding to reason.[32]

The most striking evidence that psychotic symptoms are a normal part of human experience is the finding that there are high rates of auditory and visual hallucinations in the general population. Kelleher et al.[45] conducted a systematic review and meta-analysis of psychotic experiences of children and adolescents aged 9 to 18 years in the general population. They found that for children aged 9 to 12, the median prevalence was 17%, while for adolescents aged 13 to 18, it was 7.5%. van Os et al.[46] completed a systematic review of all reported incidence and prevalence studies of population rates of sub-clinical psychotic experiences across all age ranges. They found a median prevalence rate of 5% and an incidence rate of 3%, with a broad range of variability depending on the particular cohort. They argue that a distinction can be made between people who report psychotic experiences, people who report psychotic symptoms that are associated with some distress and help-seeking, and people who meet the criteria for a clinical psychotic disorder. This concept is represented in Figure 2.

FIGURE 2. **THE PSYCHOSIS CONTINUUM**



Adapted from van Os et al. 2009.[46]

Research has also cast some doubt over whether concepts such as paranoia are clear evidence of psychosis or whether they exist on a continuum of normal human experience. For example, in a virtual-reality simulator test, Freeman et al.[47] found 'over 40% of our general population sample had paranoid thoughts' (p. 262). In a related article, Freeman[48] writes, 'Worries about other people are so common that they seem to be an essential – if unwelcome – part of what it means to be human' (p. 1).

Symptoms have meaning

An important development in psychological perspectives of psychosis championed by Bentall[33] and other researchers[49] has been viewing psychotic symptoms, including delusions and hallucinations, as having meaning. That is, considering that these symptoms occur within an individual's world view or belief system and are understandable in this context. This is a significant change from previous research, which almost by definition viewed delusions as 'un-understandable'.[50] For example, Morrison[34] notes, 'there is mounting evidence that delusional beliefs can be understood in terms of biased processing within normal belief formation … 70% of delusional ideas were overtly related to non-delusional ideas that predated the delusion' (pp. 61–62).

A significant change in approach has been advocated recently concerning auditory hallucinations specifically, particularly by organisations such as the International Hearing Voices Network.[51] Birchwood et al.[52] researched this phenomenon extensively and suggest the following: 'voice experience should not be dismissed as symptoms of the illness for which drugs alone can be used. If malevolent voices are a form of (intense and often nasty) bullying which may be rooted in earlier traumatic experiences and harassment […], then the therapist needs to align himself with the patient in reducing the experience of being bullied' (p. 1,578). Bentall[33] writes even more directly of a client who was experiencing auditory hallucinations 'it was obvious that his voices were not merely the random product of a damaged nervous system' (p. 348).

Cognitive biases in psychosis

Evidence from cognitive science has promoted cognitive models of positive psychotic symptoms (e.g. delusions or hallucinations) as being derived from cognitive or information-processing biases in which there are errors in appraisal of internal and/or external events. These cognitive and perceptual biases can occur in the context of a range of psychological disorders (e.g. depression, anxiety, post-traumatic stress disorder [PTSD] or personality disorder) and may be underpinned by dysfunctional core beliefs about self, others and/or the world, as well as neurocognitive disturbances.[53-57] In fact, individuals that do not have significant mental health problems may also experience such biases. Please see Resource 1 for a full list of common cognitive biases.

Recent psychological research on voices has focused on the concept of source-monitoring,[58] which acknowledges that inner speech is a common human activity and is used daily in a number of tasks, including those as minor as memorising and recalling telephone numbers. Source-monitoring errors occur when thoughts, images or emotions from one source are mistakenly attributed to another source. Falsely attributing internal speech to an external source is thought to lead to the experience of hearing voices when no external stimulus is present. Referring to the universal nature of internal speech in humans, Sacks[59] notes that perhaps 'one should invert the question – and ask why most of us do not hear voices' (p. 64).

Research on the role of normal psychological processes has identified thinking errors as a potential mechanism involved in the development and maintenance of psychotic symptoms.

For example, Dudley and Over[60] conducted a task in which participants were asked to guess the likelihood of a bead being a particular colour. They found that people with a diagnosis of schizophrenia were more likely to reach their opinion more quickly and with less information (i.e. jump to a conclusion) than the control participants. This makes sense when one considers that in the experience of delusional paranoia a person may come to the conclusion that they are in danger based on quite small or neutral stimuli in their environment (e.g. a person glancing at them). McRaney (2012) describes the concept of confirmation biases, in which it is a common human thinking style to search for data that supports our preferences, including political beliefs, and ignore data that does not support them.[61]

Resource 2 provides a table of the common cognitive and information-processing biases and their relationship to psychotic symptoms.

There is considerable evidence for the role of psychological and social factors in affecting the onset and symptoms of psychosis. As such, there is a strong rationale for the application of psychological interventions in treating psychosis.

PART 2

Theoretical models of psychological intervention for psychosis

Theoretical models of psychological intervention for psychosis

Overview

To date, the largest body of research into psychological interventions for psychosis has focused on CBT across the phases of psychosis, from UHR to chronic psychoses such as schizophrenia. CBT is considered an effective psychological treatment for depression, generalised anxiety, panic disorder, social phobia, obsessive–compulsive disorder, PTSD, eating disorders, substance use disorders and personality disorders.[62-64] CBT for psychosis (CBT-p) was first developed for treating residual positive psychotic symptoms.[65] However, its use has more recently been expanded to include treatment of young people in the UHR and early phases of psychosis to treat negative symptoms and enhance social and functional outcomes.[54]

There are a number of newer complementary theoretical models such as acceptance and commitment therapy (ACT) and mindfulness[66,67] that provide valuable perspectives on the treatment of psychosis and are gaining research evidence as effective treatments. Many of these models are already established and readily used for the treatment of common co-occurring conditions such as anxiety and depression. They also address cross-diagnostic goals such as assistance with interpersonal relationships, distress tolerance, acceptance, coping and personal values. In addition, a number of treatment approaches have been developed for young people with early psychosis, including Cognitively Oriented Psychotherapy for First-Episode Psychosis (COPE),[68] Systematic Treatment of Persistent Psychosis (STOPP)[69], and Active Cognitive Therapy for Early Psychosis (ACE).[70] Each of these models emphasises the importance of engagement and the therapeutic relationship, the use of a case formulation-driven approach and the importance of supporting young people to return to an optimal developmental trajectory.

A cognitive–behavioural model is the primary theoretical framework used in this manual, with strategies from other models incorporated as appropriate.

The cognitive–behavioural model

The CBT model has evolved over time and incorporates elements of behavioural and cognitive therapies developed in the 1960s and 1970s in an effort to understand and treat depression.[71] The cognitive model, developed by Aaron Beck suggests that our emotions and behaviours are influenced by our perception of events.[72] This model relies on the assumption that an event or situation alone does not determine how a person feels. Instead, it is the interpretation or appraisal of meaning that an individual makes about a situation that determines their emotional and behavioural response (see Figure 3).

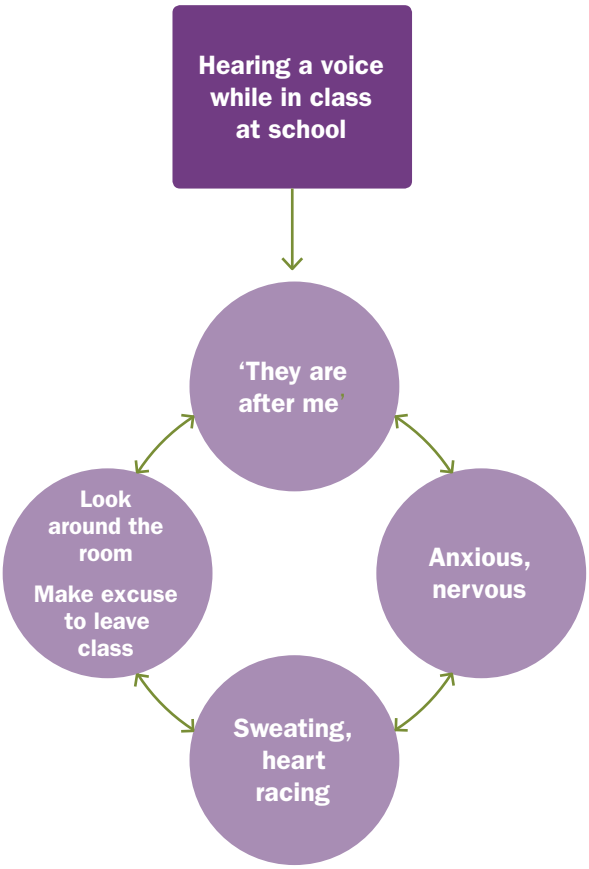
FIGURE 3. **THE COGNITIVE ASSUMPTION**

Within a biopsychosocial model of psychosis, the cognitive–behavioural model is particularly useful in considering the role of interpretation or appraisal in the onset and development of psychotic symptoms, as well as the distress related to these symptoms. The cognitive–behavioural model allows us to consider that there may be psychological origins of psychotic symptoms, which may be linked with early developmental experiences and the formation of pervasive beliefs about self, others and the world. It also allows us to consider the cognitive or information-processing biases young people may have that influence the manner in which their experiences are interpreted.

The cognitive–behavioural model emphasises the importance of identifying thoughts, assumptions and beliefs and related emotional and behavioural responses that are common to particular syndromes.

For young people with psychosis, the experience of psychotic symptoms may be conceptualised as trigger 'events' (e.g. hearing a voice), which may impact their body state (e.g. dissociation), or impact on their cognitive appraisal (e.g. paranoid thoughts) (see Figure 4).

FIGURE 4. **CROSS-SECTIONAL CBT MODEL**



What do we mean when we talk about 'cognition'?

The cross-sectional CBT model (see Figure 4) highlights how thoughts or cognitions experienced in particular situations are related to emotional, physical and behavioural responses.

The term 'cognition' is relevant not only to these moment-to-moment thoughts, but also to the longer term beliefs and attitudes that people hold about self, others and the world.

Therefore, cognition in CBT can refer to any of the three levels of thought: automatic thoughts, rules or assumptions or core beliefs (Figure 5).

Automatic thoughts

Automatic thoughts refer to the rapid and brief thoughts that are not the result of deliberation or reasoning. They pop up in people's minds automatically and can appear as images, memories or in verbal form.

In much the same way that people are not always consciously focused on their breathing or the way they walk, nor are they always consciously aware of what they are thinking about. Thinking can be habitual and automatic, as the brain constantly runs through a range of thoughts and ideas as new situations are encountered.

Automatic thoughts can be emotionally negative, positive or neutral, and although people may be unaware of the thoughts they are having, they are often aware of the emotion or feeling that follows. As such, people are likely to accept uncritically automatic thoughts as being true, particularly when the associated emotion is strong.

Rules or assumptions

Automatic thoughts are triggered by unarticulated beliefs, rules and assumptions about self, others and the world. These rules or assumptions influence the interpretation of situations or emotions and guide people's daily actions and expectations. Rules or assumptions are not as easily accessed or as obvious as automatic thoughts and it may be necessary for clinicians to make inferences about them by examining a young person's behaviour in particular situations.

Rules or assumptions usually take the form of a conditional statement such as 'if … then …' or 'I should or I must'. They generally operate across a number of situations and have been developed in the person over time as a means of making sense of experience and being able to predict and respond to situations in a coherent manner.

For example, a young person who has the attitude 'It's terrible to fail at things' may hold the assumption that 'If I only choose to do things that are very easy, I will not fail' or the rule that 'I must avoid difficult tasks'.

Core beliefs and schema

Core beliefs are similar to rules or assumptions in that they have developed over time, usually from childhood and through experience of significant life events or circumstances. These beliefs are strongly held, rigid and inflexible and may be about the self, others and the world.

Core beliefs are maintained by the tendency to focus on information that supports the belief and ignores evidence that contradicts it. Core beliefs are viewed by the individual as central and fundamental to the extent that even if they are not articulated, they are considered by the individual to be absolute truths.

Core beliefs are sometimes apparent but not always. Generally, they can be activated by specific situations or states, for example, in social situations or when difficulties arise in close relationships with others.

The terms 'core belief' and 'schema' are often used interchangeably across different theoretical orientations. Schema are referred to in this manual using the definition developed by Jeffrey Young as 'broad, pervasive themes or patterns of memory, emotion, cognitions and bodily sensations'.[73] Similar to core beliefs, these patterns relate to our attitudes, expectations and response to self, others and the world and have been developed from childhood in response to significant life experiences. 'Schema' may be considered to be a broader concept than 'core beliefs'. For example, a young person may hold multiple core beliefs (e.g. 'others will hurt me', 'I deserve to be punished') that are congruent with a single schema (e.g. mistrust/abuse). Further information about schema can be found in Jeffrey Young's text 'Schema Therapy'.[73]

FIGURE 5. **THE THREE LEVELS OF COGNITION**

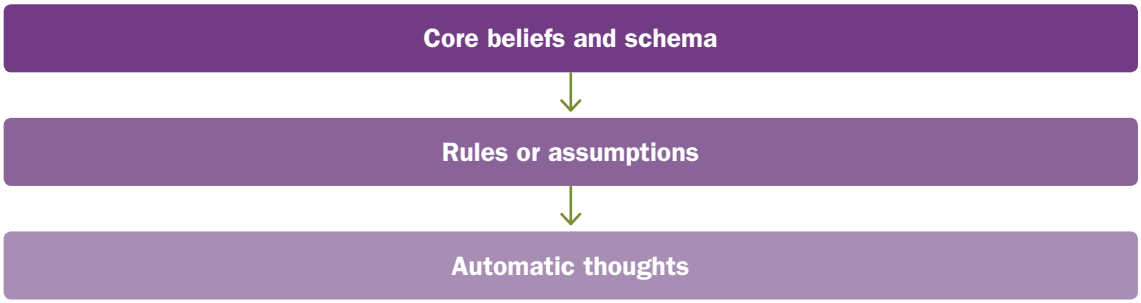


Figure 6 demonstrates that the different levels of cognition vary across the three dimensions of specificity, modifiability and accessibility. Automatic thoughts are more specific, modifiable and accessible, which is why they are often considered the place to begin to bring about more rapid change. However, for some young people it may be necessary to work at the core-belief or schema level, particularly when the belief underpins difficulties across numerous domains of the young person's life. This work takes longer, as core beliefs and schema are less specific, less modifiable and often less accessible. As such, it is important for the clinician to be extremely patient if attempting to work with a young person at this level.

FIGURE 6. **LEVELS OF COGNITION**

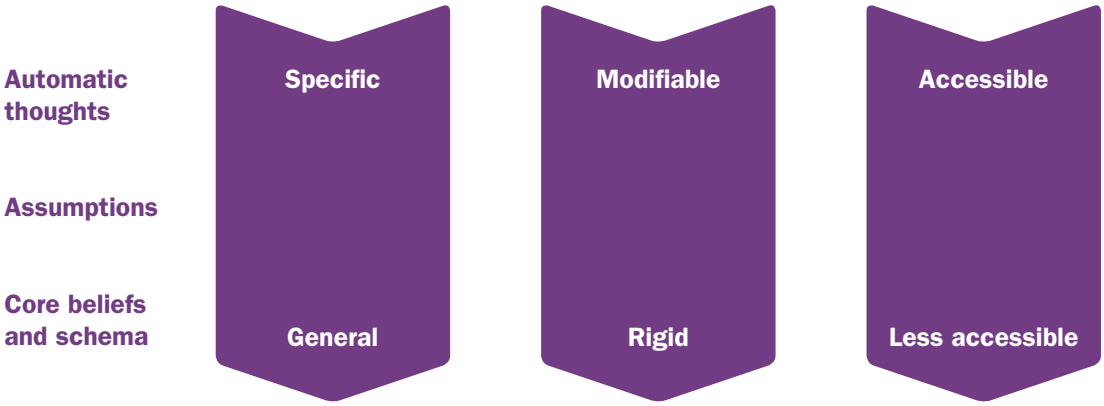
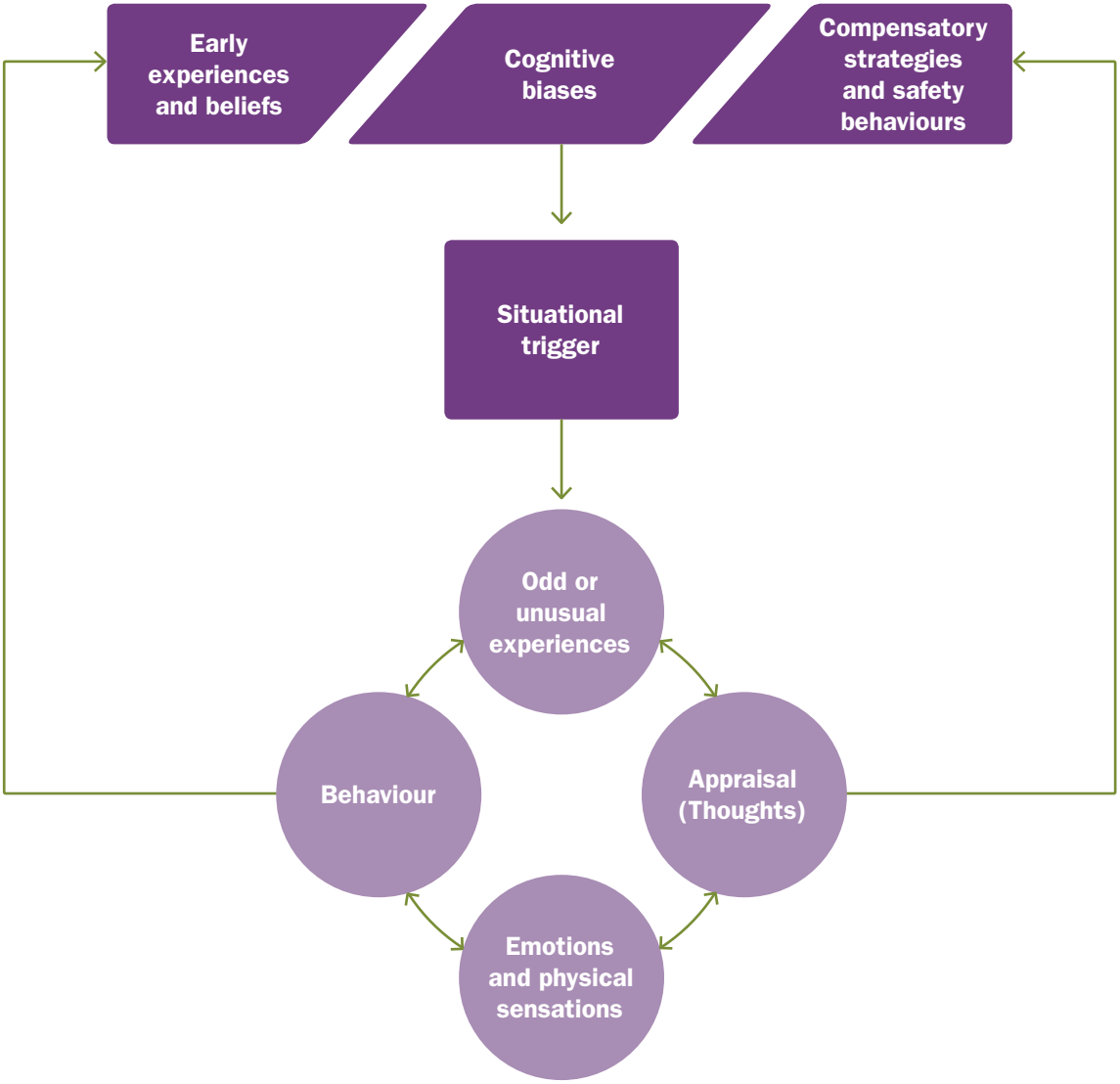


Figure 7 presents the relationship between early life experiences and beliefs (incorporating core beliefs and schema, rules and assumptions), cognitive biases, compensatory strategies and safety behaviours, and the cross-sectional CBT model. It includes 'odd or unusual experiences' such as hearing a voice or experiencing tactile hallucinations, which may act either as a 'trigger' or response. Cognitive biases may influence the perception and appraisal of situational or internal triggers which can lead to a number of automatic thoughts that then impact on emotional, physical and behavioural responses.

FIGURE 7. **THE LONGITUDINAL CBT MODEL**



PART 3

Psychological assessment, formulation and treatment planning

Psychological assessment, formulation and treatment planning

Psychological assessment and monitoring

The overall aim of a psychological assessment is to build an individualised formulation that informs treatment interventions. From a cognitive–behavioural perspective, the clinician needs to understand the following factors:

- distressing emotions or odd or unusual experiences that the young person wishes to address
- relationship between these emotions and the odd or unusual experiences, and the behaviour and thoughts that are triggering or maintaining these
- predisposing, precipitating, perpetuating and protective factors that are related to the experiences the young person wishes to address
- young person's explanation for their distress and odd or unusual experiences.

Once a young person has been referred to a case manager within the early psychosis service, a comprehensive biopsychosocial assessment should have been completed that considers information about psychotic symptoms, co-occurring symptoms, as well as impact of the symptoms on social and occupational functioning. Please see the ENSP manual *Let me understand: assessment in early psychosis*[74] for comprehensive information on assessment in early psychosis.

Detailed psychological assessment is useful to inform ongoing treatment for specific problems identified as important to the young person. Such assessment may include the use of clinical interview, standardised questionnaires, or individualised scales or recording tools that may be completed by the young person alone or together with clinicians.

This section will provide an overview of some general and specific assessment tools including the following:

- guided discovery
- timelines
- thought records
- visual analogue scales
- downward arrow
- functional assessment of voices
- structured assessment tools.

Clinical interview and general assessment tools

General principles of assessment of a young person include using open questions, normalising the young person's experience, symptom expectation and avoiding the use of medical or psychological jargon in communication.[74] Both general and psychological assessments are ongoing processes embedded into clinical dialogues and interventions.

Guided discovery

One of the core therapeutic skills in CBT is the use of Socratic questioning. This is a conversational style of questioning intended to encourage the young person to consider and convey additional information that may be useful for reducing their distress, solving their problems and increasing their insight or cognitive flexibility.

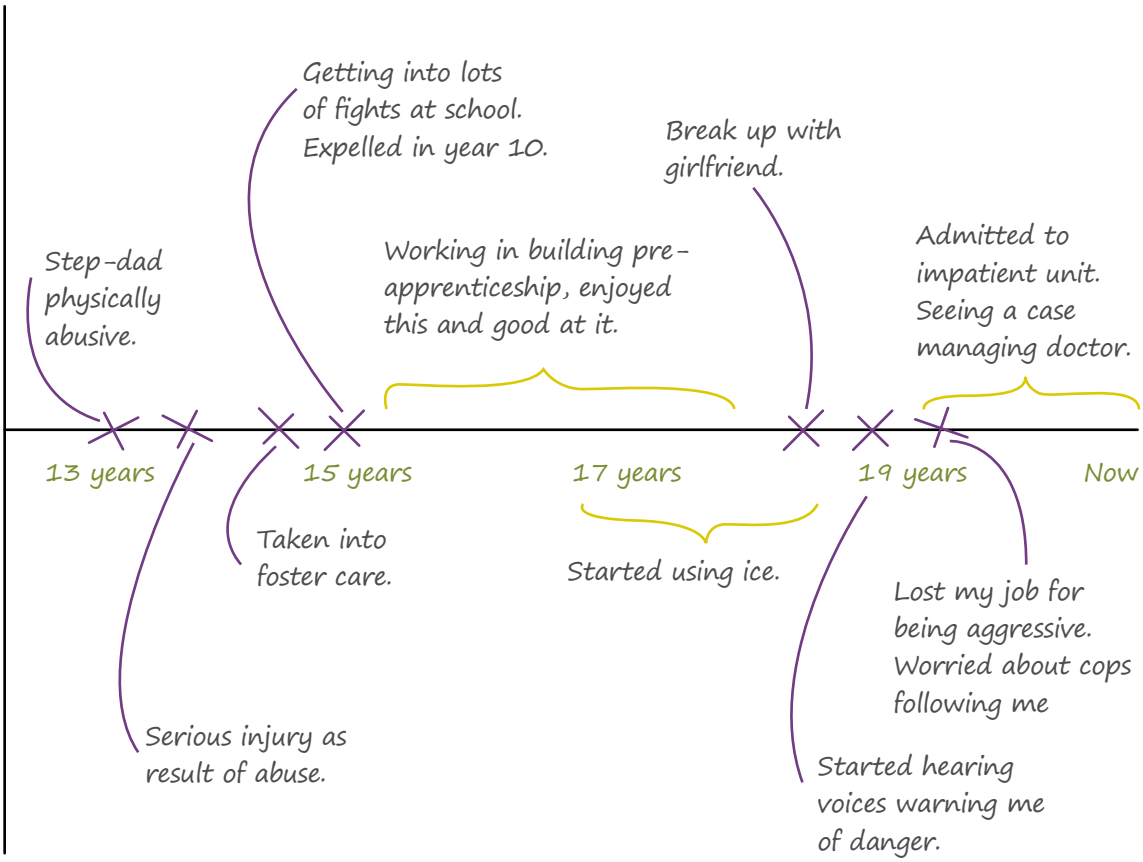
Padesky[75] describes the best Socratic questions as being a form of 'guided discovery'. Guided-discovery questions should allow a broad review of evidence with the aim of obtaining a bigger picture of presenting concerns. This means that clinicians must take a stance of genuine curiosity about the meaning of the thoughts and beliefs of the young person with whom they are working.

Timelines

Timelines are useful assessment tools that can be used to collate a variety of complex information in one place. Generally, the timeline is simply presented as two axes.

The x-axis expresses time, and can be used to look at the young person's entire lifespan or focus in detail on the previous few years of their life. Along the x-axis, the young person can list significant life events that are negative (e.g. break-up with girlfriend) or positive (e.g. getting a new job). The y-axis can be used in a flexible manner. It can be used specifically to express either the presence or severity of a particular symptom (e.g. feeling paranoid) or more generally to express fluctuations in distress, psychotic symptoms or co-occurring issues. Figure 8 provides an example of a completed timeline for young person Eddie.

