Staying Well after Psychosis: A Cognitive Interpersonal Approach to Emotional Recovery and Relapse Prevention

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Feelings of fear, depression, helplessness, hopelessness, embarrassment and shame are common prior to relapse in psychosis. This paper describes a psychological treatment approach dedicated to relapse prevention and facilitation of emotional recovery.

Introduction

In this paper I plan to show that relapse prevention and emotional recovery are inextricably linked acting as twin reciprocal goals, which are encapsulated by the term Staying Well after Psychosis'. These dual outcomes are unified by one central therapeutic task which is the development of affect regulation. I will begin the paper by outlining the empirical evidence for the relationship between affect regulation and relapse. I will then outline the early developmental and interpersonal precursors to affect regulation and show how these are relevant to and inform our therapeutic stance towards emotional recovery and relapse prevention for persons with psychosis. I will then show empirical evidence for the link between emotional well-being and relapse and then outline our cognitive interpersonal approach to staying well after psychosis (Gumley & Schwannauer, 2006) .

Relapse Prevention as a Problem of Affect Regulation

The phenomenological evidence shows that feelings of fear, depression, helplessness, hopelessness, embarrassment and shame are common emotional experiences prior to relapse, and that these emotional responses arise from the development of low level psychotic like experiences such as cognitive perceptual anomalies, hearing voices, suspiciousness and interpersonal sensitivity. The combination of these experiences is sensitive but not specific to relapse (See Table 1). This means that whilst most relapses are preceded by these experiences, the occurrence of low level psychotic experiences in combination with affective distress does not necessarily lead to a relapse. Therefore it is more appropriate to consider early signs of relapse as an "at risk mental state".

Table 1. Studies of the sensitivity and specificity of early signs to relapse in schizophrenia

Study	Assessment of early signs	Number of relapses	Sensitivity %	Specificity %
Subotnik & Neuchterlein (1988)	Observer rated	17	59	NR
Birchwood et al. (1989)	Self rated Observer rated	8	63	82
Hirsch & Jolley (1989)	Self rated	10	73	NR

Table 1. Studies of the sensitivity and specificity of early signs to relapse in schizophrenia				
Tarrier et al. (1991)	Observer rated	16	50	81
Gaebel et al. (1993)	Observer rated Observer rated Observer rated	162	8 14 10	90 70 93
Marder et al. (1994)	Observer rated	42	37 48	NR
Malla & Norman (1994)	Self rated Observer rated	24	50	90
Jorgensen (1998)	Self rated Observer rated	27	78 30	45 58

The person's cognitive, behavioural and interpersonal coping reactions and resources probably moderate the intensity of emotional distress. For example, maintaining a reflective awareness characterised by a non-catastrophic reaction combined with productive coping and recruitment of help and support from others is likely to decelerate and abort relapse. However, for many individuals the threat of relapse is likely to lead to catastrophic expectations and a disorganisation of the person's coping responses.

It is now established that the experience of psychosis is traumatic and is often associated with the development of psychosis related post traumatic stress disorder which is characterised by intrusive memories linked to the experience of psychosis, hypervigilance and fear, and sealing off and avoidance. The threat of recurrence of psychosis is therefore likely to generate competing and disorganising reactions such as catastrophic appraisals of relapse, fear, vigilance and interpersonal threat sensitivity on the one hand, and cognitive, emotional and behavioural avoidance and delayed help seeking on the other (Gumley & Macbeth, 2006). Fear of relapse has been previously identified in retrospective studies of the phenomenology of early relapse (e.g. Herz & Melville, 1980). We investigated the sensitivity and specificity of *fear of recurrence* to relapse in a large two centre randomised controlled trial of relapse detection which compared fortnightly monitoring of fear of recurrence versus fortnightly monitoring of symptoms of relapse. Table 2 shows that both approaches were equally sensitive to the detection of recurrence in the two weeks prior to relapse.

Table 2. Predictive validity of increased score of early signs to psychotic relapse						
Early signs	**Participants suffering a relapse**			**Participants not suffering a relapse**		
	n	**Sensitivity**	**95% CI**	**n**	**Specificity**	**95% CI**
Fear of recurrence	25			46		
5	18	72	52–86	25	46	32–60
10	15	60	40–76	11	74	59–85
15	6	24	12–44	7	85	72–92
Standard early signs	33			42		
5	26	79	62–89	30	35	23–50

Table 2. Predictive validity of increased score of early signs to psychotic relapse						
10	12	36	22–53	17	63	46–76
15	5	15	7–31	11	76	62–86

Crucially optimal detection of relapse was sensitive in the two weeks prior to recurrence showing that the window of intervention is limited and that delayed detection or help seeking will probably increase the likelihood of recurrence. Furthermore, although delayed help seeking can be conceptualised as a defensive response to the threat of relapse, there is an accompanying probability that this unintentionally increases the likelihood of increased severity of psychotic experiences, admission to hospital and use of involuntary procedures thus fulfilling catastrophic expectations.

Therefore relapse detection and prevention relies heavily on the presence of a productive and secure working relationship between service users and care providers including health professionals. This fact is not lost on service users, who value services as a secure base for exploration and proximity seeking (Goodwin, Holmes, Cochrane & Mason, 2003). This provides us with an important link to the developmental and interpersonal roots of affect regulation (or dysregulation) based on the organisation (or disorganisation) of attachment representations, which in turn are likely to inform us about the nature and vulnerability to problematic recovery from psychosis.

Developmental and Interpersonal Roots of Recovery From Psychosis

It is well established that good premorbid child and adolescent academic and social adjustment is a predictor of better outcome after first episode psychosis (Torgalsboen, 1999) and that this predictor is independent of duration of untreated psychosis (Marshall et al., 2005). Conversely poor premorbid adjustment predict poor outcome. It is a major problem that these data have been interpreted as evidence supporting a neo-Kraepelian model of neurodevelopmental pathogenesis of schizophrenia. Such data can however be understood from a developmentally based attachment perspective.

There is now evidence to suggest that attachment security may be compromised or even disorganised in infants who are later diagnosed with schizophrenia. It has been shown that the mothers of persons who go on to be diagnosed with schizophrenia are more likely to have experienced loss or trauma in the two years prior to or after childbirth (Pasquini et al., 2002). In addition, there is also evidence that being an unwanted child increases risk of becoming psychotic in later life. Both of these types of events are highly significant risk factors for infant attachment disorganisation. Furthermore there is a crucial role for stressful life events. It is now becoming established that attachment organisation is unstable over the longer term in high risk populations. Maintenance of attachment insecurity and transition from attachment security is predicted by stressful life events. Therefore it is significant that the AESOP study (Aetiology and Ethnicity in Schizophrenia and Other Psychoses (Morgan & Fisher, 2007; Morgan et al., 2007) has found that separation from, and death of, a parent before the age of 16 were both strongly associated with a two- to threefold increased risk of psychosis. In addition, it is now well established that rates of trauma including childhood sexual abuse are prevalent in persons diagnosed with schizophrenia (Read, Van Os, Morrison, & Ross, 2005). Life events such as sexual abuse, homelessness, assault and being in care (Bebbington et al., 2005) predict risk of developing psychosis, even after controlling for mood, substance use and inter-dependence of these life events. These life events are also known to lead to the collapse and disorganisation of

attachment characterised by impaired mentalisation and theory of mind; fragmentation, dissociation and segmentation of episodic memories; and use of competing and inconsistent coping responses. Consider these findings in the context of the literature on the relationship between premorbid adjustment and outcome after first episode psychosis which shows us that academic failure and limited, restricted social networks in childhood and adolescence predict poor outcome.