FIGURE 8. **TIMELINE FOR EDDIE**



The following are some of the benefits of using a timeline:

- the timeline as a document is open for the young person to see, reducing the sense of mystery or concern about the clinician's note taking
- the timeline provides a visual cue with prompts, meaning that the young person is able to make changes or correct errors
- the timeline can be used to inform psychological interventions
- the timeline can be used to guide discussions around the young person's explanatory model and offer the young person opportunities for self-reflection and developing insight about the relationships between presenting problems.

Resource 3 contains a timeline template for use in clinical practice.

Cognitive–behavioural assessment of psychotic symptoms

Psychotic symptoms such as hallucinations, delusions or negative symptoms can be conceptualised within the CBT model as part of the cognitive, affective and behavioural response to situational triggers. An example of the CBT model was presented earlier on page 22. Anomalous experiences that are common to psychosis may include perceptual disturbances, thought blocking or dissociation – these are described in this manual as 'odd or unusual experiences'.

There are a number of assessment tools to support the development of a cognitive–behavioural formulation. The primary technique is the use of a clinical interview, which may be supplemented by the use of visual aids or tools to organise and record information in a manner that makes sense to the clinician and the young person. In addition to clinical-interview methods, the following tools may be useful to assess the impact of beliefs related to delusions, hallucinations or co-occurring problems such as depression or anxiety.

Thought records

One method commonly used is a thought record (see Table 2). This method can provide insight into the common triggers for psychotic experiences and related distress, as well as the appraisals the young person is making about their experiences and the emotional, physical and behavioural consequences.

In Table 2, the young person's experience of hearing a voice acts as an internal trigger for distressing thoughts and beliefs related to increased anxiety and coping efforts.

TABLE 2. **THOUGHT RECORD: RESPONSE TO HALLUCINATION**

Trigger/Odd or unusual experience	Thoughts and beliefs	Emotional and physical response	Behaviour
Hearing a voice say 'You are stupid'	*I'm losing my mind*	*Worried* *Agitated* *Shallow breathing* *Light-headed*	*Try to ignore voice after*

In Table 3, the young person responds to a situational trigger and experiences the distressing thought that they are in danger. The resulting emotional response and perceptual disturbance lead to the young person's efforts to protect themselves.

Resource 4 contains a thought record template for use in clinical practice.

TABLE 3. **THOUGHT RECORD: PERSECUTORY BELIEFS AND VOICES**

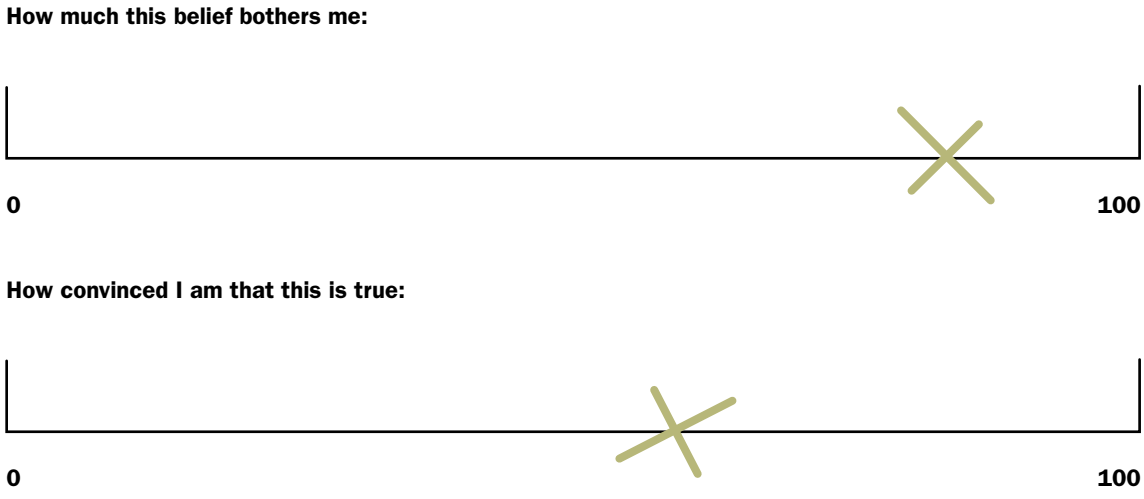
Trigger	Thoughts and beliefs	Emotional and physical response	Odd or unusual experiences	Behaviour
Noticing a stranger looking at me on the train	*He looks dodgy* *He is following me* *I'm not safe*	*Angry* *Fearful* *Agitated* *Feel hot*	*Hear a voice telling me to 'get him'*	*Become aggressive* *Yell at the man*

Visual analogue scales

Visual analogue scales provide a dimensional rating of the strength of beliefs and the degree of preoccupation with these beliefs as part of clinical assessment and ongoing monitoring. The scale (as presented in Figure 9) is simply a line with a range from 0 to 100% and can be used to assess beliefs related to depression, anxiety, psychosis or other distress-inducing beliefs. It is important that the label for the belief or preoccupation expressed on the rating scale be chosen with the young person. Figure 8 demonstrates how a visual analogue scale is used with young person Eddie.

These ratings can be used for any kind of beliefs and may be repeated from session to session as a way of reviewing any changes in preoccupation or conviction over time.

FIGURE 9. **VISUAL ANALOGUE SCALE: 'UNDERCOVER COPS ARE TRYING TO SET ME UP'**



The downward arrow

The downward-arrow technique is an approach that may be used to help young people to uncover or analyse the meaning of unhelpful or distressing thoughts and beliefs. These underlying beliefs are their core beliefs or their schema about themselves, others and the world. For example, when working with a young person with psychosis, it may be common to have conversations about *why* they believe others are persecuting them, or *why* they believe they have special powers. Using the downward-arrow technique, the dialogue becomes more focused on *what it means* for the young person to be persecuted or *what it would mean* about the young person if they did not have special powers.

The initial line of questioning would generally focus on a recurring or distressing thought to discover more about the belief system relating to a particular problem.

Questions should gently tease out the personal relevance of a thought or belief by asking questions such as 'If that were true, what would it mean?'; 'What does that say about you?' or 'What would that mean about your future'. For example:

> **Clinician:** If the police were trying to set you up, what would that mean?
>
> **Young person:** That one of my friends had ratted on me.
>
> **Clinician:** If one of your friends had ratted on you, what would it mean?
>
> **Young person:** That I can't trust anyone.
>
> **Clinician:** And if you can't trust anyone, what does that mean?
>
> **Young person:** I'm alone, I don't have anyone to look out for me.

In this example the young person has disclosed their fear that a friend might have 'ratted on them' to the police, leading to anxiety and distress.

Using the downward-arrow technique, it becomes clear that this anxiety is driven by their fear of being alone or abandoned by others. This may well be something the young person has experienced during their psychotic episode and earlier in life. Once this information has been discovered, strategies for working with the young person may then focus less directly on the experience of paranoia, and more specifically on their fear of abandonment and examining and discussing any evidence for or against their belief that they are alone and cannot trust anyone.

Functional assessment of voices

As discussed, voices and other perceptual disturbances may be conceptualised within the CBT model as 'triggers' that result in emotional and behavioural responses based on the young person's appraisal (thoughts and beliefs). Therefore, exploration of a young person's beliefs about the voices they hear and other perceptual disturbances help to understand what is maintaining their distress.

The following are some useful structured tools that can be completed with the young person to gain further information about the nature of their experiences and their beliefs about voices:

- Beliefs About Voices Questionnaire Revised (BAVQ-R)[76]
- Maastricht Interview [77]
- *Victim to victor: working with voices*.[78]

Alternatively, the use of clinical interviewing to explore the areas listed in Table 4 will allow the clinician and the young person to gather sufficient information to complete a cognitive–behavioural formulation. There is a prompt sheet containing more examples of assessment questions in Resource 5.

An example of a functional assessment for Eddie's experience of hearing a voice is shown in the case scenario on the next page.

TABLE 4. **FUNCTIONAL ASSESSMENT OF VOICES**

Description of voices	Ask the young person to describe the voices: e.g. How many voices do you hear?
Content	Explore with the young person the content of what the voice says: e.g. Does the voice comment on what you are doing?
Triggers	Determine whether there are particular situational or personal triggers when the young person is more likely to hear the voice: e.g. When do you hear the voice?
Response	Ask the young person to describe their emotional, physical, cognitive and behavioural response to hearing the voice: e.g. What do you do when you hear the voice?
Beliefs about voices	Explore with the young person their beliefs about the voices, particularly whether they are perceived to be powerful, benevolent or malevolent: e.g. Do you believe that the voice is powerful?

EDDIE

CASE SCENARIO: FUNCTIONAL ASSESSMENT OF VOICES

Eddie has identified two voices: one male and one female, which he hears every day for about an hour. The voices are muffled but Eddie is able to hear what they are saying when he is alone. The voices talk to each other or provide a commentary on Eddie's actions or thoughts. These comments may be neutral, ('he's leaving the house') or critical, ('you're stupid'). Sometimes they give him advice, for example, 'you should leave now' but he denies any experience of commands. Eddie hears the voices most often when he is alone at his home or in another quiet place. He also reports that the voices can be more frequent when he is feeling anxious or ruminating about something negative.

In response to the voices, Eddie reports feeling 'on edge' and anxious with increased heart rate and feeling hot. He may sometimes yell at the voices when he is alone, but will pay more attention to them when in public, and at times follow their advice (e.g. taking a side street because the voices tell him there are cops on the road ahead).

Eddie says the voices may be other people, but is unsure about why he is able to hear them when others can't. He says at times he believes the voices are helpful, as they give him warnings so that he can keep himself safe. At other times, he experiences them as being cruel or critical, trying to hurt or worry him. Eddie states that he does not believe the voices are powerful, but that they appear to have insight or information about things that he does not. This is why it is important for him to pay attention to them. He would like to be able to ignore them more, but is worried that if he does, he would be more likely to be caught by the cops.

Structured assessment tools

In addition to the use of the clinical interviews and tools discussed, it may be useful to use questionnaires or other structured tests to assess components of psychotic symptoms, co-occurring problems and strengths.

The benefits of using this kind of assessment include the following:

- quick and easy to complete
- provides an objective rating of severity and frequency of symptoms over time
- may indicate whether interventions are effective or ineffective
- allows the young person to view their progress towards goals and the improvement in their symptoms over time
- can provide a detailed assessment of the quality and meaning of symptoms (i.e. beyond frequency and duration) for a young person
- regular assessment and monitoring may become a form of intervention in addition to informing comprehensive assessment and formulation
- may provide access to information that the young person is uncomfortable sharing face-to-face.

Some recommended questionnaires or clinician-administered tests for the assessment of psychotic symptoms, co-occurring problems and strengths are outlined below. None of these measures should be considered diagnostic tools, but rather measures to assist with developing a more detailed understanding the young person's experiences.

Measures to assess the experience of and characteristics of psychotic symptoms

- Brief Psychiatric Rating Scale (BPRS)[79]
- Psychotic Symptoms Rating Scales (PSYRATS)[80]
- Peters *et al* Delusions Inventory (PDI)[81]
- Paranoid Thought Scales[82]
- Beliefs about voices questionnaire (BAVQ-R76)
- Maastricht Interview[77]
- Comprehensive Assessment of At-Risk Mental States (CAARMS)[83]
- PQ-16 Screening Questionnaire[84]
- Subjective Experience of Negative Symptoms Scale (SENS)[85]
- Scale for the Assessment of Negative Symptoms (SANS)[86]
- Assessment of Thought, Language and Communication (TLC).[87]

Measures to assess functioning

- Children's Global Assessment Scale (CGAS)[88]
- Global Assessment of Functioning (GAF) scale.[89]

Other useful measures for young people with early psychosis

- Personal Beliefs about Illness Questionnaire (PBIQ).[90]

Measures to assess co-occurring issues

- Depression Anxiety Stress Scale (DASS)[91]
- Beck Depression Inventory (BDI)[92]
- Beck Hopelessness Scale (BHS)[93]
- State Trait Anxiety Inventory (STAI)[94]
- Impact of Events Scale (IES)[95]
- PTSD Checklist – Civilian Version (PCL-C)[96]
- Yale-Brown Obsessive Compulsive Scale[97]
- Eating Disorder Inventory (EDI)[98]
- Young Schema Questionnaire (YSQ-3).[99]

Measures to assess strengths and attributes

- The Valued Living Questionnaire-II (VLQ-2)[100]
- The Strengths Questionnaire.[101]

Following any assessment, it is best practice to provide feedback to the young person in a manner that is simple, brief, free of jargon, transparent and provides qualitative information. Ideally, if the clinician is regularly completing assessment tools, these will be integrated into therapeutic interventions during each session. If questionnaires or thought records are completed but not referred to or used in a meaningful manner, the young person may understandably lose motivation to complete such tools.

Using cognitive–behavioural formulation to guide psychological interventions

Case formulation in early psychosis

Clinical case formulation is the process of collating information that has been gathered during the assessment process. It is an attempt to synthesise information across the biological, psychological and social domains and provides a cohesive narrative about what may have led to the symptoms and difficulties being experienced by the young person. The case formulation offers hypotheses about the factors that have led to or maintain the presenting problems. Importantly, the collaborative nature of case formulation provides an opportunity to include a discussion of the young person's strengths and protective factors, which may ameliorate the impact of the mental health problems.[102,103]

An expanded description and rationale for the use of clinical case formulation for young people at UHR of psychosis, and those experiencing a first episode of psychosis can be found in the ENSP manuals A *stitch in time: interventions for young people at ultra high risk of psychosis*[4] and *Let me understand: assessment in early psychosis*.[74] These resources describe the biopsychosocial (Five Ps) approach to case formulation summarised in Table 5. This manual will focus on the use of cognitive–behavioural formulation or conceptualisation, which is complementary to the broader biopsychosocial approach.

TABLE 5. **THE FIVE PS OF CASE FORMULATION**

Presenting problems	Initial signs, symptoms or other issues that are clinically important for the young person	e.g. paranoia, low mood, homelessness
Predisposing factors	Factors that confer vulnerability or increase the risk of developing the presenting problems	e.g. early-childhood trauma, family history of psychotic disorder
Precipitating factors	Personal or circumstantial stressors or triggers associated with the onset of the presenting problems	e.g. a relationship break-up, starting to use cannabis, bullying
Perpetuating factors	Factors that maintain or exacerbate the presenting problems	e.g. regular substance use, interpersonal problems, poor social support
Protective factors	Personal or circumstantial factors that buffer or ameliorate the impact of the presenting problems	e.g. previous success at school, supportive family, good coping skills

Cognitive–behavioural case formulation

The following model integrates elements of the Five Ps model of case formulation and elements of cognitive–behavioural case conceptualisation as described by Aaron and Judith Beck[72] and Morrison et al.[53] It elaborates on psychological factors such as core beliefs or schema and cognitive biases and their impact on the development and maintenance of psychotic symptoms and other symptoms and distress.

The key elements of a cognitive–behavioural case formulation include the following:

Early experiences and beliefs

- early development and significant life experiences
- core beliefs or schema about the self, world and others (e.g. I am vulnerable)
- cultural and spiritual beliefs
- rules or assumptions
- beliefs about psychosis or other mental health experiences (e.g. insight about own thinking processes)

Cognitive and information-processing biases

- deficits in social cognition (e.g. theory of mind)
- source-monitoring bias (e.g. external v. internal sources)
- jumping to conclusions bias
- other cognitive biases also common to depression and anxiety (e.g. mental filtering where the individual pays attention only to information that confirms beliefs)

Compensatory strategies or safety behaviours

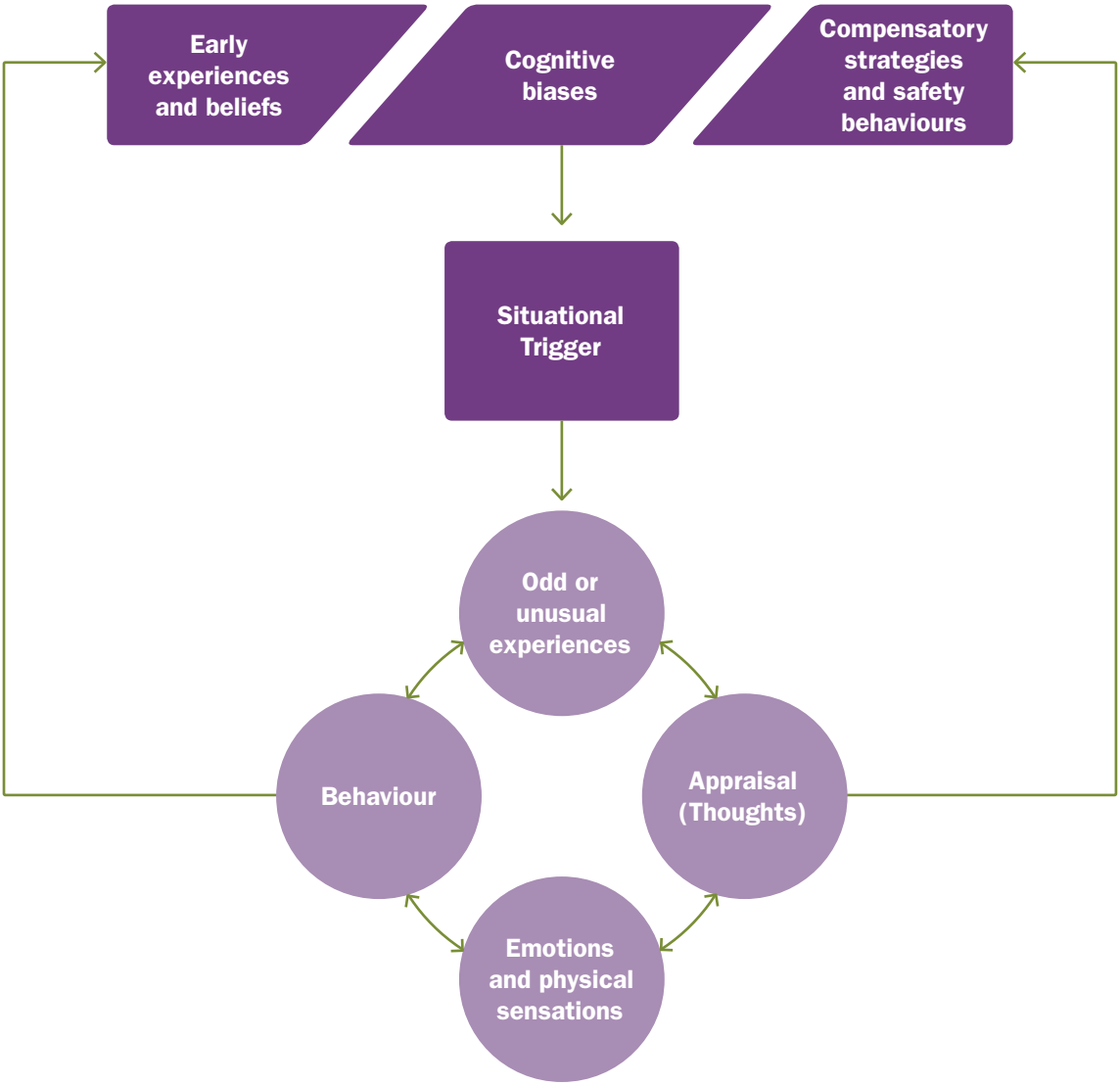
- avoidance (e.g. remaining inside their home to avoid people who may harm them)
- escape (e.g. leaving a room when someone unknown enters)
- situational behaviours (e.g. carrying a weapon when in feared situations)
- precipitants, triggers or significant events
- situational triggers (e.g. leaving the house)
- ambiguous social information (e.g. individual noticing a person looking in their direction)
- environmental and situational (e.g. changes in the weather or hearing about a plane crash on the radio)
- negative or irritating experiences (e.g. train delays)

Internal experience and responses

- odd or unusual experiences (e.g. hearing a voice)
- thoughts or images (e.g. intrusive thought such as ‘I’m being followed’)
- physical sensations (e.g. heart racing)
- emotions (e.g. fear)
- behaviours (e.g. avoiding others)

The relationship between these factors is presented in Figure 10.

FIGURE 10. **COGNITIVE–BEHAVIOURAL FORMULATION**

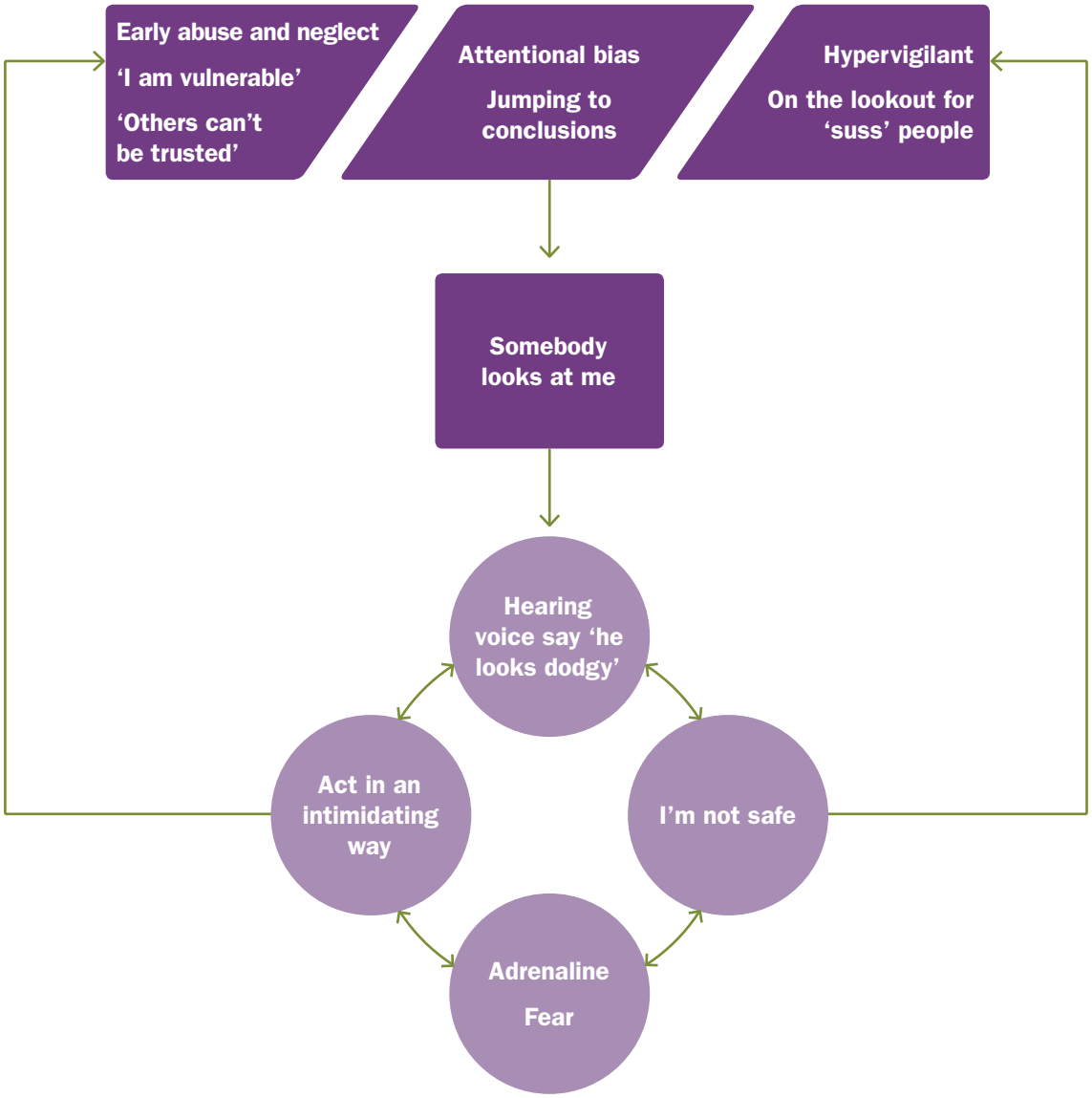


Pulling together information about moment-to-moment responses with an understanding of early experiences and long-standing beliefs is essential for forming a comprehensive treatment plan. For example, young person Eddie's early childhood was characterised by multiple placements in foster homes, and experiences of abuse and neglect. He has described long-standing beliefs that 'people will abandon me', 'others can't be trusted', 'I am alone' and 'I am vulnerable'. Eddie has described a rule of 'I must look out for myself' and has reported that he is always on the lookout for people who are 'suss', demonstrating a possible attentional cognitive bias. Given these longer term patterns, it is likely that Eddie will respond to persecutory beliefs with self-protective and hypervigilant behaviour and focus on information that confirms his beliefs.

Figure 11 presents an example CBT case formulation for Eddie's distressing beliefs.

Resource 6 contains a cognitive-behavioural case formulation template for use in clinical practice.

FIGURE 11. **EDDIE'S CBT FORMULATION**



Discussing case formulation with a young person

Case formulation is a collaborative process between a clinician and a young person that usually begins at the same time as assessment and engagement. However, it important to remember that case formulation should be revisited regularly and may evolve over time. Sharing the formulation with the young person in verbal or written forms is an opportunity to enhance engagement and often, to promote optimism in the young person.[104] It demonstrates that the clinician is interested in understanding the 'whole person' and helps to articulate clearly how treatment will be specifically targeted. Formulation should be flexible and be adapted as needed to developments that occur during treatment.[105]

Methods for presenting the case formulation vary and may include the use of diagrammatic representation or a letter to the young person, and should be tailored to the individual. The online ENSP module 'Introduction to case formulation' provides detailed information on how to use case formulation in clinical practice.

Goal setting and treatment planning

Setting goals

Before commencing any psychological interventions, it is important to set collaboratively some specific, measurable and realistic goals for the clinician and young person to work on together. For clinicians working in an integrated role as case manager/therapist, careful consideration should be given to the young person's priorities and hierarchy of needs. For example, if a young person requires assistance with finding housing and support with forensic issues, this may be prioritised in the short term over commencing psychological treatment for anxiety or low mood. The ENSP manual *Keeping on track: functional recovery in early psychosis* provides an expanded discussion on goal setting with young people with early psychosis.