Most recent evidence shows that attachment insecurity is associated with the use of avoidant coping strategies which correlate with problematic service engagement including lack of help-seeking (Tait, Birchwood, & Trower, 2003, 2004). Using the Adult Attachment Interview, Dozier and colleagues (Dozier, 1990; Dozier & Lee, 1995; Dozier & Lomax, 1994; Dozier, Lomax, Lee, & Springs, 2001) have shown that psychosis is associated to an insecure avoidant attachment organisation which is related with a closing off of affect and episodic memories associated with affect. Also this attachment organisation is associated with minimisation of symptoms, reduced help-seeking and greater caseworker and family anxiety. It is noteworthy that most of these attachment transcripts were also classified as unresolved with respect to loss or trauma. It is significant that such a sealed off or avoidant style of affect regulation is likely to locate greater anxiety in busy case workers and may produce greater use of more catastrophic or coercive strategies in community based teams thus maintaining a sense of relational insecurity and entrenched non-engagement.

Emotional Recovery and Relapse Prevention

Birchwood and colleagues (Birchwood et al., 1989; Birchwood, Mason, MacMillan, & Healy, 1993; Iqbal, Birchwood, Chadwick, & Trower, 2000; Rooke & Birchwood, 1998) have shown that a substantial proportion of individuals following an episode of psychosis develop depression and suicidal ideation. Firstly, Birchwood et al. (1993) showed that depression following an acute episode of psychosis was associated with individuals' perception of being unable to prevent or control relapse (e.g. "I am powerless to influence or control my illness") or the fear of psychosis itself (e.g. "My illness frightens me"). Rooke and Birchwood (1998) followed up this group of patients 2.5 years later. In this group, levels of depression were persistent over time, as were appraisals of entrapment (inability to control or escape from psychosis), loss of social role and self-blame. Individuals who were depressed felt greater entrapment and loss in relation to their psychosis. In addition there was evidence that these appraisals were consistent with participants' personal experiences of psychosis. For example, participants with depression were more likely to have experienced more compulsory admissions and loss of, or drop in, employment status. Theoretical perspectives derived from evolutionary psychology as exemplified by social ranking theory (Gilbert, 1992) provide theoretical framework to explain these findings. A person's perception of their social attractiveness and acceptability to others confirm their sense of rank, importance and place within their social and interpersonal environment. Therefore life events that evoke feelings of loss (e.g. loss or disruption in important attachments or friendships) or events that threaten an individual's social ranking or importance (e.g. feeling humiliated by an episode of psychosis) are depressogenic via their impact on the lowering of perceived self esteem and social status. In relation to people with a diagnosis of schizophrenia, these processes can be observed in two important recent studies. Iqbal et al. (2000) found that, in a sample of 105 individuals, a proportion of 36 % developed Post Psychotic Depression (PDD) without concomitant changes in positive and negative symptoms. Participants who developed PPD were more likely than their non-PPD counterparts to attribute the cause of psychosis to themselves (self-blame), perceive greater loss of autonomy and valued role, and perceive themselves as entrapped and humiliated by their illness. In

addition, individuals with and without PPD aspired to similar social and vocational roles. However, consistent with the predictions of social ranking theory, those who developed PPD saw their future status as lower. These participants also had greater insight into having a psychotic illness. Therefore, psychosis can be conceptualized as a life event that triggers depression via awareness of its social, interpersonal and affiliative implications. Individuals, who develop depression following psychosis, appraise this life event as representing a humiliating threat to their future status, leading to the loss of valued social roles, from which escape is blocked due to actual or feared relapse, or indeed persistent symptoms.

We have also found that feelings of entrapment and low self esteem characterise social anxiety in persons diagnosed with schizophrenia (Gumley, O'Grady, Power, & Schwannauer, 2004) and that feelings of entrapment predict a variety of anxiety and affective disorders which are co-occurring with psychosis (Karatzias et al., In press). When we compared relapsers (n = 24) versus non-relapsers (n = 42) over the period of one year we observed significant changes between groups in terms of feelings of self blame ($F(1, 52) = 5.78$, $p = 0.02$) and shame ($F(1, 52) = 4.02$, $p = 0.009$) as illustrated in Figures 1 and 2 respectively.