Nonetheless, psychological interventions will be indicated to support a broad range of goals, including supporting functional recovery, symptom management and reducing distress.

Questions to pose to the young person to elicit their goals may include:

- What do you think would be helpful for us to work on together?
- Are there things that are most important to work on first?
- What things in your life would you like to be different to how they are now?
- Would working together on … be a helpful thing for you?

It is important to be hopeful and optimistic about the young person's capacity for recovery; however, when setting specific treatment goals, clinicians should consider the capacity of both the young person and the treatment approaches available. For example, the focus of the psychological interventions may be to support the young person's capacity to cope with psychotic symptoms rather than to eliminate the symptoms entirely.

'I thought, wow, these people are looking after me. They're like making a healthcare plan for me. And I actually felt incredibly safe … the safest I'd felt in a long time, and I needed that.'

Young person
EPPIC, Orygen Youth Health Clinical Program

EDDIE

CASE SCENARIO

The following dialogue demonstrates how Eddie and his case manager developed some shared treatment goals around his experience of psychosis.

CM: Eddie, now that we have spent some time understanding some of what has been happening for you, I was wondering what you think would be helpful for us to work on together?

Eddie: I just want to be able to see my friends and go to work and be normal. Just to be able to leave the house and see people without getting into fights all the time.

CM: It's been really challenging for you to continue with work and seeing friends recently. What do you think would need to change for you to reach that goal?

Eddie: To be able to get out of the house I would need to be less worried about the cops. That they are setting me up.

CM: Sure, you've said that you spend a lot of time thinking about that at the moment. What else would look different?

Eddie: I overreact pretty quickly, especially when I hear the voices. To be a bit calmer and not get so angry or scared would help.

CM: Fantastic. We can definitely work on those things, it sounds like there are a number of smaller steps there. Let's write them down.

The goals developed by Eddie and his case manager were:

- To be less preoccupied with my worry that the cops are trying to set me up.
- To be able to calm myself down and relax when I hear voices.

Using the cognitive–behavioural formulation presented for Eddie earlier, there are a number of indicated psychological strategies to support him to meet his goals. These include developing a shared formulation, identifying 'thinking errors', gathering evidence for beliefs, coping strategies and behavioural strategies for responding to feelings of fear or anger. A brief description and rationale for each intervention can be found in Table 6.

TABLE 6. **PSYCHOLOGICAL INTERVENTIONS FOR EDDIE**

Intervention	Description and rationale
Shared formulation	Use of the CBT formulation to develop shared understanding of how Eddie's behaviour maintains his belief that others are targeting him and how early experiences and core beliefs may be related to his current belief
Identify 'thinking errors'	Provision of psychoeducation about common cognitive biases or 'thinking errors' and ask Eddie to identify those that he may make regularly; focus on general examples and normalise biases; make connection/s to early experiences and the adaptive or protective function of these biases (e.g. attentional bias to be aware of threat) earlier in his life
Evidence for belief	Eddie wishes to reduce the amount of time he spends thinking about his belief that the cops are trying to set him up; this intervention may allow him to reflect on what he is using as 'evidence' to confirm his belief (e.g. reacting to anxiety, paying attention to voices, jumping to conclusions); it will also allow him to collect evidence or pay attention to information that does not support his belief (e.g. friends that wish to help him or spend time with him, lack of any direct police contact)
Coping strategies	General relaxation and stress-management strategies may assist Eddie to reduce anxiety and hypervigilance; specific coping strategies should be formulated for when Eddie experiences critical or fear-inducing content from voices
Responding to anger or fear	Eddie is currently restricted to responding to feelings of fear or anger by using aggression: psychoeducation should be used to normalise learnt response based on early experiences; there should be planning of alternative responses and when these may be effective (e.g. taking time out, crossing to other side of the street, using evidence testing, using relaxation strategies)

The next part of this manual is designed to be used based on each young person's case formulation and goals for treatment. Most young people who have experienced a first episode of psychosis will benefit from interventions to support adaptation, reduce stigma and address experiences of trauma related to the episode. All young people should be offered relapse planning and prevention interventions. Other interventions targeted at specific issues such as psychotic symptoms or co-occurring issues should be selected based on the needs of the young person.

PART 4

Psychological interventions for early psychosis

Psychological interventions for early psychosis

This part of the manual focuses on the introductory principles for using psychological interventions with young people with early psychosis. Therapeutic strategies that work will vary from young person to young person and it is vital that clinicians keep in mind the primary aims of using psychological interventions (see box below). The interventions discussed here are working with strengths and resilience, and applying adaptation and coping interventions for young people experiencing psychotic symptoms. This discussion does not cover CBT-P, as it is considered to be an advanced level intervention that is beyond the scope of this manual but will be addressed in future ENSP training products.

PRIMARY AIMS OF PSYCHOLOGICAL INTERVENTIONS FOR PSYCHOSIS

- Reduce distress
- Reduce negative impact on functioning
- Maintain engagement in a collaborative therapeutic relationship
- Support positive adaptation and coping following an episode of psychosis
- Importance of reducing symptoms or content of belief is secondary to the above aims

Recognising what is right: working with strengths and resilience

What do we mean by strengths and resilience?

McQuaide and Ehrenreich (1997) define strengths as 'The young person's capacity to cope with difficulties, to maintain functioning in the face of stress, to bounce back in the face of significant trauma, to use external challenges as a stimulus for growth and to use social supports as a source of resilience.'[101]

What is a strengths-based approach?

A strengths-based approach to early psychosis care and intervention utilises positive processes in therapy to effect change and promote personal growth. It does this through an exploration of the young person's future ambitions, goals and values, as well as by utilising their personal resources and achievements.[106-108] This can be challenging for clinicians who have been trained using more traditional problem-based approaches, which emphasise the assessment and treatment of symptoms and deficits. The strengths-based approach concentrates on the individual strengths the young person has, acknowledging that each young person has unique and individual strengths and difficulties regardless of their illness. The strengths-based approach purposefully focuses on what the young person *can do*, rather than on their deficits or difficulties.

The aim of a strengths-based approach is also to develop the young person's independence and agency, rather than promoting dependence on supports, but at the same time, acknowledging that all people are interdependent and rely on each other.[108] The community is viewed as an oasis of resources and is the primary setting for all psychosocial interventions.[108]

Identifying strengths and resilience

Strengths-based approaches should be incorporated as part of the usual way clinicians work with young people and their families. For example, using a strengths-focused assessment when developing goals for intervention encourages the young person and their family to talk about their aspirations and needs, rather than focusing on perceived difficulties.[106] It may not always be easy for young people to identify their own strengths, particularly if they come from a background where their strengths have not been recognised. In such cases, the role of the clinician is to act as an advocate for the young person, and to become a positive voice in their life, as they may not have had this previously.

This can be achieved by reflecting back to the young person how they are being experienced in therapy. This can include sharing your observations about the young person's progress in areas such as developing trust, motivation to change, being open to challenging their fears, or their willingness to seek help. Being a positive voice for the young person may also involve providing a reframing perspective of their defences (e.g. self-harm or being guarded) as protective mechanisms that have been developed to cope with recent or early trauma that others may have labelled 'problematic behaviour'.

It is useful when assessing for strengths to consider information about the following:

- areas of weakness
- areas of strengths
- deficits in the young person's environment
- resources in the young person's environment that can be mobilised to improve functioning.

Central to this process is the emphasis placed on developing a genuine and collaborative therapeutic relationship. It is important to allow the young person to be in control of therapeutic process and to have agency in making decisions about the course of their recovery.

USING A STRENGTHS-BASED APPROACH

- Remember that this process takes time. The use of a strengths-based approach will evolve more naturally over the course of therapy as the young person has the opportunity to reveal more information about themselves.
- It is important to be authentic. As with most therapeutic processes, recognising and discussing strengths with the young person should occur naturally once therapeutic relationship has been formed.
- Ensure that timing is considered carefully. For a young person seeking help for a problem, a premature effort to assess strengths may be viewed as a rejection or an inability to understand their problem and to tolerate their experience of negative emotion.
- Ensure an appropriate use of language. Meet the young person where they are at: use their language and metaphors or help them to find their own metaphors.
- Scaffold strengths-based interventions. Decide on an intervention based on the strengths and weakness of the young person. Begin at a level they are ready to handle and work through with your support.

Ciarrochi et al.[109] provide a useful tool for assessing strengths and resilience. A free copy of this tool can be downloaded from http://www.actforadolescents.com/for-professionals/resources-and-freebies/.

Using strengths in therapy

Some examples of strategies that clinicians can employ to explore the strengths and values of a young person in therapy include:

- positive reframing – the clinician's ability to listen to a young person describing a problem (which will often be loaded with negative material) and be able to find genuine positives in what they are saying
- balancing strengths and weaknesses – taking the view that strengths and problems (weaknesses) are not at opposite ends of a spectrum and that a behaviour or trait that currently causes problems (e.g. dissociation under stress) may be a strength in another

situation or at another time (e.g. when unable to protect themselves from abuse as a child)

- using metaphors to access strengths and create a narrative of resilience – it can be helpful to explore with young people any metaphors or images that come to mind that symbolise strengths or values (e.g. a soldier who is wounded in battle but becomes stronger and more resilient despite their scars); this can encourage the young person to use these images and metaphors to view themselves navigating future goals and challenges in their lives
- using the therapeutic process to highlight strengths – clinicians may use themselves and the therapeutic relationship as tools to notice and reinforce strengths demonstrated by the young person, for example, the young person's commitment to attending appointments with their case manager and their willingness to speak about difficult topics can be viewed as a strength upon which to build and to generalise beyond the therapeutic context
- instilling hope and empowering – using a solution-focused approach to encourage change and instil confidence in the young person that they have the resources to navigate their current problems or difficulties; the clinician should reflect on how the young person has demonstrated resilience previously and embed these examples of resilience in action plans.

Adaptation

Adaptation to psychosis

The experience of a psychotic episode, or being diagnosed with a psychotic disorder, can in itself be traumatic and have a profound effect on a young person's identity. Coursey[110] notes, 'In our rush to discover the basic biology of schizophrenia, we have ignored the human experience of schizophrenia' (p. 350). Young people are often negotiating significant developmental tasks across social, sexual, educational and occupational domains at the time of experiencing a first episode of psychosis. The onset of the psychosis can signify a disruption to the expectations the young person might have of themselves and their future.

In addition, psychotic diagnoses such as schizophrenia are 'still associated with considerable stigma, fear and limited public understanding'[17] (p. 5). The first few years are often distressing and tumultuous, and during this period there is an increased risk of suicide.[17] Therefore, the role of a clinician working psychotherapeutically with young people is to assist them through an adaptation process following a first episode of psychosis.

Given early psychosis commonly occurs during an important developmental period, helping young people to adapt following the experience and maintain self-esteem is a crucial part of the psychological work to assist recovery from psychosis. Young people need space to understand and process the experience of psychosis, explore their ideas about the meaning of their symptoms and their experiences of treatment, as well as ideas about the meaning of having had a psychotic episode and what this means for their future expectations of themselves and their life. It is essential to instil a sense of hope and realistic optimism for recovery. This can mean challenging stigma and attitudes towards mental illness in the person's family and culture.

Exploring the experience and meaning of psychosis

When young people and their families' first encounter clinicians at an early psychosis service, there are justified expectations that clinical staff will provide information, tell them what has happened and what kind of prognosis and outcomes can be expected. The careful and timely provision of accurate and plain-language psychoeducation is essential; however, sometimes the perspectives of young people and their families can be lost as clinicians step into the role of 'expert'. Personal reactions to an experience of psychosis vary dramatically and it is vital that clinicians take considerable time to allow the young person space to talk about the meaning of their experience from their own perspective.

When working with young people, clinicians should consider the following questions relating to the young person's experience and personal meaning of psychosis:

- What are the young person's ideas about why psychosis happened to them at this point in their life?
- Do any of their symptoms relate to specific experiences that they have had in the past?
- What do they think their particular symptoms mean?
- Do they have other experiences of psychosis in family or friends?
- What are their expectations for their recovery?

- What do they need to learn to cope with differently?
- Has their experience of psychosis, including experiences of treatment, been traumatic?
- Are there opportunities to notice and encourage post-traumatic growth?

This process allows the young person to be able to use a narrative approach to telling their story, including expressing the difficulties of being diagnosed with psychosis, distressing symptoms and the resulting impact on their functioning across social, educational, occupational, sexual and spiritual domains. The aim of such an intervention is for the young person to have the space and time to reconstruct new meaning, and to allow for the incorporation of optimism and hope for their future. As discussed, the clinician's role throughout this process is to notice and draw attention to the strengths and resilience demonstrated by the young person's ability to cope with distressing psychotic experiences, and navigate a return to their developmental trajectory.

Ensuring the young person has the space to express their experience from their own perspective is useful and serves multiple purposes. It communicates to the young person that it is normal and expected to require a period of reflection and that the clinician can tolerate their grief and distress. It promotes insight and personal awareness of their own ability to cope and adapt in the face of life's adversities. Finally, it instils in the young person hope and optimism that they can develop a different relationship with themselves, others and the world as they become aware of their strengths and learn new skills.

For young people who are experiencing trauma symptoms following a psychotic episode, anticipating this may be helpful. Clinicians can introduce the idea that they understand the young person may have had many distressing or traumatic experiences related to the psychosis itself, or related to their treatment (see Table 7) and ask the young person directly about whether they have had any of these experiences.

TABLE 7. **DISTRESSING EXPERIENCES OF PSYCHOSIS AND TREATMENT**

Psychotic symptoms	Treatment experiences
Hearing voices that are controlling, commanding or threatening	Being taken against my will to the hospital by police or ambulance
Believing that people were trying to hurt me	Experiencing scary or hurtful treatment
Feeling afraid of going 'crazy' and losing touch with reality	Physical or chemical restraint
Behaving in odd or embarrassing ways	Seclusion from others while in hospital
Putting myself or others in danger	Feeling scared of other people or patients in hospital
Feeling that I was being controlled by an external force	Experiencing a serious side effect from medication
Hurting myself or others	Being forced to take medication

It is important to ask the young person whether they are still distressed or still experience problems in their day-to-day life that are related to their experience of psychosis or treatment. It is common for young people to experience post-traumatic responses following an episode of psychosis, [111] but many clinicians feel reluctant or worried to explore this area with young people due to fears of worsening the young person's symptoms.[112] It is not necessary to ask the young person to relive or recount in detail the specific experiences that have distressed them, and in fact, this may be damaging or re-traumatising if they do not have the skills to cope with intrusive memories and emotions. However, it can be extremely validating and normalising to acknowledge that particular experiences may have been traumatic and to assess for trauma symptoms. The following lists some tools that may be useful to screen for trauma symptoms:

- Impact of Events Scale (IES)[95]
- Children's Revised Impact of Events Scale (CRIES-13)[113]
- PTSD Checklist – Civilian Version (PCL-C)[114]

There are a number of models of intervention for young people experiencing co-occurring psychosis and trauma symptoms that are currently being developed.[115] General recommendations for best practice approaches for case managers include providing normalising psychoeducation about trauma symptoms, ensuring safety through the provision of coping strategies, distress tolerance and a clear risk plan. A range of individualised psychological strategies based on a case formulation approach may then be drawn from CBT and related third-wave paradigms such as ACT or mindfulness.

Post-traumatic growth following a first episode of psychosis

The concept of post-traumatic growth refers to the potential for transformative change that occurs because of the experience of trauma, in this instance, following a first episode of psychosis. The experience of the trauma itself does not lead to growth. Growth can develop as a consequence of the impact and response of the young person as they cope with their experiences.[116] Research has found that in addition to experiences of distress, many young people identify positive or adaptive outcomes following a first episode of psychosis.[117-119]

In their recent study with young people following a first episode of psychosis, Dunkley et al.[119] demonstrated that post-traumatic growth was evident across a number of domains including the following:

- perspectives on psychosis and recovery – viewing recovery as a journey (e.g. there will be 'ups and downs' during the process of recovery) and developing acceptance and moving forward (e.g. accepting a loss of control over aspects of the experience)
- recovery processes and outcomes – self-directed recovery (e.g. use of personal coping responses), use of interpersonal resources to facilitate recovery, functional recovery (e.g. increased self-worth and confidence, contributing to society) and social recovery (e.g. re-establishment of social skills)
- constructive change – developing deeper and closer relationships (e.g. recognising loved ones who have 'stuck by me'), improved or confirmed view of others (e.g. awareness of the positive qualities of others), desire to invest in relationships, increased awareness and compassion for others, greater appreciation of life, new possibilities and life direction, and the development of mastery and personal strength.

There is great benefit to clinicians being aware of the potential for negative and positive responses to a first episode of psychosis and subsequent post-traumatic growth. The following case example presents an example of a dialogue between a young person (Nadia) and her case manager in which they are exploring growth following psychosis.

NADIA

CASE SCENARIO

Nadia is a young woman who experienced a traumatic involuntary inpatient admission due to manic symptoms in the context of a first episode of psychosis. Prior to this admission, Nadia had been escorted by security from her workplace due to her erratic and intrusive behaviour towards colleagues while manic. During her fifth appointment at the early psychosis service, Nadia and her case manager have the following interaction.

Clinician: I know that you returned to work this week. How has that been for you?

Nadia: It's been mixed really. I was very anxious about seeing the other women at work because the last time I saw them was humiliating … especially Tanya, because I said some really crazy things to her.

Clinician: You were worried about what they would think about you … whether they would treat you differently.

Nadia: Yeah … that they would think I was a freak because I felt like a freak and that I wasn't as good as them anymore.

Clinician: I think that anyone would find it hard to return to work if they were feeling that way. It's impressive that you managed to go despite those fears. What happened once you were there?

Nadia: Well, that's the funny thing. I mean I definitely got some 'looks' … you know … from a few people. But then a couple of my colleagues just seemed really happy to have me back … they weren't awkward and one or two told me about family members who have experienced the same thing as me.

Clinician: So, there were some reactions similar to when you told your close friends what had happened? It sounds as if you've been surprised by the positive responses from people.

Nadia: Yeah. I feel like in some respects as much as this has been a really horrible experience, it has changed my relationships in positive ways. I'm still pretty terrified of the symptoms coming back, or having to go back to hospital, but just the way I think about people in my life … it just feels different.

Clinician: Can you tell me in what way you are thinking differently about people?

Nadia: I suppose some of the superficial stuff has fallen away. That people have seen me at my worst, but that they are still able to see 'all' of me … and sort of just accept the good and bad bits.

Clinician: That you can just be who you are and not worry about being rejected by others?

Nadia: Yeah, exactly! Which is funny because I was always the kind of person who cared so much about what other people thought of me. How I looked, what I wore, whether I was smart enough, likeable enough. But now, I guess I really value those people who I can be more open with and I kind of realised that I have a choice about whose opinion I pay attention to.

Clinical practice recommendations for working with meaning of psychosis and trauma following a first episode of psychosis include the following:

- Time spent reflecting on both the negative and positive outcomes of psychosis is important.
- Clinicians should listen for statements that reflect growth and use opportunities to explore these experiences further.
- Discussions about growth and positive change should include family and significant others.
- Reflection on growth and positive change should occur at a number of stages during the course of treatment, particularly at points where there is often a greater focus on the negative consequences of psychosis (e.g. relapse planning and prevention).

> We talked about the dark, nitty gritty things for a year. Then, when I was coming towards being discharged, I thought, I'm going to go with this now and focus not on the dark stuff but work on everyday living and coming to peace with all the stuff I talked about.
>
> Young person
> EPPIC, Orygen Youth Health Clinical Program

Addressing stigma and normalising

As outlined previously, the impact of a psychotic episode may go beyond the experience of distress due to symptoms. For young people and their families, the term 'psychosis' and related diagnostic labels of 'schizophrenia', 'schizoaffective disorder' or 'bipolar disorder' can carry a highly stigmatised meaning.

Young people may have family members from earlier generations that have spent extensive time in long-term care or with poor outcomes who were given these diagnoses. This can lead to an assumption that they face a similar prognosis. In addition, despite advances in mental health literacy, there remains significant ignorance and stigma around psychosis in the general community. Young people may have previously held quite stigmatised views about people who were 'psycho' or 'schizo'.

> My Gran has bipolar, and I now have bipolar also, and [being diagnosed] did instantly make me think, 'My life's over'.
>
> Young person
> EPPIC, Orygen Youth Health Clinical Program

Yanos et al.[120] investigated a number of interventions used to reduce self-stigma in relation to serious mental illness. They found that while diverse, there were some common mechanisms employed by each intervention, for example:

- Using psychoeducation and information to counteract myths about mental illness.
- Acquiring corrective knowledge supports the individual to critically examine and reject prejudiced statements or behaviours to which they are exposed in daily life; this reduces the likelihood of internalising attitudes associated with social stigma.
- Cognitive techniques provide opportunities to learn and practise skills to identify and challenge self-stigmatising thoughts and beliefs.
- Using personal narrative can allow each person to make sense of and derive meaning from their experiences.
- Encouraging behavioural decision making can be achieved by providing tools or experiences designed to empower individuals, increase motivation and encouraging them to select and act on personal goals and values.

Clinicians should adopt an attitude of openness to discussing diagnostic labels and enquire about whether the young person and their family hold any particular beliefs that are distressing to them.

It is particularly helpful to reassure young people and family members about the inaccuracy of media portrayals of psychosis, and the relatively recent treatment advances that mean the young person is likely to have very different experiences to older family members that have experienced psychosis.

The following may be helpful for explaining psychosis in a normalising manner:

- viewing psychosis on a continuum
- viewing psychosis as a response to extreme circumstances (e.g. explaining sensory deprivation studies)
- using positive first-person accounts of other people who have experienced psychosis.

One useful resource is *Trips and journeys: personal accounts of early psychosis*.[121] Please also see the ENSP manual *A shared understanding: psychoeducation in early psychosis* for more information about discussing psychosis with young people and their families.

Identity and self-concept

Developmental tasks of adolescence

The onset of psychosis most commonly occurs during a developmental phase characterised by considerable change and flux. Young people may achieve tasks of adolescence and early adulthood at different rates, leading to a broad range of development and maturity levels for young people of the same age. Depending on where a young person is on their developmental trajectory, the experience of a first episode of psychosis can be significantly disruptive to this process.

During adolescence, a young person moves through a process of physical, psychological and social changes including the following:

Cognitive changes

- developing a greater level of abstract thought, reasoning and problem-solving ability[68]
- gradual maturity of brain structures involved in attention, reward- and goal-directed behaviour and impulse control[122]

Emotional changes

- increased emotion recognition and capacity to regulate emotion (more common in later adolescence)[122]
- seeking new experiences and risk-taking
- emotional upheaval ‘ups and downs’ in response to dynamic interaction of social, cognitive, and physiological changes

Independence and individuation

- moving away from dependence on parents and family of origin as a means of defining self
- exploring identity through new roles and relationships with peers, school, work and community institutions
- attaining functional skills and independence; moving away from home, living independently, becoming self-sufficient

Sexuality, intimacy and social relationships

- developing greater physical and sexual maturity
- developing intimate and sexual relationships
- having friendships and peer relationships become more important

Educational and vocational identity

- ongoing education (high school, university, vocational training)
- first experiences of employment and pursuit of career goals

Identity

- exploring personal identity that occurs as part of dynamic interaction with other developmental tasks
- being influenced by the social and environmental context
- forming a stable self-concept central to ongoing healthy development as the young person moves into adulthood.[68]

During a psychotic episode, the young person’s developmental trajectory may be disrupted in the following ways:

- Educational and vocational performance may be affected by neurocognitive problems or even prevent completion of education and attainment of vocational identity.[123-125]
- Social development may be halted as the young person withdraws during acute or recovery phases, leading to a disruption to peer relationships.[126-128]
- Intimate relationships can also be affected by social withdrawal and young people may be fearful of pursuing intimate relationships following a psychotic episode, which can interfere with their psychosexual development.[129]
- Stigma and self-stigma related to mental ill health can have a detrimental impact on self-concept and self-esteem for young people.[130]
- Personality and identity development can be affected by the trauma of the experience of a psychotic experience and lead to identity diffusion.[131] The resulting impact on a young person’s identity may result in low self-confidence and there is a risk that the low self-confidence will become enmeshed with the psychosis itself and the young person may view themselves as ‘sick’.
- The process of individuation from parents may be delayed because the young person may need additional support from family and a reliable and secure environment.[132] For the young person, this may feel like a step backwards, while for family members there may be uncertainty about ‘letting go’ and allowing the young person the independence that is developmentally appropriate.

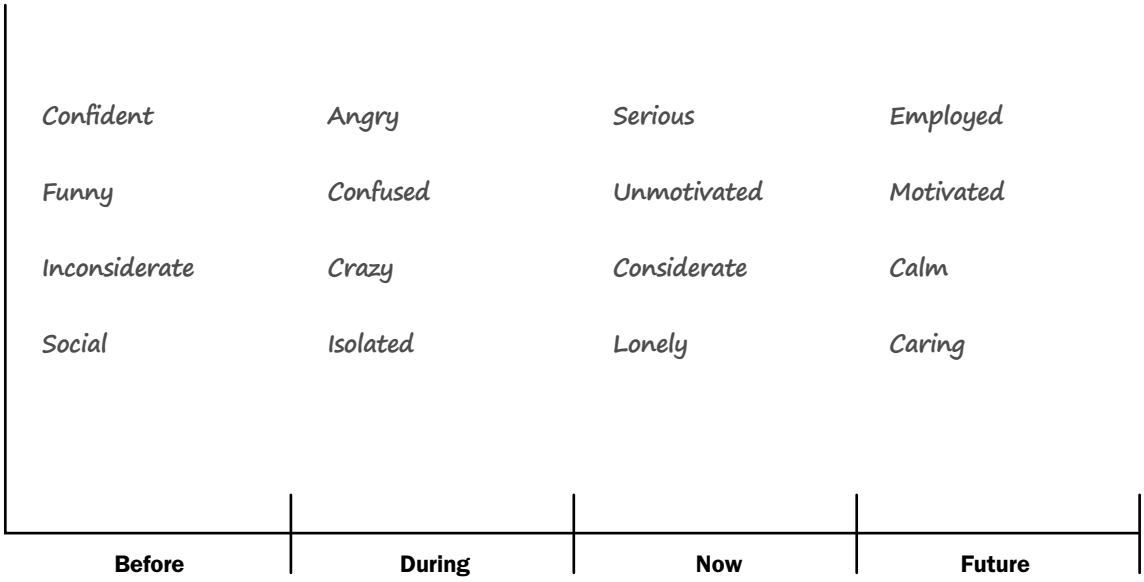
Therapeutic interventions should aim to support the young person to re-establish a positive identity and view of themselves in the future that is not enmeshed with their experience of psychosis. To achieve this, clinicians should explore how the young person defined themselves before the psychotic episode, how they see themselves currently, and how they view their 'future self'. A repertory grid or timeline (see Figure 12) may be useful tools for facilitating this conversation and exploring the impact of stigma related to the experience of psychosis with the young person. Clinicians can use the repertory grid or timeline to ask the young person questions such as the following:

- How do you see yourself now?
- How do you see yourself in the future?
- How do you see people who have a mental illness?
- How do you see people who have psychosis?

Resources 7 and 8 provide templates of a timeline and repertory grid for use in clinical work.

A process of guided discovery can then be used to challenge negative views held by the young person and set realistic short, medium and long-term goals. It is important to validate the real impact of psychosis and re-orient the young person to what is possible. Again, the attitude of the clinician towards the young person's potential for recovery is essential.

FIGURE 12. **NADIA'S IDENTITY TIMELINE**



Understanding and working with symptoms of psychosis

Coping interventions for voices and distressing beliefs

Coping strategies for voices or distressing beliefs are not qualitatively different to coping strategies that may be used for any kind of distress related to low mood, anxiety or feelings of shame or worry.

Interventions to support young people to cope with voices or distressing beliefs are most useful if the clinician has a good understanding of the meaning and distress-causing appraisals that the young person holds in relation to these symptoms. One of the most straightforward ways of structuring this kind of detailed assessment is to use a cognitive–behavioural framework that identifies triggers, appraisals, emotional, physiological and behavioural responses.

Research has demonstrated that natural coping efforts directed at psychotic symptoms are very common, with at least 70% of individuals able to identify one coping strategy.[133-136]

The range of self-initiated coping strategies is broad and covers the following domains:

- behavioural (e.g. avoidance of trigger situations)
- cognitive (e.g. listening to the voices)
- physiological (e.g. use of relaxation strategies).

With respect to the experience of distressing voices, coping styles can be grouped by their mechanism of action (e.g. competing auditory stimuli such as turning up the volume on the radio; vocalisation such as singing or humming; or distraction such as watching a movie) or by coping style (e.g. active acceptance, passive coping or resistance coping).[133]

Each young person needs an individualised coping response for particular psychotic symptoms. There should not be a 'one-size-fits-all' approach. While the use of distraction-based coping may be sufficient for one young person to reduce distress and function when hearing a voice, for another young person, it may be important to focus on what the voice is saying and to use active responding or cognitive strategies such as self-statements.

There is no clear consensus about what constitutes the most 'adaptive' or successful coping strategies for psychotic symptoms, although there is some indication that active acceptance and passive coping may reduce distress more than resistance coping.[133]

Generally, the best approach is to encourage young people to experiment to find what works for them and to support the acquisition of coping strategies that support broader functioning rather than exclusively focusing on symptom control. For example, the use of self-harm or withdrawal from social contact may be very helpful for some young people in their efforts to reduce intrusive and distressing psychotic symptoms. However, the broader consequences of these strategies may be detrimental to broader functioning (e.g. cause physical injury and/or social isolation).

Understanding existing coping strategies

Clarify with the young person the nature of the experience that they are finding distressing. This may be relatively clear, but it is important not to make assumptions that a young person will want to get rid of, or feel the need to cope with, all of their psychotic symptoms.

Some young people may indicate that they are not aware of any efforts they make to cope in response to psychotic symptoms. In this case, it can sometimes be useful to encourage the young person to increase their awareness of their responses by keeping a diary to monitor the onset of symptoms and their responses.

Once the clinician has identified the primary distressing experience and completed a cognitive–behavioural assessment with the young person, they can begin to explore with the young person the strategies they are already using to cope with their experience.

Clinicians should take time to explore each coping strategy in detail. Asking following questions may be helpful to achieve this:

- What is the strategy?
- How is the strategy helpful?
- In what situations is this strategy helpful or unhelpful?
- How often is this strategy helpful or unhelpful?
- Does using this strategy have any other consequences that are helpful or unhelpful?

Resource 9 includes a worksheet for identifying coping strategies with young people.

Developing new coping strategies

There are a number of resources that may be used with young people to introduce ideas about new coping strategies. Websites for groups such as the Hearing Voices Network (http://hearingvoices.org.au) have a number of free resources available to download that list a broad range of commonly used coping strategies.

The following sections list some of commonly used strategies that young people may find useful to cope with odd or unusual experiences. This content is also available in Resource 10 as a handout to be used with young people. It is important when introducing or offering suggestions that the clinician remind the young person that what works for one person may not work for another, and that a process of selecting and experimenting with one or two strategies may be more helpful than trying multiple strategies at the same time.

Normalising

Remind the young person that they are not the only person who has these kinds of experiences. Experiences of hearing voices or having visions is reported by many people in the community, particularly in situations such as when they are under a lot of stress, when they are falling asleep or waking up, when a loved one dies, or in the context of mental health problems.

Distraction

Finding something else to do that will occupy some of the young person's attention can be very helpful as a short-term coping strategy. Try to choose something that they enjoy such as listening to music, going for walks, calling a friend, watching a movie or doing something creative such as drawing or writing.

Reality testing

Young people who experience hearing voices or having distressing beliefs should be prepared for their mind to play tricks on them, and to try to slow down and not jump to conclusions when having a distressing thought or experience. Sometimes the young person will respond to their emotions before taking time to see if there is any evidence for what they are thinking or worrying about. It can be difficult to reality test and sometimes it can be useful to verify things with a trusted family member or friend.

Self-talk

Experiences such as hearing a voice can contain a lot of negative, critical or even threatening content. It can help for the clinician to remind the young person that the things being said to them are not true, and that they should try to focus on aspects of their life that help them to feel in control, supported, proud or optimistic.

Relaxation

There are a number of breathing and relaxation strategies that can be used to cope when feeling distressed. Slowing down breathing, using progressive muscle relaxation (PMR), visualising a safe place or other mindfulness and meditation techniques are all useful approaches to relaxation. Some strategies take some time to learn, so it is beneficial for the clinician to help the young person find something that works for them and encourage them to take time to practise when they are not feeling very distressed or anxious.

Acceptance

This strategy involves taking an 'observer' view of internal experiences (e.g. thoughts, feelings, sensations) without trying to modify or change anything. By doing this, the young person can stop struggling or resisting unpleasant thoughts, feelings or sensations and accept that they are happening and that they will pass eventually.

Getting active

Engaging in regular exercise can be helpful to improve wellbeing across multiple domains. This does not need to be complicated: simply going for a walk can provide a distraction, and enhance mood and reduce anxiety in addition to providing physical health benefits. Sometimes even changing environment, moving to a different room, walking to the local shops may act as a 'circuit breaker' for intrusive experiences such as voices or distressing thoughts.

Singing, humming or using earplugs

Making noise through singing or humming can activate the same parts of the brain that are used when people hear voices. Some young people find that they do not hear a voice while they are using this strategy. Another strategy to block out voices involves using an earplug to block one ear; this can block or reduce the volume of a voice.

Creating a coping plan

With the young person, the clinician may be able to create a coping plan based on existing strategies or decide that some new or different ways of coping need to be developed.

If effective coping strategies are already being used, the coping plan may focus on encouraging the young person to use the same strategies more frequently, in a more planned or structured way, to initiate them earlier, or combine a number of existing strategies.

If there are limited or unhelpful coping strategies the clinician may find that a young person is restricted to one or two strategies that have only limited effectiveness. In this situation, it may be helpful to look at coping strategies that have worked for other problems for the young person, or to provide information about alternatives used by other young people and test these with the young person for effectiveness. For example, a young person may be able to cope with voices when alone using singing or vocalising strategies, but may have no strategies for coping when the voices become distressing at school or with friends because they feel embarrassed.

The following lists questions that can be used as prompts to develop a coping plan with the young person:

- What is the experience you would like to cope with better?
- What strategy do you want to use to cope with this experience?
- What resources or skills do you need?
- When and where will you use this strategy?

Some strategies may require some formal skill acquisition (e.g. relaxation or visualisation strategies) that the clinician can practise with the young person before they try to use them as a coping technique. Other strategies may require some planning such as being able to look for evidence or using positive statements. Once the young person feels that they are able to use the coping strategy they wish to trial, it is helpful to find a way to record the success of their attempts. This may be achieved by using a worksheet (see example in Table 8) or asking the young person to make a note in their smartphone or diary about how well each strategy worked.

Resource 11 provides a coping plan worksheet.

TABLE 8. **EXAMPLE COPING PLAN**

Day or date	What was happening at the time?	How distressed was I? (0–10)	What coping strategy did I use?	How distressed was I after I did this? (0–10)
Thursday evening	*I was feeling lonely and the voice started telling me I was worthless*	*7/10*	*Put on some happy music and started singing*	*4/10*
Saturday morning	*Hearing a voice tell me that nobody likes me when out with my friends*	*8/10*	*Found a quiet place and focused on reminding myself that I have friends who care about me and who I am with right now*	*6/10*

Interventions for negative symptoms of psychosis

Negative symptoms of psychosis are defined as those whose action is to 'take away' from normal human experience. This includes limitations on the experience of pleasure (anhedonia), motivation (avolition), social engagement (asociality), emotional expression (affective flattening) and verbal expression (alogia). Negative symptoms are known to impact on functioning and quality of life in a manner that is can be more substantial and often more disabling than positive symptoms. Negative symptoms are also associated with poorer long-term outcomes.

It can be difficult to identify negative symptoms for a number of reasons such as overlap with symptoms of other disorders or problems such as depression, substance use or the side effects of medication. The very nature of negative symptoms means that young people may find it difficult to help-seek, or to articulate difficulties. Young people who are affected by negative symptoms are often less 'noisy'; they may find it hard to attend appointments, and may not come to attention as readily as young people who are troubled by positive symptoms such as hearing voices or having delusional beliefs or mania. Young people and their families may also mislabel their experiences as personality flaws or 'laziness', rather than being to psychosis. There is a limited evidence base for interventions that are effective in the treatment of negative symptoms, including biological treatments.[137-139]

Application of psychological interventions to negative symptoms

Some clinical studies have found that cognitive–behavioural interventions may reduce negative symptoms.[30] Specific strategies include:

- behavioural-activation interventions (see: 'Behavioural interventions for co-occurring symptoms and conditions' on page 63)
- challenging unhelpful thoughts and beliefs that maintain avoidance and withdrawal behaviour (see: 'Cognitive interventions for co-occurring symptoms and conditions' on page 73)
- strengths-based interventions (see: 'Recognising what is right: working with strengths and resilience' on page 39).

Other approaches to working with negative symptoms

A number of other interventions for working with negative symptoms have been developed from occupational, functional, social and neurocognitive approaches but are beyond the scope of this manual. These include:

- cognitive adaptation and remediation (see ENSP manual *Getting back on track: functional recovery in early psychosis*)
- working with families (see ENSP manual *All in this together: family work in early psychosis*)
- psychoeducation (see ENSP manual *A shared understanding: psychoeducation in early psychosis*).

PART 5

Cognitive–behavioural interventions for co-occurring symptoms or conditions

Cognitive–behavioural interventions for co-occurring symptoms or conditions

This section describes interventions that support clinicians to work with young people that are experiencing common co-occurring symptoms or conditions in addition to early psychosis, for example, depressed mood, anxiety, trauma or poor self-esteem. The strategies described here address identifying emotions, rating distress, stress management and relaxation, distress tolerance, behavioural interventions, and working with thoughts and emotions.

Co-occurring conditions in early psychosis

Research has demonstrated that between 40 and 70% of young people with early psychosis will experience at least one co-occurring condition such as depression, anxiety, substance use or personality disorder.[111,140,141]

For some young people, an experience of psychosis can lead to post-psychotic depression, social anxiety, or PTSD as they recover from acute psychotic symptoms. These young people may not have experienced a mental health problem before their psychotic episode. Given the significant disruption and trauma that can occur during and following a first episode of psychosis, it is understandable that young people are likely to experience other difficulties during their recovery.

In other cases, the young person may have a longer standing history of mental health problems that may have contributed to increased stress before the onset of psychosis. In such cases, co-occurring conditions may mean that treatment for psychosis is more complicated, that there may already be self-stigmatising beliefs about mental illness, and that prioritisation of treatment interventions may be more complex. For example, young people who have a comorbid diagnosis of borderline personality disorder are likely to benefit from specific intervention strategies aimed at supporting them with both their experience of psychosis and personality traits. The ENSP manual *A different way of thinking: working with borderline personality disorder in early psychosis* provides clinical guidelines for treating young people with co-occurring psychosis and borderline personality disorder.

For the group of young people identified as UHR for psychosis, one of the key aims of treatment will be to support the young people to manage co-occurring conditions. Reducing the distress caused by comorbid conditions is likely to reduce the risk of transition to psychosis in the UHR group.[4] The following section provides a summary of common co-occurring conditions that clinicians need to assess and provide interventions for as part of a comprehensive treatment package.

Common co-occurring conditions in early psychosis

Mood disorders

Major depression

Major depression is characterised by a depressed mood or loss of interest or pleasure in nearly all activities for a period of 2 weeks or more. In young people, their mood may manifest as irritable rather than sad. In addition, young people may experience changes in appetite or weight, sleep, psychomotor activity, fatigue; they may also experience feelings of guilt or worthlessness, difficulty concentrating or making decisions, or have recurrent thoughts of death and suicidal ideation, plans or attempts.

Bipolar disorder

Bipolar disorder is defined by episodes of mania, and for some individuals this is accompanied by episodes of depressed mood. Manic episodes are characterised by periods of elevated, irritable or expansive mood lasting for at least 1 week. Young people with mania exhibit increased energy and activity levels, rapid or pressured speech, reduced need for sleep and may engage in risky or reckless behaviour.

Psychotic symptoms may also accompany periods of elevated or depressed mood. Some young people with early psychosis may have a primary diagnosis of a mood disorder with psychotic features.

Anxiety disorders

Problematic anxiety symptoms are very common in early psychosis, with common diagnoses being generalised anxiety disorder and social anxiety disorder. Other anxiety disorders include panic disorder, specific phobias and agoraphobia.

Generalised anxiety

Generalised anxiety is characterised by excessive anxiety or worry that is difficult to control, relates to a number of different events or activities, and occurs on more days than not for a period of at least 6 months. It is also characterised by having at least three (or one for children) of the following symptoms: feeling restless, easily fatigued, concentration difficulties, irritability, muscle tension, disturbed sleep.

Social anxiety disorder

Social anxiety disorder is characterised by disabling fear and anxiety occurring in the context of social situations (e.g. speaking, performing or eating in front of others) that endures for a period of at least 6 months. Young people with social anxiety disorder may avoid social situations or use safety behaviours to cope.

Obsessive–compulsive disorder

Obsessive–compulsive disorder is characterised by unwanted or intrusive thoughts (obsessions) that the young person may respond to the use of repetitive or compulsive behaviour or mental action (compulsions) as a means of reducing distress.

Post-traumatic stress disorder

High rates of trauma symptoms are reported by young people following a first episode of psychosis.[111] PTSD is characterised by intrusive thoughts, images or sensations that are related to an experience of trauma. Young people with PTSD may experience flashbacks, feel that they are reliving the trauma, or have nightmares and disturbed sleep. They may cope through cognitive or behavioural avoidance of people or situations that remind them of the trauma and have difficulty remembering certain parts of the traumatic event.

Borderline personality disorder

Borderline personality disorder is characterised by intense uncontrollable emotions, patterns of troublesome relationships, and a disturbed sense of self and identity. Young people with borderline personality disorder may respond to their experiences of extreme emotions by using self-harm to cope.

Substance use disorders

Substance use is common in young people generally, and rates of co-occurring substance use are very common in early psychosis. Young people may meet the criteria for a substance use disorder when their use of substances is prolonged, excessive, or is causing problems with their physical health, or social or occupational functioning. The ENSP manual *A matter of substance: working with substance use in early psychosis* provides clinical guidelines for treating young people with co-occurring psychosis and problematic substance use.

Autism spectrum disorders

Autism spectrum disorders are developmental conditions that affect young people in two principal areas:

- impaired communication and social interaction
- restricted, repetitive patterns of behaviour, interests or activities.

Techniques for working with co-occurring symptoms and conditions

This section introduces techniques that can be helpful for managing co-occurring symptoms (e.g. anxiety and depression) and for supporting young people with challenges related to personal identity and self-esteem that commonly accompany early psychosis.

Identifying emotions

Understanding feelings and emotions such as anxiety, stress or low self-esteem is the first step towards being able to manage emotions. By monitoring their emotions, young people with early psychosis can begin to understand how they respond to different circumstances and situations, the types of thoughts that might contribute to their emotions and how they might achieve greater control over their emotions (and ultimately their mood state).

It is valuable to help the young person to develop a vocabulary for their emotions. This can be achieved by prompting them to name or label the emotions they have recently experienced. The clinician can perhaps use a personal experience the young person has shared in a session, or provide some simple scenarios (personalised as far as possible) and ask the young person to describe how they would feel in that situation. For example, 'Your friend didn't message you about a party at her house' or 'Your girlfriend bought tickets for you to see your favourite band'.

If the young person is struggling to describe their emotions, the clinician should acknowledge that recognising and naming feelings can initially be very difficult and that many young people find it hard. The following lists some techniques to help the young person begin to recognise their emotions:

- using an emotion faces chart to help recognise emotions
- explaining the difference between thoughts and feelings
- asking the young person to recognise physical sensations (e.g. tightness, heaviness all over, butterflies in their stomach, feeling shaky) as a way of recognising emotions.

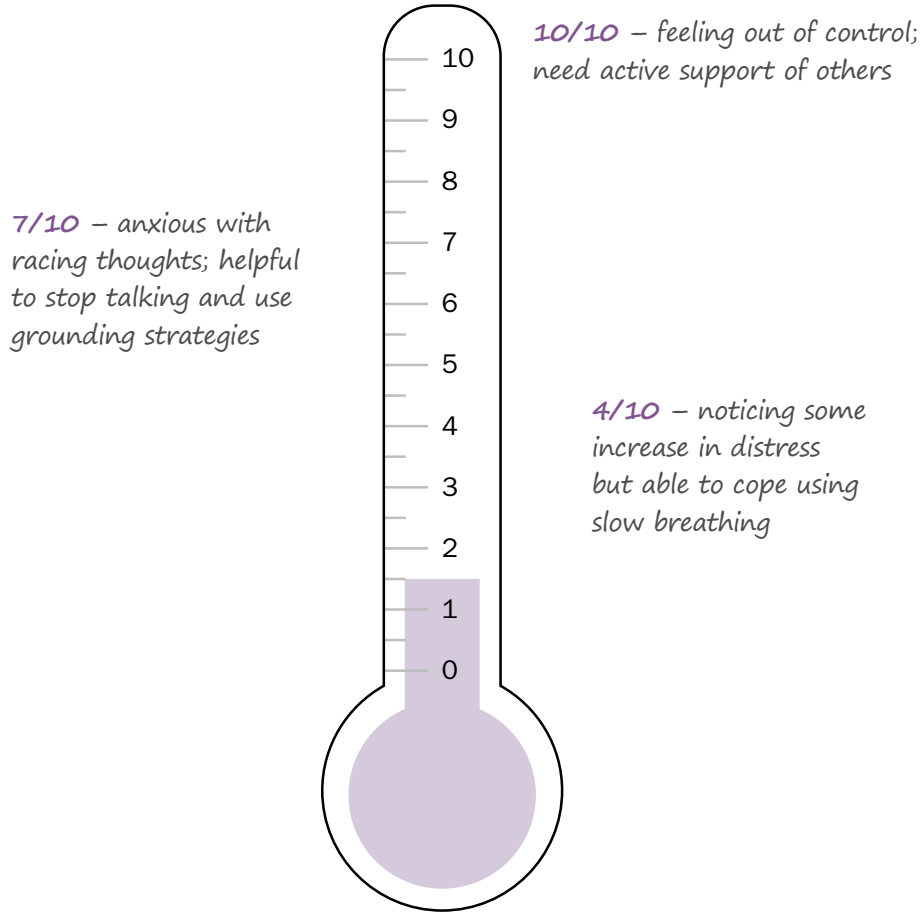
Rating distress

A very simple tool is the use of a rating scale using numbers, colours or images relating to the intensity of emotional distress. One commonly used tool is the distress thermometer (see Figure 13), with which greater temperatures reflect increasing distress. Clinicians can introduce this concept to the young person and then personalise the preferred scale or model together to create a document that can be used collaboratively in session.

Once the young person feels that they are able to identify accurately increasing levels of distress, it is helpful to find an agreed upon method of 'checking-in'. For example, the young person may identify signals and responses that will allow them to 'put the brakes on' and initiate coping strategies in session.

As you repeat this process, it is helpful to match responses to rating scores (e.g. below 4/10, the young person feels comfortable to manage distress without changing the topic; at 6/10, the young person may require a pause or shift of topic to use calming strategies; at 8/10, the young person would like the clinician to check in and talk them through a breathing or grounding strategy).

FIGURE 13. **DISTRESS THERMOMETER**



Modelling this process repeatedly within sessions allows the young person to feel confident in their ability to regulate emotional affect and therefore, to tolerate increases in distress. This may lead to overall reduction in distress, and support the use of other psychological interventions. Resource 12 provides a template for a distress thermometer for use in clinical practice.

Stress management and relaxation

For young people with psychosis, or indeed other mental health problems, developing a repertoire for coping with life stressors is an essential component of therapeutic work. As discussed previously, the stress–vulnerability model[142] places significant emphasis on the role of stress in precipitating the onset of FEP and maintaining symptoms, and its impact on recovery and the risk of relapse. Clear pathways through which this occurs are unclear, but are likely to be multifactorial via biological,[143] psychological and social processes. Given the high rates of young people experiencing psychosis who report previous trauma and that psychotic symptoms and treatment can themselves be traumatic, work on physiological arousal can be helpful. Additionally, there is evidence that people who have a psychotic disorder may exhibit a greater intensity of emotional response to daily life stressors, irrespective of whether they are currently experiencing psychotic symptoms.[144]

The following interventions are likely to be useful for working with young people who have difficulty tolerating distress, experience chronic anxiety, have an anxiety disorder (e.g. social phobia, panic disorder or generalised anxiety) or experience symptoms of trauma. This section outlines strategies for coping with the physiological symptoms of anxiety and distress, and may be useful for supporting additional cognitive and behavioural interventions for anxiety described later in this manual.

Stress, anxiety and the body

What is stress?

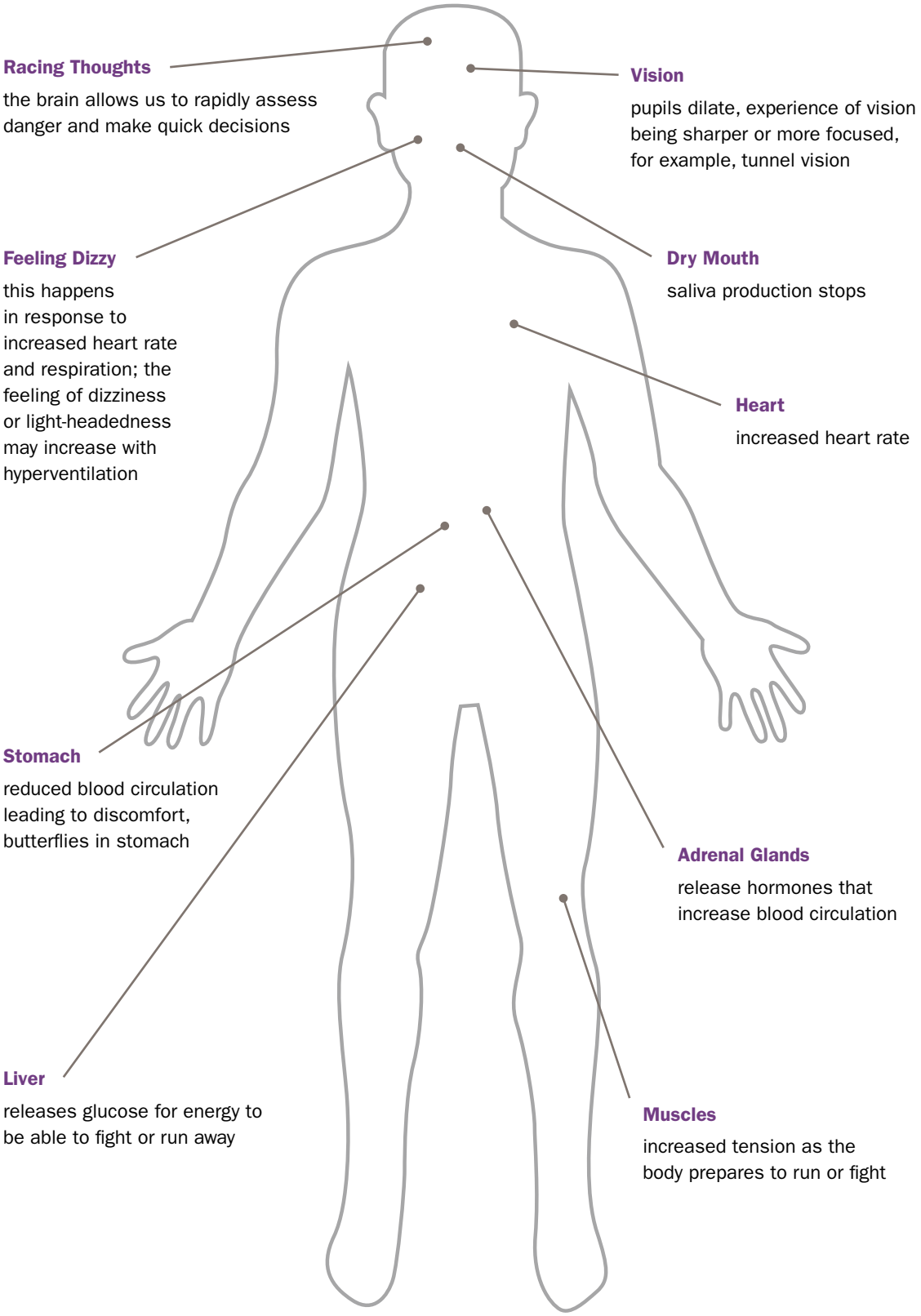
Stress has been defined as experiencing challenging or demanding circumstances that are seen as personally significant, and exceed a person's resources for coping.[145] The occurrence of these circumstances may result in a subjective experience of emotional strain, tension or worry that can occur in response to an acute stressor (e.g. the sudden death of a close friend); cumulative or multiple stressors (e.g. losing a job followed by severe illness and then a relationship break-up); or chronic stress (e.g. ongoing demands, experiences or worries for which there is no foreseeable end or resolution). It is common for everyone to report experiences of stress when faced with life challenges, yet the triggers and responses to stress differ from person to person.