Figure 1. *Appraisals of self blame (relapsers versus non-relapsers)*

Figure 2. *Appraisals of shame about illness (relapsers versus non-relapsers)*

In addition, although we did not observe differences between these two groups in terms of positive and negative symptoms, negative appraisals of illness and psychological distress as measured by the Brief Symptom Inventory when they completed the study after 12-months participants who relapsed had significantly higher levels of Somatisation ($p < 0.01$), Obsessive Compulsive symptoms ($p < 0.05$), Interpersonal Sensitivity ($p < 0.001$), Depression ($p < 0.001$), Anxiety ($p < 0.05$), Phobic Anxiety ($p < 0.05$), Psychoticism ($p < 0.01$). In addition, we have found that relapsers have significantly greater feelings of self blame, loss and low self esteem (Gumley et al., 2006). These data attest to the psychological toxicity of relapse and thus show how relapse prevention and emotional recovery are interlinked dual outcomes.

In our study of cognitive behavioural therapy (CBT) for relapse prevention (Gumley et al., 2003) we randomised 144 persons with a diagnosis of schizophrenia to CBT (n = 72) or treatment as usual (TAU; n = 72). CBT was delivered in two phases. The initial engagement phase focussed on the development of an individualised formulation of relapse risk, which was then used to devise an idiosyncratic early signs monitoring measure. This measure was then sent to participants on a fortnightly basis by post and returned by participants in a sealed envelope. Individuals were eligible for the second phase of CBT (Targeted CBT) if they had an increase in early signs or did not return their early signs for two or more occasions. Of those randomised to CBT (n = 72), 66 (92 %) engaged in the treatment. Of those who either relapsed or were deemed at risk of relapse (n = 34), 28 (82 %) engaged in targeted CBT. The study found a significant reduction in relapse (See Figure 3 below), a significant improvement in psychotic symptoms, negative symptoms and social functioning. In addition, those participants receiving CBT showed greater improvement in PBIQ loss and Rosenberg self-esteem (Gumley et al., 2006). Since this study we have further extended and manualised this intervention and incorporated a developmentally based understanding of affect regulation.

Figure 3. *Kaplan-Meier plot of time to relapse for CBT and TAU*

Cognitive Interpersonal Therapy

Cognitive interpersonal therapy (CIT) is a formulation based psychological therapy, which has as its primary focus an emphasis on affect and affect regulation. Based on client problem lists, priorities and goals the therapist systematically identifies barriers to emotional recovery, relapse detection and relapse prevention and works with the client to develop productive coping, self-soothing and helpful affect regulation strategies are identified, developed and strengthened.

Overview

Cognitive interpersonal therapy for staying well is designed as a 25 to 30 sessions intervention, which is conducted over nine months. It is divided into three distinct but overlapping phases: engagement and formulation; transforming beliefs and problematic interpersonal strategies; end phase and closure. Over these phases the frequency of therapy is variable with frequent sessions (once per week) at the beginning of therapy when the therapist is focused on the development of a shared formulation, alliance and mutuality of goals and tasks, less frequent in the middle phase (once per fortnight) allowing for greater reflection and exploration of predominant cognitive themes and interpersonal strategies, then more frequent in the end phase to enable issues such as loss, separation and dependency to be addressed.

For some individuals who engage well in psychotherapeutic work and who might focus on particular areas of interpersonal functioning it can be important to keep the therapeutic frame stable and to keep the regularity of weekly sessions throughout the treatment. Contracting such a long period of therapy can be difficult for many individuals. Therefore, therapy may be contracted in blocks of sessions determined by agreement between client and therapist. For example, initial sessions may be contracted to explore whether therapist and client get on with each other and whether goals can be formulated which are suitable for psychotherapeutic work, whereas later sessions may contract work on specific problems.

Just as the frequency of therapy is variable, so is the pacing of sessions. Therapists need to be mindful of exploring experiences and cognitive themes that are associated with strong affect. High levels of affect can overwhelm clients' ability to reflect on their own experiences and to mentalise the beliefs and intentions of others. It is important at this juncture that a therapeutic relationship is established that allows clients to explore difficult emotional content or particular experiences within a containing and safe interpersonal context. In working with this client group, therapists often need to model the expression of tensions and uncertainties in the room and allow for these anxieties to be verbalised as they can often become roadblocks in the interpersonal context of therapy and therefore prevent an open exploration of emotions attached to psychotic experiences.