What is anxiety?

Anxiety is generally conceptualised as a normal physiological, psychological and behavioural response to stress. It is widely referred to as the 'fight, flight or freeze' response and has evolved as an adaptive reaction driven by the autonomic nervous system, which is triggered by an individual's appraisal of 'threat'. When a situation is identified as threatening, an automatic response is triggered to enable the individual to react in a way that will ensure safety.[146] Physiological responses include increased heartbeat and respiration, sweating, muscle tension and feeling queasy or shaking (see Figure 14). Psychological responses include feelings of apprehension, unease or fear, and thoughts or appraisals about the potential danger of the situation (e.g. thoughts such as 'they are going to hurt me' or 'I'm going to say something stupid') or the meaning of other anxiety symptoms (e.g. 'I'm going crazy' or 'I'm going to have a heart attack'). Behavioural responses to anxiety may include 'freezing' (e.g. thinking you hear someone breaking into the house), withdrawing from or avoiding potentially stressful situations (e.g. school refusal), or the use of safety behaviours (e.g. always sitting close to an exit).

Resource 13 contains a fight, flight or freeze response template for use in clinical practice.

FIGURE 14. **FIGHT, FLIGHT OR FREEZE RESPONSE**



Psychoeducation about the physical and psychological impact of anxiety

For young people who are distressed by their experiences of anxiety, it can be useful to normalise the experience of physiological symptoms related to anxiety and assist them to take notice of how their experiences can be understood as a positive and normal response to stress. A moderate level of anxiety can be helpful to assist with performance, and even severe anxiety may be viewed as normal in the context of highly stressful situations.

However, for young people with psychosis who are experiencing problematic levels of anxiety or anxiety disorders, physiological responses may be triggered more frequently by situations or stressors that are automatically and erroneously appraised as 'dangerous'.

In cases where the response to anxiety is problematic for the young person, clinicians should implement the following strategies:

- introduce the concept of the 'fight, flight or freeze' response
- ask the young person to consider a common example in which the anxiety response would be adaptive (e.g. encountering a dangerous animal in the wild)
- explain that experiences of panic or social anxiety are an identical response to that which is triggered in situations when we are in physical danger
- identify with the young person their symptoms of anxiety using a cognitive–behavioural model (e.g. thoughts, feelings, physical sensations, behaviour)
- use a distress rating scale or metaphor that the young person finds useful (e.g. a distress thermometer, car speedometer, a 0 to 10 scale); ask the young person to notice and label experiences of anxiety and distress in a quantifiable manner.

These strategies set the scene for further interventions that rely on the young person's capacity to identify and communicate the nature and severity of their distress.

Breathing and relaxation

Most relaxation and distress-tolerance strategies rely on quite simple skills such as slowed breathing, counting each breath, tensing and relaxing muscles, or purposeful noticing and awareness of the senses.

These strategies are most effective when the young person understands how and why they are effective and when they are practised regularly while in a less anxious state (i.e. a rating of 6/10 or less on the distress scale).

Why focus on breathing?

The way people breathe is directly related to whether they feel anxious, distressed or calm and relaxed. When people breathe normally, there is a balance between the quantity of oxygen taken in to the body, and the amount of carbon dioxide expelled when breathing out.

When people become anxious, their rate of breathing increases and they take in more oxygen and expel more carbon dioxide. This may be useful if the person needs to run somewhere quickly or defend themselves, as the body uses the extra oxygen to fuel the muscles and as a result produces a balanced amount of carbon dioxide.

However, when this anxiety response is triggered in the absence of physical exertion (e.g. fighting or running away), the body is not able to balance the levels of oxygen and carbon dioxide. This can result in feeling light-headed, becoming hot or sweaty, or experiencing numbness or tingling in the extremities.

When breathing is slowed to a regular rate, the level of carbon dioxide in the body returns to normal, leading to reduced anxiety symptoms. By teaching young people strategies to control their breathing, the clinician can provide them with a highly effective tool to use when they are feeling anxious or distressed.

The case scenario on the next page outlines an example of introducing the rationale for slowed breathing with young person Laura.

LAURA

CASE SCENARIO

CM: Last time we met, we talked about what happens when you begin to feel anxious and have a panic attack. I know that you've noticed that one of the things that happens is you begin to breathe very quickly and hyperventilate.

Laura: Yeah, it's like I can't get enough air. I feel really hot, and then I get dizzy.

CM: Sure, and it sounds as if once you get to that point, you feel that you need to leave the room.

Laura: It's so embarrassing, it feels like I'm going to die it's so bad, but then as soon as I go and lie down in the sick bay, I feel better pretty much straight away.

CM: I wonder, what changes do you notice with your breathing once you are in the sick bay?

Laura: I feel like I can breathe … it's slower I guess.

CM: Great. Which makes sense. Your breathing is the best tool that you have for telling your body to calm down and reducing those panicky feelings. When you breathe rapidly, you send a signal to your body to get into that fight or flight mode. The adrenaline starts pumping, you get hot and if you are hyperventilating, then that will bring on the dizzy feeling you described. But the best thing is that simply by slowing your breathing down you can reverse that message … even if you initially still feel anxious … you can actually trick your body and eventually your mind will follow.

Laura: I feel like I can't help it though, once I get that worked up.

CM: Yes and that's the tricky part. Probably once you get to that point where you are a 9/10 on the thermometer?

Laura: It's more like 11/10.

CM: So once you have reached that level of anxiety, it's pretty challenging to use the thinking part of your brain. That's why we're going to teach you to start using slow breathing much earlier, when the anxiety is more like a 5/10.

Breathing and relaxation strategies

There are a number of breathing exercises that young people may use to learn to regulate their breathing. When teaching each strategy, it is helpful for the clinician to ask the young person to rate their level of stress or tension on a scale from one to ten before and after completing the exercise. Once the young person understands how to use each strategy, the clinician should work with them to plan a regular schedule for practising the new skill (e.g. first thing in the morning, before bed, during a 5 minute break at work).

Slow breathing exercise

The clinician should ask the young person to sit comfortably in their chair with eyes open or closed and talk them through the following instructions:

- breathe in slowly and steadily through your nose for a count of four
- hold your breath for a count of two
- breathe out slowly for the count of four.

Repeat this cycle for 5 minutes or until the young person is comfortably maintaining a rhythm of slow breathing.

Diaphragmatic breathing exercise

Ask the young person to sit comfortably in their chair and to place one hand on their chest and the other on their abdomen. Instruct them to breathe as they normally would and to notice which of their hands is moving the most as they do so.

Young people who have been experiencing a lot of anxiety or tension may notice that the hand on their chest moves while the hand on their abdomen remains still. If this is the case, provide some information about how shallow breathing or hyperventilation can exacerbate feelings of anxiety.

Then, ask the young person to try breathing slowly in through their nose and allow the air to flow all the way to their stomach. Reassure the young person that changing the way that they breathe can take time but that if they practise, it will become more natural.

Progressive muscle relaxation

PMR is a technique that involves tensing (for approximately 10 seconds) and then relaxing (for 15 to 20 seconds) different muscle groups in succession. The rationale for this technique is that for people who carry a lot of tension, it can sometimes be difficult to know when they are actually 'relaxed'. The process of tensing then relaxing allows the individual to notice purposefully the difference between two extremes.

The clinician should explain the rationale for using PMR to the young person, and ask them to sit comfortably in their chair with their eyes open as the clinician models how to tense and relax each muscle group.

The clinician should remind the young person that the focus of their attention should be on the muscle group they are tensing or relaxing and the clinician should try to notice if the young person's attention wanders so they can bring it back. Other muscles in the body should be comfortable and relaxed as much as possible.

Use the PMR script (see Resource 14) to guide the young person through the relaxation. The exercise should take approximately 20 minutes to complete. The clinician can provide recommendations for audio files (e.g. on the internet, CD or as a smartphone app) that the young person can use at home.

Distress reduction

Young people with early psychosis who experience chronic distress, difficulty coping with emotions or trauma symptoms may find it difficult to identify and label emotions or recognise the early signs of distress before they become overwhelmed. These young people may describe rapid and powerful increases in feelings of anxiety, distress and negative affect. Using psychological interventions focused on the content of thoughts and beliefs is likely to be too challenging for these young people and has the potential to make things worse for them. The key role of the clinician can be to create a safe environment, and provide the young person with tools and strategies that infer control over the pacing of any emotional content that occurs during the therapeutic work.

LAURA

CASE SCENARIO

Laura has been working with her case manager for the past 8 months following treatment for an episode of mania with psychotic features. She experienced grandiose delusions and irritability during her episode, which has resulted in her now feeling humiliated by her behaviour in front of friends, family and work colleagues. Laura has reported long-standing difficulties regulating her emotions and dramatic 'ups and downs' in her interpersonal relationships. She has a history of physical abuse and emotional neglect from a young age and before her episode had ended a relationship with a partner who was physically violent towards her.

Laura is very friendly and superficially engaged in sessions, but when challenging topics are discussed she becomes detached, distant or makes an excuse to leave the session early. Her case manager is aware that Laura is experiencing regular flashbacks, intrusive thoughts and nightmares related to her manic episode and to her earlier trauma. However, she is unable to tolerate any conversations that relate to these topics.

When are distress-tolerance strategies useful?

Young people who have a co-occurring personality disorder or a history of trauma may have developed unhelpful strategies for coping with distress. Clinicians may find that providing a young person with distress-tolerance strategies is useful in the situations discussed in the sections below.

Avoidance

The use of cognitive or behavioural avoidance can be a highly effective coping strategy for young people in reducing distress or minimising situations in which they feel distressed. Research consistently finds that avoidance coping is associated with persistent psychological impairment.[147] Clinicians may notice young people regularly cancelling or not attending appointments, avoiding other situations that cause them distress, discussing superficial topics or changing the subject, or using alcohol or other substances to avoid experiences of negative emotions or intrusive thoughts.

Harmful or risky behaviours

Young people may respond to distress by using self-harming behaviours (e.g. cutting or burning), expressing suicidal ideation or making suicidal gestures, placing themselves in risky situations, or becoming aggressive or threatening towards others (including clinicians). For some young people, there may be a seemingly fine line between feeling 'okay' and becoming rapidly distressed and suicidal, which can be very challenging to respond to for family, friends and clinicians.

Dissociation

Dissociation is characterised by a feeling that one is 'not real' or that 'the world is not real'. Young people may describe feeling that they are 'numb' or detached or that they are 'floating' away from their body. This symptom is commonly seen in young people who have had early experiences of trauma. Dissociation may have previously been a particularly useful strategy if the young person was unable to protect or defend themselves and had to cope through detaching mentally from the traumatic experience.

Strategies for distress reduction

Useful strategies for distress reduction can be found across a number of therapeutic modalities including CBT, ACT, mindfulness and dialectical behaviour therapy (DBT). Clinicians will find that each young person differs in the strategies that are most acceptable to them or that are most effective for them. Simple techniques include the use of distraction, grounding or awareness, developing a 'safe place' visualisation, and acceptance or mindfulness strategies.

Distraction

The judicious use of distraction as a distress-management technique can help young people to gain a sense of control over their emotions. It may be most helpful when confronted with 'inescapable' stressors such as hearing a voice, or when travelling on public transport. Use of distraction may include listening to music, watching television, calling a friend, washing the dishes, or any activity that will allow them to shift their attention to focus on another task. For some young people, distraction will not work and may exacerbate distress if they are unable to divert attention. For others, the use of distraction may be helpful in some situations, but unsatisfactory as a long-term strategy.

Grounding

Grounding involves asking the young person to 'ground' themselves in the present by bringing awareness to the five senses. For example, a clinician may instruct a young person to notice the feeling of the chair against their back and the ground beneath their feet. This strategy is helpful when the young person has experienced dissociation or a traumatic flashback. It is important to remind the young person that they are in a safe, contained environment and that the experiences that are distressing them are no longer happening.

Safe place visualisation

Creating a 'safe place' for use as a visualisation serves a similar purpose to grounding strategies. However, rather than asking the young person to focus on the present moment, the clinician will coach them to use visualisation to turn their full attention to a 'safe place'. Clinicians can ask the young person to describe a place from the past or present where they have previously felt calm and safe. Alternatively, the clinician and young person can develop an imaginary safe place together. It is helpful to write down a description of the safe place while the young person is visualising themselves there. Clinicians can ask something along the lines of 'What can you see, hear, smell or feel when you are in this place?' In session or alone, the young person can practise using visualisation to go to the safe place. Resource 15 provides a clinical worksheet for developing a 'safe place'.

Acceptance and mindfulness

Acceptance and mindfulness strategies take the perspective that tolerance of distress and unpleasant emotions can be increased by practising observation and acceptance of experiences (e.g. thoughts, emotions, physical sensations, intrusions, hallucinations). There is emerging evidence that mindfulness approaches are acceptable and effective for individuals with psychosis, particularly those who also experience depression or anxiety.[66] Some caution should be used when considering whether to use mindfulness strategies with young people who are experiencing ongoing positive psychotic symptoms which can make use of these techniques difficult and potentially distressing. Morris et al.'s *Acceptance and commitment therapy and mindfulness for psychosis*[66] provides more information on these strategies.

Behavioural interventions for co-occurring symptoms and conditions

It is common for young people to experience symptoms of depression, anxiety and lowered self-confidence following a psychotic episode. The reasons for this vary and are understandable because the experience of psychosis often impacts on multiple domains of a young person's life. Common precipitants of depression or anxiety following a psychotic episode are feelings of shame about behaviour displayed while psychotic and loss of involvement with occupational and social activities following acute psychosis. In some cases, young people may develop negative psychotic symptoms after a psychotic episode. Many young people cope with these experiences by avoiding activities they previously enjoyed such as social interaction and participation in work or school.

Behavioural interventions are useful for working with young people towards increasing their social and occupational participation, reducing anxiety, improving low mood and improving self-confidence. It is important to use a case formulation based approach to selection of interventions at all times.

Behavioural activation

Behavioural activation is a common intervention that is helpful in the treatment of depressive symptoms, including low mood, anhedonia and low motivation.[148] There is evidence that behavioural activation may also be useful for addressing the impact of negative psychotic symptoms.[149]

Young people experiencing early psychosis will often discuss a sense of wanting to feel better before attempting to return to previously enjoyed activities. Avoidance of and withdrawal from social and occupational settings is common, and young people may become stuck in a vicious cycle that reinforces their avoidant behaviour. Waiting until symptoms have resolved before attempting to engage in enjoyable activities may result in prolonged low mood, anhedonia and withdrawal from usual functioning.

The premise of behavioural activation is to encourage the young person to identify activities that they previously found enjoyable or rewarding and to assist them to re-engage gradually with these activities.

One explanation for the effectiveness of this intervention emphasises the importance of including social interaction and opportunities for positive reinforcement as part of behavioural-activation planning. The young person may increase opportunities to experience positive social feedback, which may counter negative beliefs they hold about themselves due to ongoing depressive, anxiety or psychotic symptoms.[150] Other explanations of the effectiveness of behavioural activation vary but include the potential physical benefits of engaging in activities such as exercise[151] and light exposure, as well as improvements that may occur in the young person's circadian rhythm due to increased structure and occupation during the day and limiting daytime sleeping.

Using behavioural activation with young people

To support the young person to identify pleasant activities it may be helpful for the clinician to employ the following strategies:

- enquire about the young person's past (e.g. What used to be fun or give the young person a sense of satisfaction?)
- work through a checklist of pleasurable activities and ask the young person to circle things they think would work for them
- break larger activities into smaller steps if the young person does not feel that they can achieve them at once (e.g. cleaning out one drawer in their room instead of cleaning the whole room).

The following case scenario demonstrates a case manager introducing a behavioural activation intervention with a young person, Rita.

RITA

CASE SCENARIO

CM: You've said that it feels too scary to return to the athletics team at the moment because of your concerns about how to explain why you've been away.

Rita: Yeah, and why I'm fat all of a sudden … it just sucks though because it's also the one thing that I know makes me feel good and so I know I'm missing out but I just can't do it.

CM: Can you tell me a bit more about why it makes you feel good?

Rita: I suppose because it's something I'm good at … but just moving … being outside and being completely focused on something is really rewarding. Also, usually being around other people is normally something that makes me feel happy.

CM: I can see how things are really tricky at the moment; something that brings a lot of positives into your life doesn't seem that available to you. Can you tell me, is there anything that doesn't involve quite so many people that might give you some of the same benefits? Something that might feel like a step towards going back to training?

Rita: I know where you're going with this! (Laughs.) Yeah I mean normally I would also be training on my own, going for a run by myself or with a friend. I guess it just has all seemed like there is no point if I can't go to training.

CM: I wonder what it would be like to put together a bit of a plan, not just for training, but for other stuff that you know used to make you feel good but that you've stopped doing recently.

Rita: Yeah, that would be ok. I think even starting with a walk with mum might be good. She keeps offering to go with me.

When working with young people to increase their involvement in previously enjoyed activities it is important for the clinician to provide them with a clear rationale that is in line with their identified goals. Slow pacing and graded increases in activities are vital strategies to ensure that the young person does not misinterpret suggestions to increase activities as a belief that they are 'lazy' or that their symptoms are not valid. It may be helpful to build an activity schedule using small, incremental steps to maximise the chance of completion of tasks and success. If the young person is unable to identify any previously enjoyable or rewarding activities, it may be helpful to provide a list of examples. Resource 16 provides suggestions for pleasant activities.

The following are considerations for the clinician when using behavioural activation:

- It is important to reassure the young person that it is normal to feel reluctant or uncertain about whether engaging in activity will have an impact on their mood, distress or energy levels.
- Identifying challenging situations or unpleasant thoughts, emotions or physical responses can be important.
- Frame the activity as an experiment, where a number of attempts may be required to experience obvious benefits and that these benefits are likely to be cumulative in nature (e.g. the young person may not feel like going to a big party with many friends but they may enjoy spending one-on-one time with a close person as a step towards increasing their level of social connectivity).
- It is important to remind the young person that part of the experiment will be for them to notice the small but important gains or fluctuations in mood that may occur. If the young person has been previously high functioning in a number of domains, they may dismiss their own efforts and success if these are perceived to be 'less than' their usual standards of social and occupational activity.
- It is important to use a calendar or diary to plan with the young person a graded increase in activities that they enjoy or that give them satisfaction to complete. The most important part of this exercise is to include sufficient activity so that the young person can attain a sense of achievement, but not so much that the plan is unattainable and they feel disheartened.
- It is important to ensure that the young person has a way of keeping track of what is planned and for when, and then noting when it is achieved or completed. This may mean using the calendar or tasks list in the young person's phone, or using a paper diary or calendar that they can put on their fridge at home. Table 9 presents an example of Rita's plan.

There may be a temptation to dismiss behavioural activation as not useful for young people who are experiencing significant difficulties (e.g. with leaving home or socialising). Yet however basic an activity seems, the opportunity to engage in and notice success in completing small and rewarding tasks (e.g. having a shower, watching a favourite TV show, making something to eat) can lead to a sense of increased capability and help counteract hopeless and negative self-beliefs. The clinician's role is to notice and validate success in a realistic and optimistic way until the young person is better able to do this more easily for themselves.

Alongside this kind of work with a young person, the use of psychoeducation with family and significant others about depressive or negative symptoms and behavioural activation may assist to reduce negative appraisals of the young person. Involving family in this planning process means they may assist in noticing and reinforcing gains made by the young person in between sessions.

TABLE 9. **RITA'S ACTIVITY PLAN**

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Morning		Walk with mum for 40 mins	Meeting at school with year-level co-ordinator	Walk alone for 40 mins	Do 1.5 hours of school work		Go to the market with mum
Afternoon	Do 1.5 hours of school work			Do 1.5 hours of school work		Friend over for the afternoon	Make some healthy lunches for the week
Evening	Have a warm bubble bath	Call a friend and invite over for weekend	Watch TV with dad		Family dinner		

Behavioural experiments

'Behavioural experiments […] are amongst the most powerful methods for bringing about change in cognitive therapy […] They are widely used, and yet, to be successful, they require creativity and sophisticated understanding on the part of the therapist' (Bennet-Levy 2004[152]).

Behavioural experiments are collaboratively designed activities based on a cognitive–behavioural conceptualisation of a problem. They aim to test specific beliefs about self, others and the world through direct experience and observation by which new information is gathered.[152] This experience then aids the formation of new beliefs, assumptions and rules.

Why use behavioural experiments?

CBT is grounded in the principle of empiricism, where the understanding of a particular problem relies on assumptions (those of the clinician and those of the young person) that require testing. Behavioural experiments provide a clear and explicit way of testing these assumptions collaboratively with young people. They are useful for developing a shared understanding of factors contributing to presenting problems and for formulating anticipated outcomes and conclusions.

Behavioural experiments have been demonstrated to be highly effective as a therapeutic tool. The potential for powerful cognitive and affective change in response to real-world experience is potentially greater through a behavioural experiment than through in-therapy dialogue that focuses directly on thoughts and emotions.[152] However, the aim of a behavioural experiment differs from that of behavioural therapy such as behavioural activation (which aims to achieve a pattern of positive reinforcement) or graded exposure (which aims to achieve habituation to feared situations with repetition over time). Instead, the primary means of change achieved through behavioural experiments is a modification of unhelpful thoughts or beliefs that maintain the presenting problem.

Behavioural experiments may be useful to address the following problems (among others):

- avoidance of situations, people or emotional experiences that the young person thinks will lead to them becoming anxious or upset
- catastrophic beliefs the young person may have about how they will cope if they become anxious or upset
- expectations that others will respond negatively to the young person in social settings
- beliefs about particular situations that may worsen the young person's symptoms (e.g. voices, anxiety, worried thoughts, panic)
- negative beliefs of the young person about their self-efficacy, performance and capabilities.

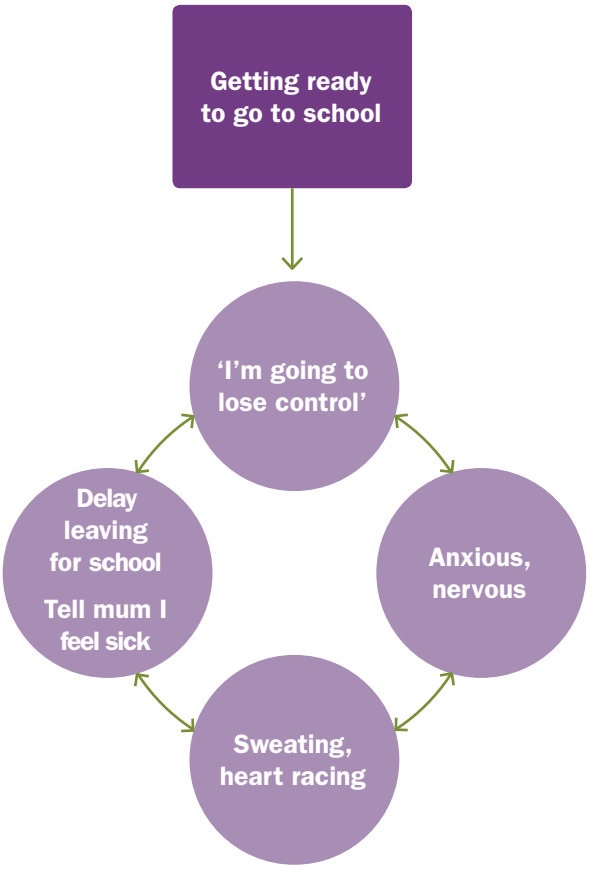
Behavioural experiments can also be useful for working with young people that have delusional persecutory or paranoid beliefs, ideas of thought insertion or broadcasting, or ideas of reference. However, it is recommended that experiments targeting psychotic symptoms be used by only clinicians with training and experience in CBT-p.

How to set up a behavioural experiment

Behavioural experiments should be primarily informed by a comprehensive case formulation that is based on a cognitive–behavioural formulation of presenting problems. A shared understanding of the triggers, emotional and physiological responses, automatic thoughts and appraisals, relevant core beliefs or schema and behavioural responses should be developed with the young person. Figure 15 presents an example of a CBT case formulation for young person Jonah, who has been experiencing social anxiety and panic symptoms since his psychotic episode.

> 'It is very powerful to do a behavioural experiment. In the end all learning is experiencing, not talking.'
>
> Professor Mark van der Gaag

FIGURE 15. **CBT FORMULATION FOR JONAH**



It is essential that young people feel comfortable with their involvement in the behavioural experiment. All experiments should be grounded in a supportive therapeutic relationship where the young person feels reassured that they will not be asked to do something that is beyond their capacity or that will leave them feeling distressed or discouraged.

Identify a belief to be tested with the young person using their language, for example, 'When I get anxious, I look like I'm going crazy'. The rationale for completing a behavioural experiment should be clear to the young person. Checking in with the young person as the clinician generates ideas for the behavioural experiment will assist with this. For example, the clinician can ask, 'Can you remind me how this will help us?' or 'Why is it that we are doing this?'

The clinician should set up a 'no lose' experiment, where alternatives result in some form of learning regardless of the outcome. The purpose of the experiment is not to prove that a particular belief is correct or incorrect, but to examine the evidence for specific predictions. It is worth investing time (potentially over a number of appointments) to ensure that the behavioural experiment is as well planned as possible. By allowing the young person to take the lead in this process wherever possible, the clinician is more likely to generate experiments in which the young person is invested. The role of the clinician is to make suggestions to shape the experiment, rather than tell the young person what to do. Ideally, it is helpful to generate two or more predictions about the outcome of the experiment that reflect the young person's current belief and possible alternative explanations.[153]

To generate various possibilities and scenarios, it may be helpful for the clinician to use an imaginal rehearsal with the young person and ask them questions such as 'What might happen?' and 'How will you understand or explain that if it happens?' This imaginal rehearsal may also help to identify the barriers to completing the experiment. For example, a young person who holds a belief that others are looking at them negatively may have difficulty paying attention to the responses of others during the experiment if they become very anxious. It may be possible to overcome such barriers by employing strategies such as using a trusted friend as observer. The plan is then revised with the young person, considering any anticipated obstacles and solutions. If it is not possible to overcome barriers, the clinician should consider with the young person the likely benefits or drawbacks for proceeding with the experiment regardless.

The next step is to conduct the experiment where the young person and any collaborators (e.g. friend, family member, clinician) observe their own responses (e.g. thoughts, emotions, behaviours, physical experiences or phenomena such as voices) and any relevant features of the event (e.g. facial expressions, what was said, physical surroundings).

When the behavioural experiment is completed, sufficient time should be spent evaluating with the young person what occurred during the experiment. It is important to do this as soon as possible after the experiment so that the young person is able to reflect accurately on their experience and interpretations of outcomes. Recording observations and responses using the behavioural experiment template or thought record is likely to support a more detailed recollection that can be reviewed in relation to the initial predictions.

Finally, as with a number of CBT interventions, it is essential that the behavioural experiment occur within the context of a strong therapeutic relationship. Generally, the clinician should not consider undertaking such work until a genuine therapeutic alliance has been established.

Table 10 presents an example of a behavioural experiment for young person Jonah. In this example, Jonah discloses that the reason he does not want to see his friends is because he is worried that when he becomes anxious he looks like he is going 'crazy'.

Resource 17 provides a behavioural experiment template.

TABLE 10. **JONAH'S BEHAVIOURAL EXPERIMENT**

Target thought
When I get anxious, I look like I am going crazy. *People will be scared of me and avoid me.*
Alternative thought
When I get anxious, I look like I am anxious. My hands get sweaty and I jiggle my leg a lot. *People may not notice that I look any different from usual.*
Experiment
Go to a public place where I usually feel anxious (e.g. waiting room, busy train station) and sit close to other people. *Get my brother to come with me and to sit at a distance where he can watch me and how people react to me.*
Predictions (percentage of belief)
My brother will think that I look like I'm going crazy – 75% *People will stare and me – 80%*
Outcome
My brother said that he could see my leg moving a lot but didn't notice anything else that was different about me. *He said that one person looked at me when I sat down in the seat next to them and then kept reading their phone. Nobody else looked at me.*
What I learnt
How I feel on the inside isn't always the same as how I look on the outside. *Other people are not as focused on me as I thought they were.*

Graded exposure

What is graded exposure?

Graded exposure is a well-established cognitive–behavioural intervention that has been used effectively to treat anxiety disorders, including social and specific phobias, obsessive–compulsive disorder, panic disorder and health anxiety.[154] It involves the young person engaging in a program of repeated exposure to anxiety-provoking situations, beginning with scenarios that trigger low levels of anxiety. As the young person experiences reduced distress and greater confidence, they progress to situations that they have identified as more challenging.

How does graded exposure work?

Many young people have learnt to cope with anxiety by removing themselves from situations that provoke the anxiety (i.e. avoidance). This can reinforce beliefs that these situations are dangerous, or that the anxiety have worsened if they were to have remained in the situation. Graded exposure works on the principle that remaining in an anxiety-provoking situation for a significant amount of time will extinguish the anxiety response. This means is that if the young person is able to remain in the situation, they will eventually begin to feel calmer.

For graded exposure to be effective, the young person needs to experience some anxiety during the intervention. However, if the level of distress or anxiety is too high, the young person may feel overwhelmed, be unable to think clearly and engage in safety behaviours to cope.

When to (or not to) use graded exposure

Graded exposure may be a useful intervention for young people who are experiencing difficulty getting back into social, educational or work activities, and who predominantly cope by avoiding these situations.

For young people with early psychosis, it is important to consider the phase of the psychotic episode. For example, while the presence of acute psychotic symptoms is not necessarily a contraindication for graded exposure, this intervention may not be appropriate if a young person's insight and judgement are grossly impaired or if the anticipated risks of attempting exposure are high. If a young person wishes to work on a particular goal (e.g. spending time with friends) despite continuing to experience symptoms (e.g. paranoid ideation), the general principle should be to begin at a very low level of anticipated anxiety and progress very slowly through the hierarchy.

Before attempting graded exposure, the young person should be able to use distress or anxiety ratings and have a number of identified coping strategies they can use and practise both in and outside of therapy sessions. The following example of Jonah highlights how graded exposure may be used to address symptoms of social anxiety.

Figure 16 presents an example of exposure hierarchy for Jonah.

JONAH

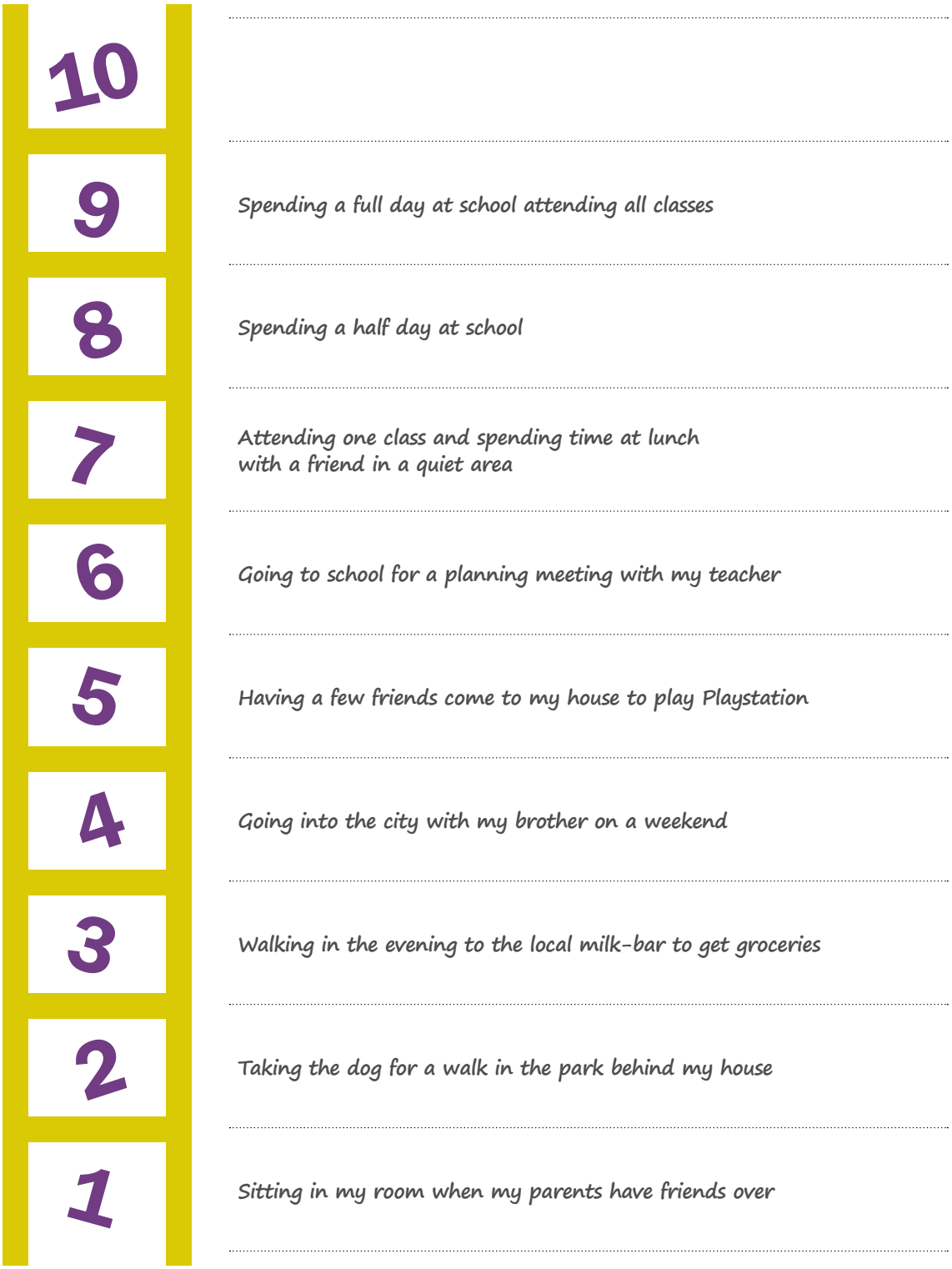
CASE SCENARIO

Jonah felt very 'on edge' and uncertain about other people's impression of him when out in public, around his friends and at school. He found it easier to stay at home and reduce the amount of time he was around other people and began avoiding his friends and attending school. This lack of activity seemed to contribute to Jonah feeling increasingly more anxious about leaving the house and he began to experience panic symptoms when getting ready to leave the house.

Jonah and his case manager developed a plan that consisted of an exposure hierarchy starting with events that caused him lower levels of anxiety (e.g. walking in the evening to the local milk bar to buy some milk, about 3/10 anxiety level), moving to events that caused higher levels of anxiety (e.g. staying a full day at school and attending all classes, about 9/10 anxiety level).

Once Jonah was able to do the lower anxiety-level activities and cope with the associated worry about what other people were thinking about him, he moved to anxiety-provoking activities that were higher in the hierarchy.

FIGURE 16. **JONAH'S EXPOSURE HIERARCHY**



Resource 18 contains an exposure hierarchy template for use in clinical practice.

Cognitive interventions for co-occurring symptoms and conditions

Cognitive interventions in early psychosis focus on identifying and understanding thoughts, assumptions and beliefs underpinning experiences of distress resulting from early psychosis and its sequelae. Perhaps more importantly, cognitive interventions can be used to identify and enhance cognitive processes that support experiences of hope, resilience and optimism. Although described separately here, cognitive interventions generally go hand in hand with other forms of intervention. For example, gathering new information or evidence for a young person's existing belief (i.e. a cognitive intervention) will likely involve some element of behavioural intervention. Conversely, encouraging young people to engage in behavioural interventions or distress tolerance will often involve discussions about thoughts, assumptions and beliefs that the young person holds (i.e. cognitive intervention).

Formal cognitive therapy can be difficult to conduct with young people with early psychosis. There are a number of reasons for this ranging from age, attention and concentration, severity of symptoms, poor engagement, low level of insight, and beliefs or expectations about treatment. It is important for clinicians working with young people with early psychosis to adapt interventions.

Above all, the clinician having an attitude of curiosity about the young person's understanding of themselves and their experience of psychosis will open up opportunities to use some of the strategies outlined below. The general principles of these strategies are quite simple and can be adapted to fit with the clinician's own clinical style and the needs of the young person with whom the clinician is working.

Common difficulties experienced when working with young people with early psychosis are the thoughts and beliefs these young people can experience that are linked to depression, anxiety, hopelessness, and sense of self and identity. The following lists ways in which such thoughts can manifest:

- 'There's something wrong with me, I am different from other people.'
- 'I will never be the person I was before the psychosis.'
- 'Nobody will give me a job if they know I have a mental illness.'
- 'I can't control my own mind.'

Identifying thoughts and beliefs

Perhaps one of the most effective interventions a clinician can provide is the opportunity for the young person to identify the role that their thoughts and beliefs play in contributing to how they feel and behave. If asked, many young people would agree that 'thoughts are not facts', but it is often far more difficult for a young person with early psychosis to experience this as being true for themselves. Young people are far more likely to gain insight and cognitive flexibility if they are able to observe their thought processes over time through a guided exploration of their thoughts and beliefs.

The thought record (introduced in 'Part 3. Psychological assessment, formulation and treatment planning') can be used as an intervention tool to gather information about the day-to-day precipitants, perpetuating and protective factors for identified thoughts, emotions, symptoms and behaviours. This structure is useful for assisting young people to differentiate between what is a 'thought' and what is an emotion or other experience (e.g. physical symptoms or voices). Initially, this process should be shared and guided by the clinician asking a series of Socratic questions that allow the young person to gain a full understanding of triggers, beliefs and consequences across a number of situations.

Over time, it may be useful to ask the young person to use self-monitoring in between sessions to gain a clearer picture of commonly occurring patterns of thoughts and beliefs. There are many benefits to this strategy. First, it is time efficient because it means less time is needed trying to remember events during the session – for many people, memory is poor and experiences are summarised or paraphrased rather than being recalled as they were experienced in the moment. Second, this strategy supports the young person to gain and practise the skill of self-observation, and encourages the act of simply noticing inner experience without judgement or analysis.

CAUTIONS: BETWEEN-SESSION WORK

- As with any between-session work, this strategy can be difficult to set up and encourage young people to stick to. Doing this may feel like 'homework' and some young people may worry about getting it 'wrong', which may lead to avoidance of therapy sessions and disengagement if they are concerned about not having completed between-session work.
- How this idea is described to the young person is very important. If the strategy is unsuccessful, it is important for the clinician to find out why, as it may be something that can be addressed throughout treatment, rather than just giving up completely. It must be acknowledged that it is likely that only a minority of young people will complete such written work.

Modifying automatic thoughts, assumptions and beliefs

Evidence testing

Before commencing with this level of intervention, it is essential for clinicians to consider if and when this technique may be useful when working with young people with early psychosis. Rather than being concerned with performing the intervention 'correctly' the primary focus should be the process by which this is achieved (i.e. the art rather than the science).

Pros and cons

When evidence testing is appropriate, an effective method for exploring the utility and meaning of particular thoughts is to examine the pros and cons of the belief being true or false. This may be a good place to start as a way of modelling genuine curiosity and encouraging the young person to engage in some 'detective work'. It can often be surprising to see where even distressing beliefs have clear 'pros', or examples in which the beliefs have been helpful at an early stage in the young person's life.

For example, a young person with an extensive history of physical abuse may hold the belief 'I deserve to be punished'. They explain that when they were little they were very careful to never do anything that upset their parents. When they were punished, they would think about what they had done, including 'thinking' the wrong thing to try to prevent further abuse. Although this belief is currently impacting negatively across many domains of their life, it can be helpful to validate the importance and even adaptive function of unhelpful beliefs.

Exploring a young person's evidence for holding particular beliefs should be grounded in genuine curiosity. If the young person experiences the exercise as a means of proving them to be incorrect in their beliefs, it is likely that engagement will be lost or the process will inadvertently reinforce other unhelpful ideas (e.g. 'I'm crazy', 'nobody will ever take me seriously'). Many psychotic beliefs relate to pre-existing schema, and may even provide some emotional protection for young people. For example, a thought such as 'people are out to get me because I am important or special' is likely to be preferable to the thought 'people aren't out to get me, but I have a mental illness'.

It is important to remember that young people with psychosis may have had multiple experiences of other people (e.g. clinicians, family, friends) telling them that their beliefs are false and that they are 'wrong'. The impact on sense of self may be demoralising and interventions that target cognitions and beliefs should not compound this further. Therefore, it is particularly important that the clinician appears open to the young person's story.

Introduce a rationale for gathering evidence

It can be important to discuss with the young person whether they would find it helpful if they found out their concerns were not 100% accurate, and whether this is something that they would be interested in examining. The young person can be encouraged to do this through using metaphors such as the young person being a detective, taking the perspective of a neutral friend, examining evidence in court, being a scientist and conducting 'tests' to discover the most likely explanation for particular thought, belief, or experience (e.g. panic symptoms, low motivation, hearing a voice). The clinician should set shared ground rules with the young person about the criteria for what can be considered facts or evidence as opposed to opinion (e.g. 'It just feels true').

Find evidence for the belief

First, the clinician should elicit evidence for the distressing thought or belief applying the ground rules. The clinician should normalise the young person's responses to strong emotions or gut-feelings. If appropriate, it may be helpful for the clinician to employ self-disclosure around their own experiences of drawing incorrect conclusions based on insufficient evidence.

Find evidence that does not support the belief

Second, the clinician should elicit evidence that does not support the distressing thought or belief and continue to apply the same ground rules. Depending on the particular thought, the clinician may need to be creative and consider the use of behavioural experiments (described earlier) as a way of exploring a particular belief and of gathering evidence.

Resource 19 provides a template for evidence testing thoughts and beliefs in clinical practice.

EVAN

CASE SCENARIO

Evidence for my belief: 'People are avoiding me because I have psychosis':

- I didn't get invited when three of my friends went to the pub for dinner last night.
- My sister told me that when I had the psychotic episode that she was scared of me.
- I don't have as much to do with people as I did before the psychosis.

Evidence against my belief: 'People are avoiding me because I have psychosis':

- I got asked to go to a party last week by some guys from footy.
- This week I avoided a lot of people because I was feeling really down.
- I can be a bit rude or mean when I think people might reject me.
- My friend told me that some of the people I thought were avoiding me don't know about the psychosis.

Developing more balanced or alternative explanations

Once the young person has gathered evidence for or against their beliefs, it is useful for the clinician to explore whether this has led to a consideration of other alternatives. This can occur naturally as new evidence is gathered and the young person can begin to determine whether alternative beliefs are more or less likely as they examine the original belief.

'My case manager always made the point of challenging the way I was thinking, which was really helpful.'

Young Person
EPPIC, Orygen Youth Health Clinical Program

CONSIDERATIONS FOR WORKING WITH THOUGHTS AND BELIEFS

- Does the target belief, symptom or behaviour cause distress? The aim should be to modify elements of distress-causing beliefs rather than trying to remove 'delusional' thinking.
- What is the function or role that the target belief provides for the young person? What may be the implications of challenging this belief for how the young person views themselves? For example, if the young person no longer believes they have special powers but instead are 'deluded', does this increase the risk of depression, shame or self-stigma?
- What is the young person's reaction to 'hypothetical contradiction'?

Remember that this process takes time. If beliefs are important to test (because of their impact on distress and functioning), it means they are unlikely to be easily rejected. The clinician should consider their own religious, political, spiritual, cultural and personal beliefs that are not necessarily shared by others and understand the manner in which they respond to challenges or criticism around these beliefs. The exploration of a young person's thoughts should be approached with the same respect and caution that the clinician (or anyone) would expect if debating beliefs with others.

When exploring alternative explanations there may be a point at which to discuss with the young person the concept of 'the grain of truth', whereby a particular belief is not necessarily disproved but in some way modified. The following case scenario presents the example of Evan, whose belief that 'people are avoiding me because I have psychosis' has resulted in him isolating himself, avoiding contact with his friends and being abrupt or rude in anticipation that others will reject him.

EVAN

CASE SCENARIO

Clinician: So Evan, we've started to look at the evidence for and against your idea that people are avoiding you because you have psychosis. I can see that you've managed to find some evidence that fits with this idea, but also some that doesn't fit so well.

Evan: Yeah, I still kind of feel like it's true but when I thought about it, sometimes I've been making it pretty difficult for people 'not' to avoid me!

Clinician: Can you tell me a bit more about that?

Evan: Well one of the things I did was look through my phone, you know how you said to find really concrete stuff … and I could see that I'd missed calls from some of the guys.

Clinician: And how did that fit with the idea that they were avoiding you because of the psychosis?

Evan: It doesn't … I mean I was kind of avoiding them in a way. Although I think that some people don't want to hang out with me still, but maybe not always because of the psychosis.

Clinician: Do you have any alternative explanations for why that could be? Could we write them down?

Evan: I think with some people definitely, it's the psychosis. But for others, I guess I haven't been that nice to people, even when they have made an effort … so no big surprises why they'd back off a bit. Like I said before … not returning calls … or even just not initiating anything myself with my friends.

Clinician: Ok, are there any other reasons you can think of?

Evan: Just normal stuff. People being busy with life. Maybe some of them have got their own problems to deal with and they're not seeing anyone, rather than just avoiding me.

Given this information, the clinician may not be able to disprove the idea that people are avoiding Evan, particularly as he has identified some ways in which his behaviour may be contributing to the problem. Some degree of a reality base may exist in situations where an individual places themselves in situations that may eventually confirm their beliefs (e.g. of physical or social threat, embarrassment, ridicule or exclusion) through behaviour resulting from the original unhelpful belief. After collecting evidence for and against his belief, Evan indicated that a more realistic belief may be 'some people may avoid me when I withdraw from them'.

One method of visually representing alternative explanations is by depicting them on a pie chart (see Figure 17). The young person can allocate a percentage that proportionately represents the likelihood of each alternative. Given the research indicating that people experiencing psychotic disorders may be more likely to 'jump to conclusions' on the basis of limited evidence, this also encourages the young person to consider that there may be a number of explanations for a situation.

FIGURE 17. **EVAN'S ALTERNATIVE EXPLANATIONS**

People are avoiding me because...

Working with meaning

Often young people are able to identify a range of alternative explanations for distressing thoughts and beliefs, but the depth of meaning and level of distress related to their thoughts means that challenging and evidence gathering is ineffective.

A common experience in CBT is for individuals to describe a sense of 'getting it' intellectually but having great difficulty with 'feeling' real relief in relation to their understanding. Working with meaning at the level of core beliefs and schema may be helpful on a number of levels. It can be normalising as young people reframe current difficulties in light of understandable and longer standing patterns that have been learnt from a young age. The clinician working from the basic idea that 'everyone has core beliefs and schemas' also assists with normalising difficulties that young people may have with challenging or modifying unhelpful beliefs.

PART 6

Relapse planning and prevention

Relapse planning and prevention

What is a ‘relapse’?

Many young people with early psychosis will experience fluctuations in their mental state over time. At times, psychotic symptoms may be completely absent, while at other times, the young person may experience mild or moderate fluctuations with symptoms reappearing or worsening in severity for brief periods. When the experience of symptoms becomes severe, it may be considered a relapse of an acute psychotic episode. The approximate rates of acute relapse for young people with early psychosis are: 20–30% will experience no relapse; 60–80% will experience at least one relapse, and approximately 20–30% will experience chronic or recurrent psychotic symptoms.[155,156]

For some young people, a relapse may be managed in the community, with more intensive support from the treating team. Other young people may require a hospital admission.

PSYCHOSOCIAL FACTORS ASSOCIATED WITH INCOMPLETE RECOVERY AND RELAPSE

A number of factors are associated with incomplete recovery from a psychotic episode. The following are potential targets of psychological interventions[12]:

- comorbidities such as substance use or depression
- poor adaptation to being diagnosed with a psychotic disorder
- long-term reduced social or occupational functioning
- lack of awareness and understanding of negative symptoms by young person and family
- impaired adherence to treatment (medical and psychosocial).

The following are examples of factors associated with relapse that may be modified by the use of psychological interventions:

- substance use
- non-adherence to medication
- cognitive flexibility
- stressful life events
- expressed emotion (from family members).

What is relapse planning and prevention?

Relapse planning or relapse prevention is an essential component of treatment for any young person who has experienced a first episode of psychosis. It incorporates elements of psychoeducation, understanding the young person's explanatory model and beliefs about relapse, recognition of early warning signs and the identification of personal strengths, and implementing coping strategies and support systems.

Providing a comprehensive relapse planning intervention aims to achieve the following:

- increase the chance of early recognition and help-seeking during relapse
- prevent a full-threshold relapse of symptoms
- reduce the duration of relapse
- reduce the severity of relapse and associated acute treatment.

Relapse planning is also designed to support young people to feel confident in their ability to recognise and respond to relapse and to experience less distress if relapse does occur.

Goals for relapse planning

Work with a young person around relapse planning should begin early in the course of treatment as appropriate to the young person's phase of psychosis. Ideally, the provision of information and relapse planning should involve both the young person and others within their support system such as family, friends, partners or other professional supports (e.g. school welfare coordinators). The key steps for comprehensive relapse planning are as follows:

- Support the young person to define 'relapse' and provide psychoeducation about relapse and recovery in early psychosis. The ENSP manual *A shared understanding: psychoeducation in early psychosis* provides more information about this.
- Provide information about early warning signs of relapse, including the relationship between stress or triggers and early warning signs.
- Identify with the young person their early warning signs and potential stress triggers for relapse.
- Discuss with the young person their beliefs about relapse.
- Complete a wellbeing plan with information about what the young person and their supports can do if they experience a relapse.

Early warning signs

Commonly, there is a period of 1 to 4 weeks preceding a relapse of symptoms of psychosis when the young person may experience a number of 'early warning signs' that they may be about to experience a relapse.[157] If these signs are recognised in time, the young person or clinicians may be able to intervene to reduce further deterioration in the young person's mental state or if a relapse does occur, reduce its impact on their functioning.

A key focus of relapse planning and prevention is assisting the young person and their family to recognise early warning signs and identify what they can do to help stop the young person's mental state from deteriorating further.

Talking to the young person's family about early warning signs is particularly important, as they are often the first people to notice when the young person is beginning to decline.

Identifying early warning signs

It is important to start discussions about early warning signs in the early recovery phase. A timeline can help connect the young person's first episode of psychosis to any events or feelings that might have indicated that they were unwell (see Box 2). These may then be identified as possible early warning signs of a relapse.

BOX 2. USING TIMELINES

Timelines can be a useful tool to work out the potential triggers for someone who may be experiencing an increase in early warning signs or a relapse. Timelines can be a helpful way to look backwards and use specific time points, events, seasons or birthdays to assist in pulling together the pieces of a story to understand potential early warning signs.

Here are some helpful prompts for creating the timeline:

- What were you doing?
- Were there any special occasions happening (e.g. birthdays, exams, family events)?
- What was the weather like?

Another useful strategy is providing a checklist or prompt cards that describe a range of potential early warning signs. This can help prompt the young person to remember their own experiences from when they had a first episode of psychosis. These cards may describe generic experiences (e.g. feeling that my thinking is affected in some way) that can be elaborated on with the young person to define their specific experiences. It can be helpful to do this exercise with a family member or a close friend or partner (someone the young person feels they can trust).

It is helpful to think of how these signs may have occurred in relation to several domains such as the following:

- changes in thinking
- changes in emotions
- changes in behaviour
- odd or unusual experiences.

The resources section of this manual contains a number of tools that can assist with identifying early warning signs including a checklist (see Resource 20) and worksheet of early warning signs (see Resource 21).

ANNA

CASE SCENARIO

Clinician: We've talked about some of the things that led to you speaking to the school counsellor, like hearing the voice. I'm wondering if you can think of any early changes in your thinking, emotions or behaviour that might have been less noticeable at the time?

Anna: Yeah, there was. I just got really worried … all the time … this feeling that something bad was going to happen. My heart would race a lot and I'd feel like I couldn't focus on stuff that other people were saying to me.

Clinician: It sounds like feeling more worried than usual was something that happened early on for you … and that this came with some physical symptoms like having a racing heart. I'm interested in what you said about being able to concentrate, can you tell me a bit more about that?

Anna: Um, I think maybe that might have been one of the first things. Because it was something that my best friend kept pointing out … that I was quieter and not quite there … you know … just away with the fairies a bit.

Clinician: Ok, it seems that there were some changes in your behaviour that other people picked up on … like being more withdrawn or distracted … is one of your early warning signs. I wonder if there are some other things like this that happened early on that you think would be good signs to look out for in the future?

Anna: Yeah, because actually that stuff … the anxiety and being a bit out of it … that was going on for ages before the voice came along. It didn't really feel that important at the time … but when I think about it, I really wasn't myself.

Clinician: It's really common that people don't notice the early stuff the first time it happens. The good thing is that we can figure out what to look out for and have a plan for how you can respond if it happens again.

Beliefs about relapse

One of the challenges of talking with young people about relapse planning will be finding a balance between being aware of and recognising potential early warning signs and conveying a pessimistic view of probable relapse in the future. Emphasising the importance of self-knowledge and subsequent capacity to be in control of their own life can assist young people to adopt a positive attitude towards relapse-prevention work.

It is also important to tell the young person and their family that fluctuations in mood or thoughts and feelings are normal and that these are not necessarily early warning signs. Although the young person and family should be alert to early warning signs, they should try not to become hypervigilant or fearful of relapse.

Often case managers working with young people over a number of years will have the opportunity to notice early warning signs and work with young people to manage them to prevent a relapse. Sometimes, the young person may experience a relapse while still receiving treatment. In either case, the experience should be framed as an opportunity to learn and revise what the young person and case manager know about identifying and managing early warning signs.

CLINICAL EXAMPLE

CM: You mentioned you've been feeling a bit more confused over the past week or so and that others are noticing that you are a bit slower to respond in conversation ... I know from when we first met back when you first had the psychotic episode that these were problems you experienced before the voices got really bad ... I wonder if it's something we need to monitor really closely and think about how we can try to decrease stress just in case ... what do you think?

Creating a wellbeing plan

A wellbeing plan will help the young person and their family identify the young person's early warning signs and the actions they can take to respond to them. A wellbeing plan also contains information about what the young person can do on an ongoing basis to keep them healthy and able to cope. Developing this plan should be a collaborative process between the clinician, the young person and their family and should include contact details of important people who can assist the young person to respond to identified early warning signs. Resource 22 contains a wellbeing plan template that can be used in clinical practice.

PART 7

Challenges and considerations for using psychological interventions in early psychosis

Challenges and considerations for using psychological interventions in early psychosis

Psychological interventions that are utilised in early psychosis such as CBT have often evolved from their use in other high-prevalence disorders (notably depression and anxiety) or with help-seeking adult populations (including those with long-standing experiences of psychotic symptoms).

Clinicians who are accustomed to implementing psychological interventions in these other settings may find that there are a number of factors particular to the early psychosis setting that make the use of such techniques challenging.

This section considers the most prominent of these factors and provides guidance on how psychological interventions can be adapted to the early psychosis context. Being mindful of these challenges and flexible in their practice will enable clinicians to deliver effectively psychological interventions for young people with early psychosis.

Challenges from the clinician's perspective

Engagement and the therapeutic relationship

A young person's engagement with clinicians, the service and their treatment forms the foundation upon which effective psychological interventions can be offered. This is the case for any young person regardless of diagnosis. However, the nature of a first episode of psychosis and its sequelae means that the therapeutic relationship can act as a tool for reducing stigma, reducing anxiety and fear of symptoms, and supporting a young person's sense of self-worth in the context of an often confusing and traumatic experience.

The following sections discuss clinician-related factors that may influence the therapeutic alliance and clinical outcomes.

Clinician attitudes

Clinicians are not immune from their own life experiences, culture, spirituality or schema influencing the therapeutic relationship. They may have particular beliefs about psychosis that unconsciously affect how they approach engaging in psychological interventions with clients. There is often stigma attached to psychosis by mental health professionals such as the belief that it is a condition from which people are unlikely to recover.

It is crucial that clinicians recognise their own beliefs about psychosis and acknowledge that these may be causing 'blind spots' in their practice. For example, research has demonstrated that when clinicians have high expectations about a young person's capacity to recover following an episode of psychosis, there is a corresponding higher level of social and functional outcomes for the young person.[158]

> 'The more hopeful your clinician is about your future, the more hopeful you are about your future, the more likely you are to feel socially included and the more likely you are to be in vocational employment six months later.'
>
> Dr Kathryn Greenwood

Power imbalance

In any health care setting, there is an automatic imbalance of power between client and clinician. In an early psychosis setting, this imbalance can be exacerbated by many factors, including:

- the young person being new in the role of 'client'
- families not always being involved or feeling able to advocate for the young person
- the nature of psychotic symptoms (which may be extremely disempowering)
- aspects of the service setting or delivery (e.g. a young person who has experienced an involuntary admission or treatment order).

Clinicians can counter the impact of the role relationship by ensuring that there is a high level of collaboration with the young person about their goals for treatment and their preferred treatment options. Use of language is also important, as is the involvement of family and other support systems for the young person.

Level of skill

Any medical, psychological or social interventions should only be used by clinicians with the requisite skills or training. Clinicians may feel self-imposed or external pressure to do 'therapy' with a young person despite not being proficient in the approach.

Therefore, clinicians need to know their skill limits and ensure that they seek supervision, consult with the treating team and/or involve senior clinicians where the needs of the young person exceeds their skill level in particular domains. Although clinicians should prioritise professional development, early psychosis services should also provide appropriate training and supervision for psychological interventions.

Challenges related to the young person and their context

Impact of psychotic symptoms

The severity and nature of the young person's symptoms, and how they are affected by them, may impact the young person's ability to engage with therapeutic material. Psychotic symptoms may impact on cognitive capacity and emotional responses in a number of ways. Negative symptoms may cause difficulties in attending to, processing and responding to therapeutic processes during and between sessions. Positive psychotic symptoms such as auditory hallucinations or intrusive thoughts with delusional content may be experienced as distracting and/or distressing, resulting in the young person expending significant effort in affective control, hypervigilance, high anxiety or arousal.

Young people experiencing psychotic symptoms such as persecutory delusions or thought disorder may also be more likely to misinterpret verbal and non-verbal communication from clinicians and the immediate environment. For example, a young person who is experiencing paranoid ideation may have difficulty trusting their case manager. They may also have a significantly different explanatory model to that which is held by their case manager or significant others (e.g. 'others are targeting me', 'I am in danger'). This scenario does not exclude the use of psychological interventions, but it may affect factors such as the choice of language used by the clinician to communicate with the young person, shared explanation of goals and plans to address them, and ongoing clarification about the young person's experience 'in the room'.

THE IMPORTANCE OF PACING

The pacing of interventions in early psychosis is crucial. Clinicians often fall into a trap of trying to do too much in one session, feeling pressure to provide relief from symptoms or distress quickly. However, trying to do too much in too little time can often undermine a clinician's best intentions, resulting in young people feeling confused or that they have 'failed' by not getting better quickly enough.

For psychological interventions to be effective, a young person must be in a mental state in which they can take in and apply new information. When a young person feels distressed or is attending to psychotic stimuli, their cognitive resources are already overloaded. Gradually introducing new ideas or information allows the young person to process information at their own pace and avoids inadvertently adding to the experience of distress by overwhelming the young person's cognitive capacity.

Working with explanatory models and level of insight

Each young person will have their own explanatory model for what is going on (e.g. what their symptoms mean, why they are occurring) and their level of insight about psychosis will vary. Insight refers to a person's recognition and acceptance that they are experiencing psychosis. Both of these factors will affect their capacity to engage with the clinician or with particular elements of psychological therapy (e.g. looking for evidence for a belief). It is possible to use psychological interventions regardless of the level of insight or explanatory model that the young person has; however, this requires creativity, flexibility and clinical skill.

Clinicians should be comfortable with differences of opinion between them and the young person with respect to delusional beliefs or other psychotic experiences. If a young person asks for a clinician's opinion, or when a clinician is introducing a new perspective, it may be helpful to use a normalising example by saying something such as the following: 'I've met many young people who have had similar experiences to you … one of the explanations that made sense to them was that their experiences may be symptoms of psychosis'. If suggestions are dismissed by the young person then explain to them that people often hold slightly different explanations, but that you will try to focus on what they think will help them to feel better.

USE OF LANGUAGE

It is particularly important to consider the language clinicians use when talking to young people about their experience. Clinicians should ensure that their language is respectful of the young person's explanatory model and social and cultural background, and is appropriate to their developmental level. This does not mean that clinicians should modify their language in a false or unnatural way, as this can appear insincere or awkward.

For example, it may be helpful for the clinician to adopt the labels and terms the young person uses to describe their experience: rather than insisting on the use of the word 'hallucination', a clinician may refer to 'voices' or another label identified by the young person.

Where and when appropriate, a clear and concise description of diagnostic or symptom labels should be provided, particularly as the young person may encounter these labels when collecting medication or meeting with their general practitioner. The provision of such descriptions should always occur in the context of normalising psychoeducation, where the young person has an opportunity to ask questions and receive further information.

Age and developmental stage

Young people experiencing a first episode of psychosis may not have any previous history of formal mental health or medical treatment. They may find it difficult to understand the role of different doctors, case managers or other clinicians as members of an ongoing treatment team. Where previously young people may have attended a general practitioner or other specialist doctor with their parents, for a number of reasons this may not be the case for initial contacts with mental health treatment. This may be due to the young person having withdrawn from their family due to psychotic symptoms, or family members feeling alienated or stigmatised. Young people may experience a significant power imbalance, experience feelings of helplessness or reject involvement from unknown adults entirely. Clinicians should be mindful of these potential barriers when engaging and working with young people with early psychosis, and use approaches such as 'checking-in' to minimise such issues.

'CHECKING IN' WITH YOUNG PEOPLE DURING SESSIONS

Young people will not always be forthcoming during sessions about issues they may be having that impact on the effectiveness of psychological interventions. For example, if they do not trust the clinician, or do not understand something, or do not feel safe.

'Checking in' with the young person regularly in a session about process (e.g. feeling comfortable, safe and able to contribute) and content (e.g. focus of session is understandable and acceptable) will help the clinician and young person to be more aware of any factors that might be exacerbating feelings of discomfort or the power imbalance between the young person and clinician.

It is the role of clinicians to address and normalise any feelings or reservations the young person might have about engaging in therapy (e.g. feeling distrustful or fearful of the clinician) and to show they are comfortable discussing this with the young person.

Statements such as 'sometimes other young people say that they have thoughts that they can't trust me, and that it gets in the way of working together' can open up conversations about the impact of symptoms on engagement.

Likewise, 'checking-in' should be done in a thoughtful and natural manner, framed in Socratic style (e.g. 'we've been talking for a while now, can you remind me why it's important that the voices get worse when you are feeling nervous or worried?'). For addressing process, an example may be to say 'I know that you've told me it can be really full on when we talk about the voices. We've been discussing them for a while now and I want to check in and see how you are feeling? Would it be ok to continue?'

This is particularly important for young people who may also exhibit trauma symptoms or who have a longer term difficulty with affective instability. These young people may benefit from the use of agreed upon cues or distress ratings rather than asking if it is ok to continue.

The role of family and other supports

Most young people are living at home at the time of onset of a first episode of psychosis. Therefore, the role of family members in treatment for early psychosis may be quite different to what is practised in adult mental health services. Where possible and appropriate, families will be engaged more in the young person's treatment, including through supporting specific psychological interventions to increase involvement in pleasant activities or to reinforce positive coping strategies.

Formal family therapy may be offered to some young people and families. The ENSP manual *All in this together: family work in early psychosis* provides more information on this topic.

Cultural background

As discussed earlier, whether a particular experience is considered 'psychotic' must be understood contextually, particularly with respect to culture. Many cultures and religions incorporate supernatural or spiritual ideas. Clinicians should not seek to impose a particular explanatory model but rather work with the young person and their family to understand what they see as the presenting problem and what they would like to be different. Often family members will be invaluable in assisting to define what lies within a 'usual' cultural experience and what lies 'outside'. For example, it may be considered normal to see visions of loved ones who have died, but not to experience this vision as controlling, commanding or impacting on daily functioning.

Impact of co-occurring conditions

Co-occurring conditions such as depression, anxiety, PTSD, substance use and personality disorder are extremely common among young people with early psychosis. These may be pre-existing issues or they may have manifested since or even in response to the young person's experience of psychosis and related treatment experiences.

It is possible that co-occurring conditions will affect the young person's experience of psychotic symptoms, how they respond to them and how they are able to cope with them. Clinicians also need to consider how any co-occurring conditions may affect the young person's engagement with treatment and the therapeutic relationship. For example, a young person who has had traumatic experiences of treatment during the acute phase of the psychosis may understandably take longer to engage with and trust a new clinician. Clinicians need to select the most appropriate treatment approach to suit the needs of the young person with co-occurring difficulties, and this approach must be guided by a formulation-based approach.

Service-related challenges

The case-manager–therapist role

Within the EPPIC Model, biological, psychological and social interventions are delivered in the context of case management. While medical treatments are provided by consultant psychiatrists and registrars, psychological interventions are largely provided by case managers and integrated with other forms of service and support.

The benefits of the dual case-manager–therapist function are that young people are not required to develop multiple therapeutic relationships and that a range of support may be provided based on their hierarchy of needs. However, the drawbacks are that for clinicians who are used to providing more structured, ongoing psychological interventions, planned therapy sessions may at times have to give way to other more pressing needs of the young person such as social, housing or advocacy needs, which represent the 'case manager' part of the role.

To manage this, clinicians need to be flexible in their approach to psychological interventions in an integrated case-management and therapist role. Pacing interventions is often purposefully slow to allow time to attend to the broader psychosocial needs of the young person. As such, the psychological goals may be addressed much more slowly or in smaller increments, perhaps addressing just one issue in a session along with case-management issues.

Service culture

Culture and attitudes within service have a significant impact on the use of psychological interventions. Services that are influenced by a primarily medical model or biological understanding of psychosis may not historically have provided the time, training or supervision for staff to implement psychological interventions. Often, time and resourcing pressures can lead to a conflict between competing organisational, administrative and case-management tasks. Services require senior advocates and 'culture carriers' for all core components of the EPPIC Model, including psychological interventions. It is helpful if these staff members are present in clinical-review meetings, facilitate individual and group supervision and are available for referrals for specialist psychological interventions.

Summary

This manual provides an overview of current research and recommendations for the use of psychological interventions with young people experiencing early psychosis and co-occurring conditions. A range of cognitive–behavioural and other psychological interventions are presented to support clinicians in providing psychological assessment, treatment planning and targeted interventions using a strengths-based approach. Strategies presented in this manual are designed to be used as part of an individualised treatment plan that is guided by the use of a comprehensive case formulation.

The aims of psychological interventions are to support the young person to regain their usual developmental trajectory, to reduce distress related to symptoms of psychosis or co-occurring conditions and to support functional recovery across social and occupational domains. Clinicians are encouraged to utilise the recommended texts and professional development training to further develop core skills in psychological assessment, formulation and the use of cognitive behavioural and other psychological interventions. The consideration of service principles, normalising and non-stigmatising treatment and clinician skill and specialisation should guide decision making about the use of psychological interventions that will best support young people with early psychosis.

Resources

Cognitive biases

Mental Filter	Viewing events through a filter where only the negative elements are noticed and the positive elements are dismissed. *'I must be so stupid because I got a bad mark on my maths exam' (but did well in three other exams)*
All or Nothing Thinking	Seeing only one extreme or the other without acknowledging that there are shades of grey. Often called 'Black and White' thinking. *'I am either a success at everything or I am a failure'*
Jumping to Conclusions	Making assumptions about what someone is thinking (mind reading) or predictions about what will happen in the future (fortune telling) based on very little or insufficient information. *'She doesn't like me because she didn't say hello'*
Emotional Reasoning	To believe that something is true based on how we feel about it. *'I feel scared so I must be in danger'*
Personalisation	Taking responsibility or blaming yourself for something without considering other plausible explanations. *'He was rude to me because I did something wrong'*
Catastrophising	Giving greater weight to the worst possible outcome, even if it is unlikely. Evaluating a situation as 'horrible' or 'unbearable' when it is inconvenient or uncomfortable. *'If I make a mistake it will be terrible, I won't be able to cope'*
'Should or Must' Statements	Having a fixed idea about how you or others should behave. Setting standards that are absolute, then feeling frustrated or thinking that you/others have failed if these standards are not met.
Labelling	Applying a fixed, global label to yourself or others *'I am such a loser'*
Overgeneralisation	Taking a past or present example and applying it to all current and future situations. *'Everyone is...' 'I always...' 'Nothing ever...'*
Disqualifying or Discounting the Positive	Telling yourself that any positive events, personal characteristics or achievements are irrelevant or do not count. *'I got a good mark, but it doesn't mean anything... I got lucky'*

Cognitive and information-processing biases common to psychosis

Perceptual biases

Selective attention for threat

This refers to paying particular attention to (and being particularly sensitive to) threat-related stimuli in the environment. For example, a person may selectively notice comments or behaviours from others that might indicate that they think negatively of them or mean them harm, yet ignore cues that do not convey this message. Similarly, indistinct perceptual experiences such as something moving in the corner of one's visual field might be interpreted as a potential source of threat (e.g. a dangerous animal or predator) rather than as a neutral or positive experience.

Source monitoring

This refers to a bias towards remembering and attributing sensations, thoughts or phrases to others rather than to oneself. This may contribute to the emergence of psychotic symptoms, particularly hallucinatory experiences. For example, a person experiencing intrusive sexual thoughts may not identify with these thoughts at all and start hearing these thoughts aloud in his head. The person may be confused by this experience and start wondering whether the thoughts may in fact have an external origin (i.e. originate from another source rather than his own mind).

Attributional biases

Hindsight bias

The hindsight bias refers to a pattern of believing that one knew a particular answer or outcome all along, even if this was not the case. The 'correcting' ability of past memories is weakened due to this bias, with the reconstructed hindsight memories seeming to support a particular conclusion. This cognitive bias may contribute to the onset of delusional thinking. For example, a person may start believing that there is a connection between the content of their dreams and events that happen the following day and start entertaining the thought that they have powers of premonition. In fact, this person may be selectively remembering or elaborating aspects of their dream that are consistent with the day's events.

Personalisation bias

This refers to a pattern of attaching personal meaning to irrelevant external events. This may contribute to ideas of reference and paranoid delusional thinking. For example, a person may start thinking that what is being spoken about on the radio may have a particular significance or meaning for them.

Covariation bias

This bias refers to an overestimation of a connection or causality between events and an underestimation of chance. This may contribute to delusional thinking. For example, a person may describe experiences of noticing others looking at them at the same time that they are thinking angry or aggressive thoughts. This person may start wondering whether other people can in fact read their mind, particularly when they are having thoughts of this nature.

Reasoning biases

Jumping to conclusions

This cognitive bias refers to quickly coming to a conclusion or adopting a particular belief without having sufficient information or data. An intolerance of uncertainty may drive this tendency to 'jump to conclusions'. This may contribute to delusional thinking. For example, a young person may describe experiences at work of his co-workers ignoring his question or seem to rush away from him, which he quickly interprets as them not liking him and thinking poorly of his work, rather than considering that this may be due to work pressure associated with tight deadlines or other reasons.

Negative expectation bias

This refers to a pessimistic cognitive style, including expecting a poor outcome of events or that you will be unable to cope with particular events. This is of course a classic feature of depression, but can also be apparent in emerging psychotic symptoms and can be associated with paranoid thinking and negative psychotic symptoms. For example, a person may describe that she has started avoiding using her car because her friend's car was stolen recently and she fears that same will happen to her car is she parks it away from her house. This expectation and behavioural pattern is one instance of her larger tendency to always think and expect the worst to happen.

Belief inflexibility bias

This cognitive bias refers to an over-confidence in one's beliefs and reluctance to examine the evidence or validity of a certain belief. This bias may contribute to delusional thinking. For example, a young person may describe thoughts that her family mean to harm her. Although she has no particularly strong reasons to hold this belief and her family members repeatedly reassure her that they do not mean to harm her in any way, she describes 'just knowing' that they do.

Emotional reasoning

This cognitive style refers to coming to conclusions about a particular situation on the basis of a subjective emotional response, at the expense of taking other factors into account. For example, a young person might describe believing that he must be in danger and that he is threatened in some way due to his high levels of anxiety. His anxiety is taken as proof of the danger.

Confirmation bias

This cognitive style refers to seeking new information that is consistent with currently held beliefs or expectations and failing to consider disconfirming information. This cognitive style can reinforce existing beliefs and thereby strengthen emerging psychotic symptoms.

Behavioural bias

Avoidance behaviour

This refers to the avoidance of situations or triggers that are considered to be threatening. Avoidance behaviour is known to be problematic in anxiety disorders because it removes the opportunity to rule out fear-inducing beliefs. This is often the case in early psychosis presentations. For example, a young person with mild persecutory ideas might avoid social situations to avoid triggering the fear associated with the belief that others might humiliate or harm them in some way.

Timeline

Thought record

Trigger	Thoughts and beliefs	Emotional and physical	Odd or unusual experiences	Behaviour
What happened?	What were you thinking? What thoughts or images ran through your mind?	What were you feeling? What physical sensations did you experience?	Were there any other experiences (e.g. hearing a voice or feeling that you were floating away)?	What did you do? How did you react?

Functional assessment of voices: Prompt sheet for clinicians

Description of voices • How many voices? • Gender of each voice? • How often do you hear each voice? • How loud is each voice? • Can you hear what they are saying?	
Content • What does the voice say? • Is the voice critical or abusive? • Is the voice kind or supportive? • Does the voice comment on what you are doing or give advice? • Does the voice command you to do things?	
Triggers • When do you hear the voice? • Are there particular places or situations where you hear the voice more often? • What about times when you don't hear the voice?	

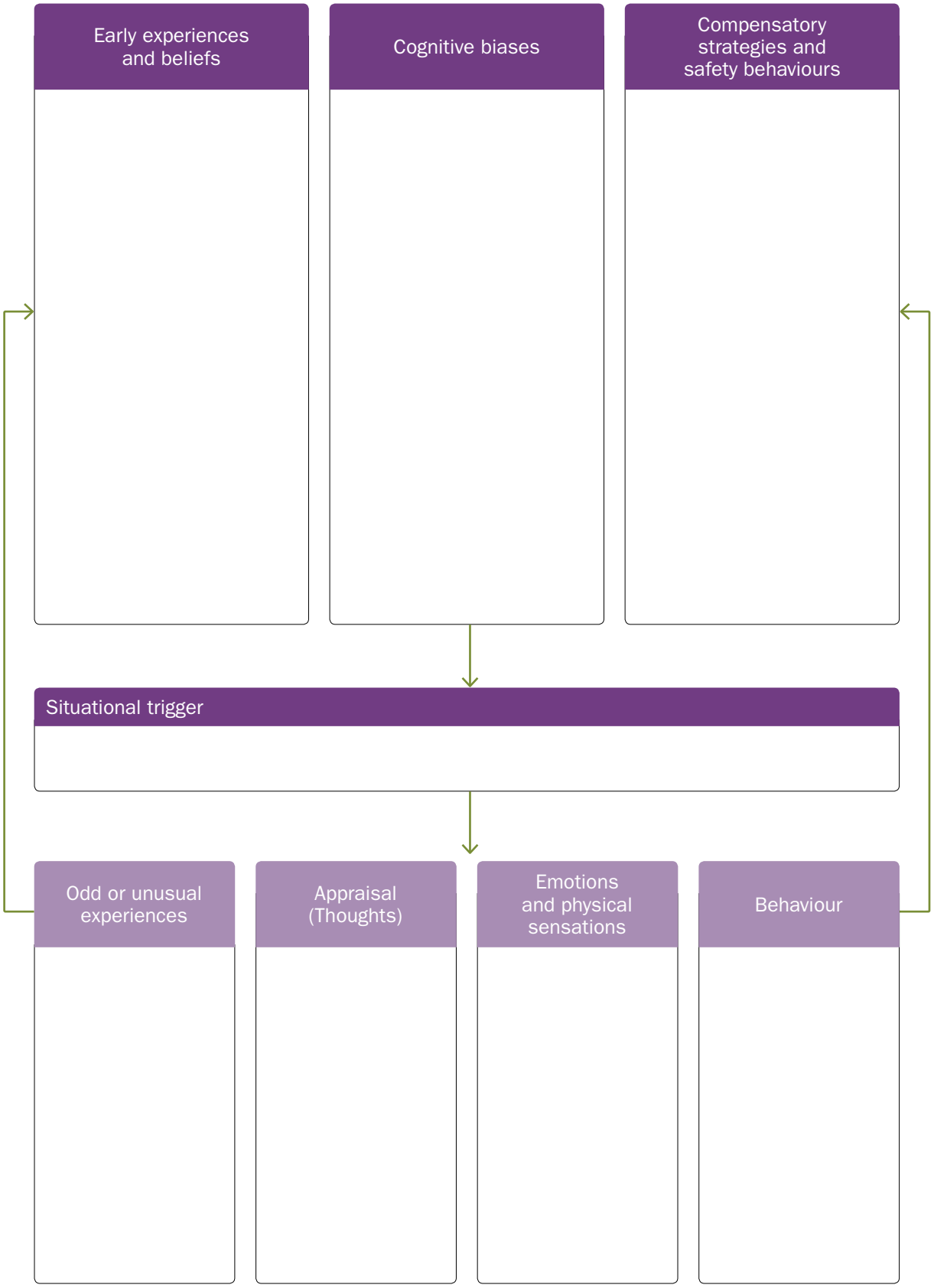
Response

- How do you feel emotionally when you hear the voice?
- Do you experience any physical sensations (e.g. heart racing)?
- What do you do when you hear the voice (e.g. try to ignore it, talk to it, comply with it)?

Beliefs about voices

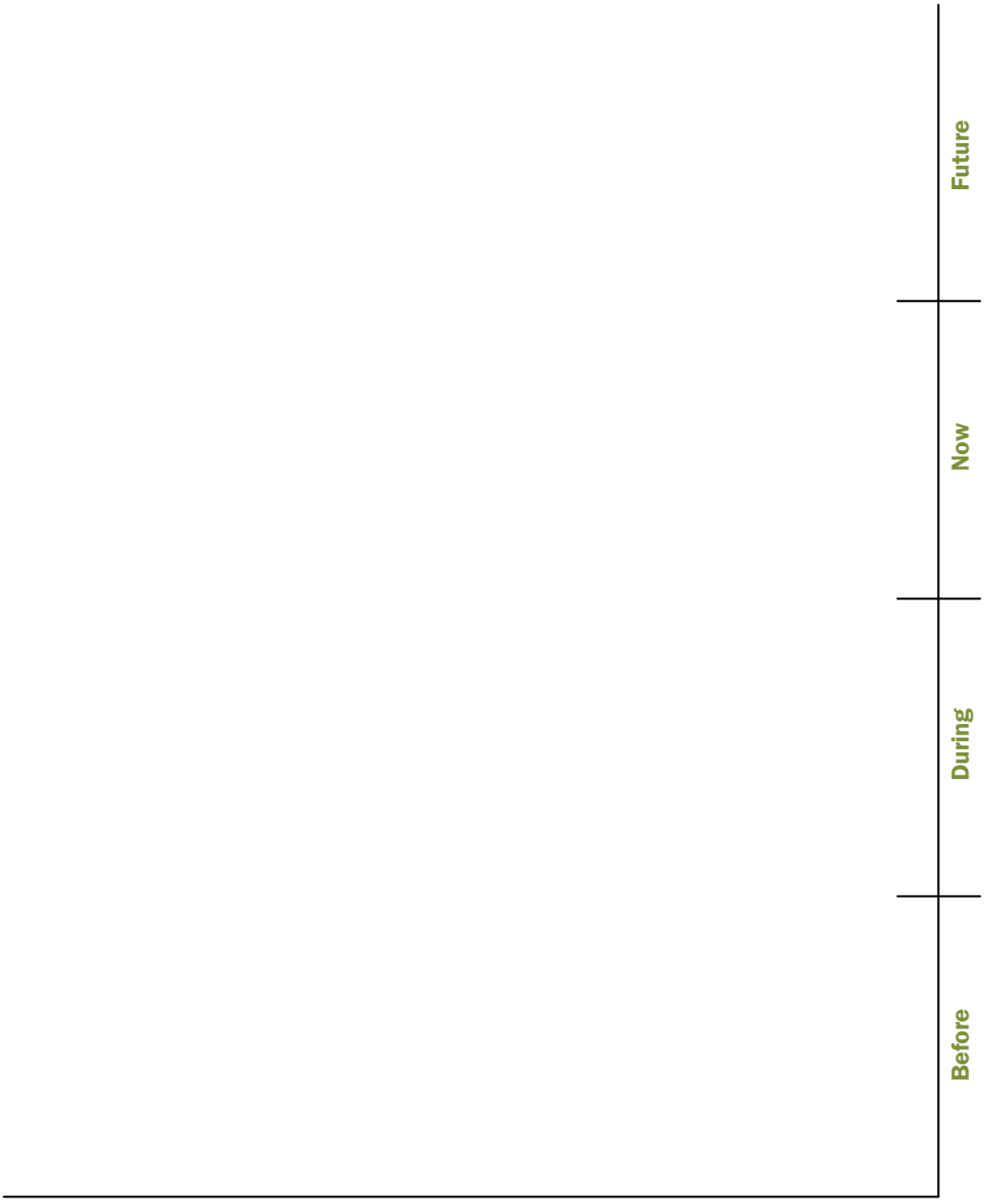
- What or who do you think the voice may be?
- Why is it that you can hear the voice?
- What is your relationship to the voice?
- Do you believe that the voice has good or bad intentions?
- Do you believe that the voice is powerful? Why do you think this?
- What would happen if you changed your response to the voice (e.g. did not comply with it, ignored it)?

Cognitive–behavioural formulation for psychosis template



Identity timeline

Take some time to think about how you see yourself over time and write your responses in the timeline below. Consider the way you would describe yourself before you experienced psychosis, during the episode of psychosis, and how you see yourself now and in the future.



Repertory grid

Complete the grid by selecting some words that describe your way of seeing yourself in the past, during your episode of psychosis, now or in the future. Consider how you or others would describe you generally, physically, your lifestyle, your abilities, your occupation and yourself in relationships with others.

Example:

How do I see myself now?

Motivated	1	2	3	4	5	6	7	*Unmotivated*
Happy	1	2	3	4	5	6	7	*Sad*

How do I see myself now?

	1	2	3	4	5	6	7
	1	2	3	4	5	6	7
	1	2	3	4	5	6	7
	1	2	3	4	5	6	7
	1	2	3	4	5	6	7
	1	2	3	4	5	6	7
	1	2	3	4	5	6	7

How do I see myself... (in the future, past, during psychotic episode)?

	1	2	3	4	5	6	7
	1	2	3	4	5	6	7
	1	2	3	4	5	6	7
	1	2	3	4	5	6	7
	1	2	3	4	5	6	7
	1	2	3	4	5	6	7
	1	2	3	4	5	6	7

Ways that I cope with odd or unusual experiences

What is the experience?	How distressing is it? 0 (not at all) to 10 (extremely)	Ways that I use to cope	How effective is my coping strategy? 0 (not at all) to 10 (extremely)
e.g. having thoughts that people are trying to hurt me	*9/10*	*Talk to my mum and sister about it* *Tell myself that it isn't true* *Listen to music when by myself in public*	*9/10* *4/10* *6/10*

Coping strategies

The following list outlines some commonly used strategies that young people use to cope with odd or unusual experiences. Remember that what works for one person may not work for another and it may take some experimenting to find strategies that work best for you.

Normalising

Remind yourself that you are not the only one who has had these kinds of experiences. Experiences of hearing voices or having visions is reported by many people in the community, particularly in situations such as being under a lot of stress, when falling asleep or waking up, when a loved one dies, or in the context of mental health problems.

Distraction

Finding something else to do that will take up some of your attention can be very helpful as a short-term coping strategy. Try to choose something that you enjoy doing such as listening to music, going for a walk, calling a friend, watching a movie or doing something creative such as drawing or writing.

Reality testing

Be prepared for your mind to play tricks on you and try to slow down and not jump to conclusions when you have a distressing thought or experience. Sometimes we respond to our emotions before taking time to see if there is any evidence for what we are thinking or worrying about. It can be difficult to 'reality test' for ourselves, and sometimes it can be useful to have a trusted family member or friend to check things out with.

Self-talk

Some experiences such as hearing a voice can contain a lot of negative, critical or even threatening content. It can help to remind yourself that the things being said to you are not true and to focus on aspects of your life that help you to feel in control, supported, proud or optimistic.

Relaxation

There are a number of breathing and relaxation strategies that can be used to cope when feeling distressed. Slowing down your breathing, using progressive muscle relaxation, visualising a safe place or other mindfulness and meditation techniques are all useful approaches to relaxation. Some strategies take a bit of time to learn, so find something that works for you and take time to practise when you are not feeling very distressed or anxious.

Acceptance

This strategy involves taking an 'observer' view of your internal experiences (e.g. thoughts, feelings, sensations) without trying to modify or change anything. By doing this you can stop struggling against or resisting unpleasant thoughts, feelings or sensations and accept that they are happening and that eventually they will pass.

Getting active

Engaging in regular exercise can be helpful to improve wellbeing in many areas. This does not need to be complicated; simply going for a walk can provide a distraction, and enhance your mood and reduce anxiety, and it provides physical health benefits. Sometimes even changing your environment, moving to a different room, walking to the local shops may act as a 'circuit breaker' for intrusive experiences such as voices or distressing thoughts.

Singing, humming or using earplugs

Making some noise through singing or humming can activate the same parts of the brain that are used when you hear voices. Some young people find that using this strategy means they no longer hear a voice while they are using it. Another strategy you could try involves using an earplug to block one ear. This may block or reduce the volume of a voice.

Coping plan

What is the experience I would like to cope better with?

What strategy do I want to use to cope with this experience?

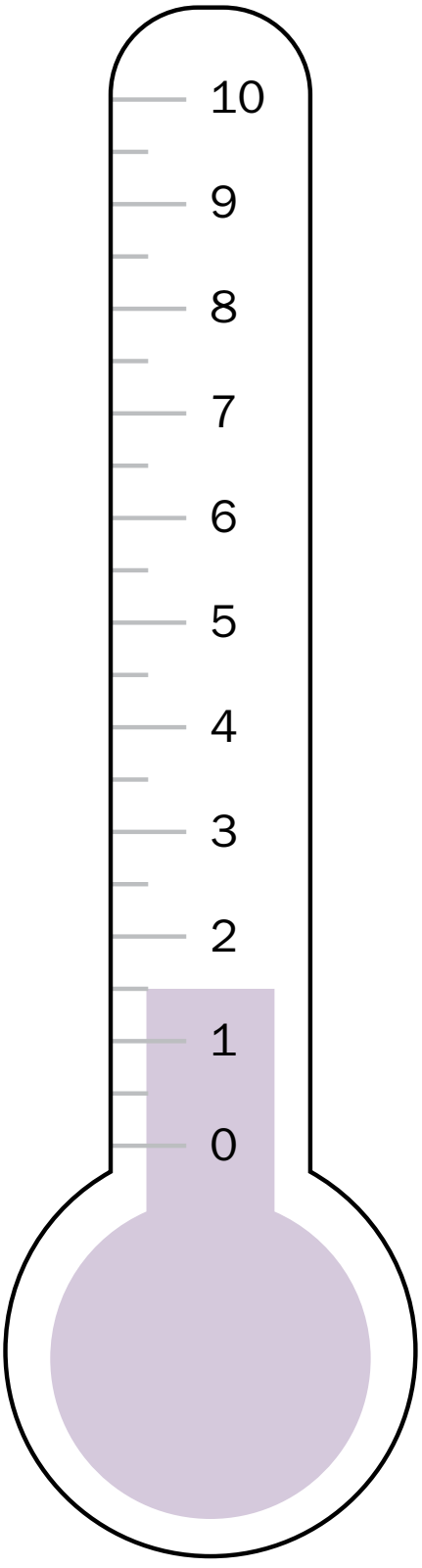
What resources or skills do I need?

When and where will I use this strategy?

Coping log

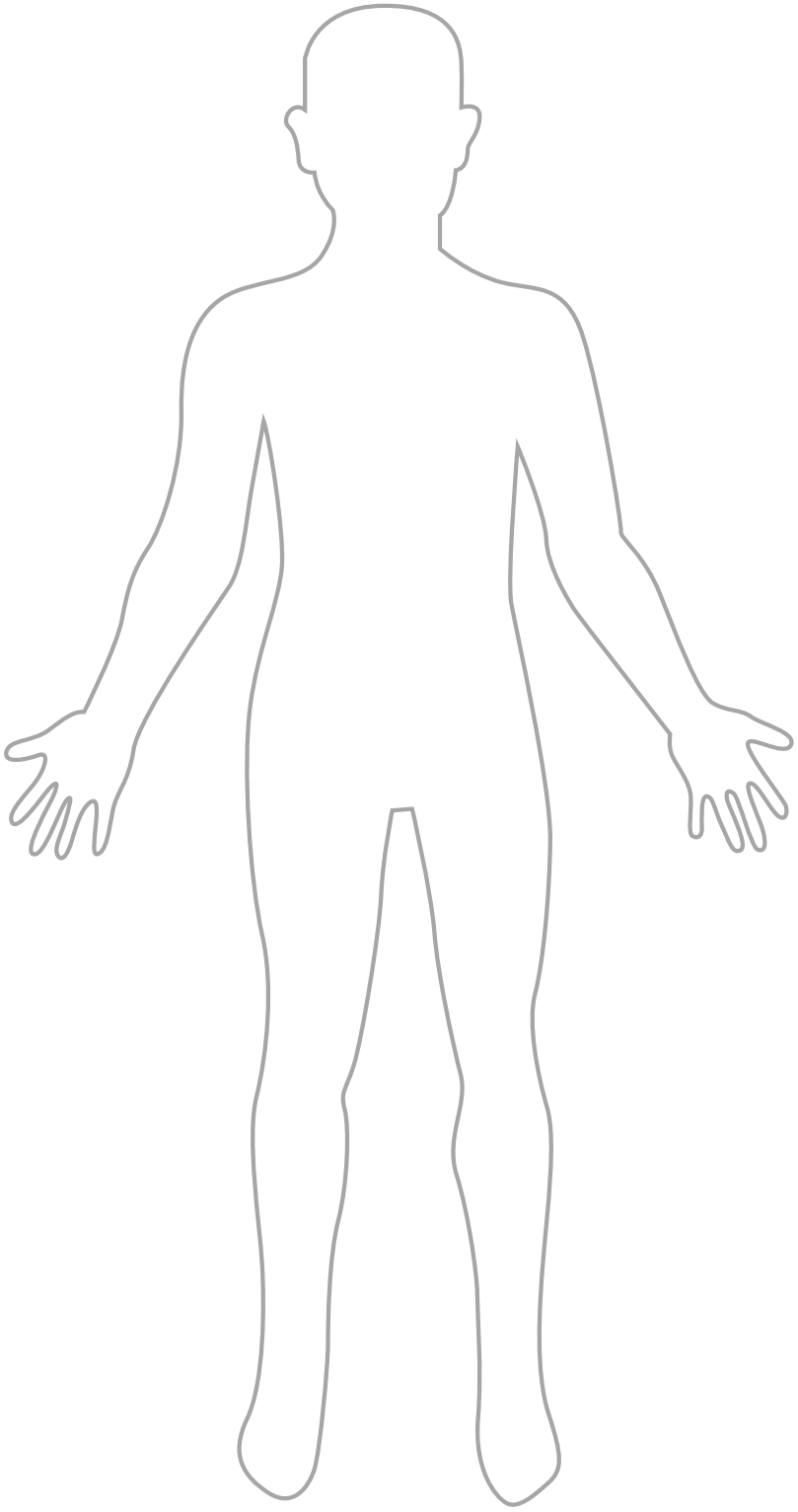
Day or date	What was happening at the time?	How distressed was I? (0–10)	What coping strategy did I use?	How distressed was I after I did this? (0–10)

Distress thermometer



Anxiety and the body

Anxiety can affect how we think, feel and act in very powerful ways. Label the physical symptoms you feel when you start to get anxious on this diagram.



Progressive muscle relaxation – take home script

At the beginning of the session, remove your glasses, watch, jewellery, shoes, loosen your belt and remove anything that will distract you or make you feel uncomfortable. Make sure your phone is turned off.

When you are seated comfortably in a chair in a quiet, softly lighted room, visualise a calm scene and begin to say "relax" to yourself each time you breathe out.

Remember, it is important to say "relax" to yourself when you release the muscle tension and breathe out.

Now begin by tensing the muscles in your right hand…

Tense the muscles tightly… Feel the tension in your right hand…Hold the tension…Now breathe out, and say "relax" and let the tension go. Relax… Now, once again, tense the muscles in your right hand… Hold the muscles tighter and tighter… Feel how tight and tense the muscles are… Now slowly breathe out, say the word "relax" and release the tension in your hand. Relax… Feel the tension dissolve…

Feel the difference now that your right hand is relaxed.

Now do the same with your…

- Right upper arm
- Right shoulder
- Left hand
- Left upper arm
- Left shoulder
- Head (turn right, then left)
- Mouth (open wide, then press lips closed)
- Tongue (press up to roof, then press down)
- Now just sit there and relax.
  Try not to think of anything…
- Eyes (squeeze tightly closed, then hold open wide)

Now take a deep breath and hold it… Relax…
Now exhale.

Breathe all the air out… all of it… Say the word "relax" to yourself…

Imagine that there are weights pulling on all your muscles making them loose and relaxed… pulling your arms and body into the chair.

Now do the same with your…

- Stomach
- Buttocks
- Thighs and calves
- Toes and feet

This completes the relaxation procedure. Now explore your body from your feet up. Make sure that every muscle is relaxed. First your toes, your feet, your legs, buttocks, stomach, hands, arms, shoulders, neck, eyes, and your forehead. All should be relaxed now. Just sit there and feel very relaxed, noticing the warmness of relaxation.

You can now finish the session with a few minutes of visualising a calm and relaxing scene.

Adapted from Bourne, E. J. (2011). *The Anxiety and Phobia Workbook*. 5th Ed. New Harbinger Publications; Oakland, CA.

RELAXATION AUDIO

Orygen Youth Health has created a CD of relaxation exercises to help young people chill out during difficult times. You can go to http://oyh.org.au/training-resources/free-downloads/pause and follow the instructions to download the audio files and use them for free.

My safe place

Imagine a place where you can feel calm, peaceful and safe. This may be a place in your life currently where you go to feel relaxed. It may be a room in your home or somewhere outdoors. Your safe place may be a place you've been to before, somewhere you would like to go, or maybe somewhere you've had a dream about or seen a picture of.

As you visualise this place, focus on what you can see around you.
Try to notice shapes, objects and colours in your peaceful safe place.

Next, notice any sounds or perhaps silence in this place.

Pay attention to any smells you notice there and try to describe or name them.

Then begin to focus on any sensations on your skin such as the ground beneath you, anything around you that you can touch, movement in the air, whether the temperature feels warm or cool, or the sensation of the sun on your face.

While you are in your peaceful and safe place, take a moment to think of a name, word or phrase that you can use to remember this image. Remind yourself that you can come back to be in this calm and safe place whenever you need to.

You can choose to stay in this place a while – just noticing how you feel calm, peaceful and safe. You can leave whenever you wish just by opening your eyes and being aware of where you are now.

Take a moment to write down details of your safe place

Where am I?

What can I see?

What can I hear?

What can I smell?

What sensations do I feel?

List of enjoyable activities

Solo activities

- Plan a holiday
- Go for a walk or a jog
- Listen to music
- Lie in the sun
- Read a magazines or a good book
- Write a poem or short story
- Go to the gym
- Cook from a new recipe
- Practice karate, judo or yoga
- Do some gardening
- Go swimming
- Draw or paint something
- Make a list of tasks and tick them off
- Play a musical instrument
- Make a gift for someone
- Practice meditation
- Do a jigsaw puzzle
- Start collecting something
- Sew something
- Buy some clothes
- Prepare your resume
- Read the newspaper
- Daydream
- Watch a movie
- Go bike riding
- Chat on the internet
- Take some photographs
- Write a letter
- Spring clean
- Join the local library
- Look at some old photos
- Do a crossword puzzles
- Dress up in something smart
- Learn a new language
- Get a massage
- Taking a sauna or steam bath
- Reorganise my cupboards
- Light some candles
- Listen to the radio
- Work on my finances
- Play a computer game
- Rearrange the furniture in my room

Activities with others

- Go to a movie
- Spend an evening with good friends
- Play a card or board games
- Join a book club
- Go to a party
- Talk to friends
- Sing in a choir
- Go to the beach
- Go ice skating or roller-blading
- Go for a drive
- Go hiking or bush walking
- Go out to dinner
- Play tennis
- Go to a play or concert
- Go to a footy game
- Go fishing
- Join a sporting team
- Go on a picnic
- Have lunch with a friend
- Play pool or billiards
- Go to a museum or art gallery
- Go surfing
- Go bowling
- Go horse-riding
- Go rock climbing
- Go window shopping

Adapted from resources from the Centre for Clinical Interventions (http://www.cci.health.wa.gov.au) and the National Cannabis Prevention and Intervention Centre (https://ncpic.org.au).

Behavioural experiment worksheet

Target thought

Alternative thought

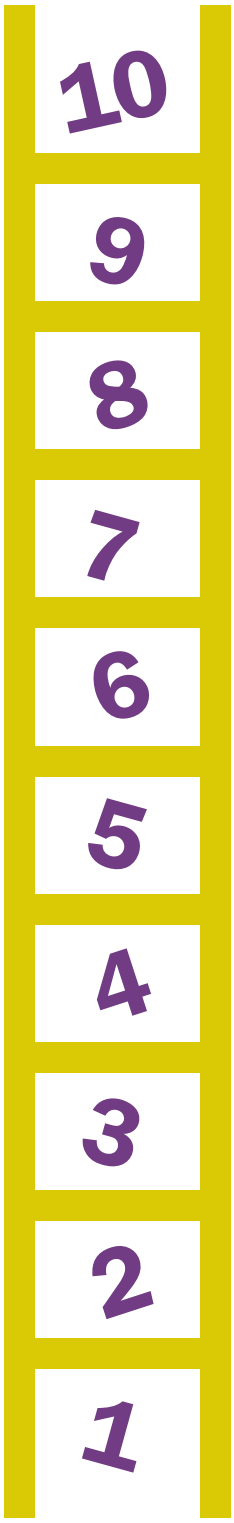
Experiment

Predictions (% belief)

Outcome

What I learnt

Exposure hierarchy - template



Evidence testing – template

What is the belief that I want to test?

What is the evidence for the belief?

What is the evidence against the belief?

What is an alternative or modified belief?

Early warning signs checklist

- ☐ Preoccupied with things
- ☐ Feeling depressed or low
- ☐ Difficulty concentrating
- ☐ Others have difficulty following what I am saying
- ☐ Feeling as if my thoughts might not be my own
- ☐ Feeling as if I am being watched
- ☐ Feeling useless or helpless
- ☐ Feeling confused or puzzled
- ☐ Feeling stubborn
- ☐ Feeling very excited
- ☐ Feeling forgetful or 'far away'
- ☐ Being open and explicit about sexual matters
- ☐ Speech comes out jumbled and full of odd words
- ☐ Sleep has been restless or unsettled
- ☐ Behaving oddly for no reason
- ☐ Feeling unable to cope
- ☐ Not feeling like eating
- ☐ Feeling like playing tricks or pranks
- ☐ Feeling quiet and withdrawn
- ☐ Talking or smiling to myself
- ☐ Not bothered about appearance or hygiene
- ☐ Feeling violent
- ☐ Thinking I could be someone else
- ☐ Feeling dissatisfied with myself
- ☐ Having aches and pains
- ☐ Losing my temper easily
- ☐ Having no interest in things
- ☐ Feeling as if I am being laughed at or talked about
- ☐ Feeling tired or lacking energy
- ☐ Movements seem slow
- ☐ Feeling as if my thoughts might be controlled
- ☐ Feeling aggressive or pushy
- ☐ Feeling irritable or quick tempered
- ☐ Feeling tense, afraid or anxious
- ☐ Feeling very energetic or needing little sleep
- ☐ Feeling very talkative or outgoing
- ☐ Feeling very confident or extremely happy
- ☐ Having the urge to spend a lot of money
- ☐ Feeling overassertive or having no regard for authority
- ☐ New ideas are constantly coming into my mind
- ☐ Feeling that I am not safe
- ☐ Not wanting to be alone
- ☐ Taking on more than I can handle
- ☐ Feeling restless
- ☐ Not wanting to get out of bed
- ☐ Feeling that I want to hurt myself
- ☐ Thinking that the radio or television are referring specifically to me
- ☐ Thinking that food or drink has been tampered with
- ☐ Having difficulty focusing and concentrating
- ☐ Thinking that I can communicate with spirits or people who have passed away
- ☐ Having difficulty getting to work, school or leisure activities
- ☐ Thinking people can read my thoughts
- ☐ Having difficulty managing everyday tasks
- ☐ Being preoccupied with one or two things
- ☐ Hearing people talking when nobody is there

My early warning signs

Thinking about my first experience of psychosis, what was the first change I noticed?

- My mood and emotions
- My thoughts and ideas
- How I felt in my body – physical sensations, energy, sleep
- My behaviour
- How I was functioning at school, work, socially, health and hygiene

What was happening for me at that time?

- What I was doing and where (e.g. holidays, exams, at home in Melbourne)
- Events/special occasions (e.g. birthday, Christmas)
- World events (e.g. natural disaster on news, AFL finals, election)
- Season/weather
- Relationships

What was the last change I noticed? What was happening for me at the time?

What were the other changes that I noticed? What was happening for me at these times?

Wellbeing plan

Name: **Date:**

Things I can do regularly that help me manage stress and look after myself

Situations that may act as 'stress triggers' for me are

Things I can do that help me to cope with 'stress triggers' are

Early warning signs that I should take notice of are

My thoughts

My feelings and physical sensations

My behaviour

Odd or unusual experiences

Steps I can take if I notice these signs

What I would like my friends and/or family to say or do if they notice these signs is

People who can support me

Family

Friends

Case manager

Psychiatrist

GP

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NOTES

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