Formulation

Case formulation is tailored according to the function of case formulation within the therapeutic progression, the client's interpersonal and recovery style, and the timing or phase in therapy. Case formulation evolves throughout therapy and is seen as a live, creative and ongoing process. It is not an event that is delivered to the patient by the therapist in a static or one-dimensional manner. Case formulation during the engagement phase is designed to capture the client's valued goals and important emotional meanings and facilitate the development of therapeutic working alliance.

Coherent narrative is emphasised as a means of capturing important meanings and overcoming paranoid states of mind or an avoidant and sealing-over recovery style. In this sense the therapist is attempting to activate the client's own attachment system by providing meaningful representations of the client's experience, which capture implicational and emotional rather than intellectual levels of meaning (Teasdale & Barnard, 1993). Case formulation is also sensitive to connecting information together on an as required' basis. For example, when working on alliance the therapist will attempt to incorporate meanings that are relevant to alliance, whereas when working with interpersonal schema the formulation will connect the client with relevant experiences (e.g. early trauma) and interpersonal responses (e.g. compliance and subjugation). This layering of formulation throughout the process of therapy is central to tracking client progress and recovery, appropriately pacing therapy, and timing specific interventions. The emphasis on narrative formulation corresponds with important exercises during therapy, which focus on the development of an integrated and coherent self-reflective stance, and the crafting of a revised and self-accepting narrative.

Therapeutic Relationship

The therapeutic relationship is central to cognitive interpersonal therapy, wherein the development of a collaborative working alliance is central to achieving client goals. In the context of staying well therapy, the therapeutic relationship becomes an important scaffold to facilitate the development of clients' understandings of their own experience and their understanding of the beliefs and intentions of others. Process factors within therapy such as those expressed in concepts derived from psychodynamic therapies (e.g. transference and counter-transference) are embraced within therapy. These are important constructs, functioning to allow the therapist to mentalise how their own affective, cognitive, and interpersonal responses within therapy may facilitate or interfere with recovery. The establishment of a containing and reflective therapeutic relationship will enable therapeutic change to take place within an interpersonal context that can in itself provide an essential corrective emotional experience. Within the structure of a stable and consistent therapeutic relationship interpersonal problems and ruptures can be detected and explored that might not otherwise be volunteered or raised by the client. This is important when considering that the client may be highly avoidant and unaware of possible problems. Alternatively, for some clients there is a lack of emotionally close or confiding relationships, and thus underlying interpersonal problems never overtly become expressed.

Narrative Style

Cognitive therapy has emphasised the importance of the therapist's use of soc-ratic questioning in guiding the person's discovery (Beck, 1976). Socratic questioning as defined by Padesky (2003) is a therapeutic process that involves asking the client questions which the person has the knowledge to answer. Questions draw the client's attention to information which is relevant to the issue being discussed, but which may be outside the client's current focus. Questions generally move from the concrete to the more abstract so that in the end the client can apply new information to either re-evaluate a previous conclusion or construct a new idea. This is a goal-orientated approach to therapeutic discourse. After new information has been discovered, idiosyncratic meanings have been heard and explored, and a summary has been constructed, the therapist completes the guided discovery process by asking the client a synthesizing or analytical question, which applies this new information to the client's original concern or belief. This is one means by which cognitive psychotherapy can foster a dialogue that develops the person's sense of agency and explorative self-

reflection. This is constructed through the development of the therapeutic processes and interactions. In particular we are concerned with how therapists encourage clients to engage in therapeutic dialogues which foster and heighten their ability to reflect on their construction of meaning in relation to their sense of agency and self. It is a process that is active and participatory rather than passive and observed. This is the essence of personal recovery and staying well.

In addition, Greenberg and Pascual-Leone (1997) and Greenberg, Rice and Elliot (1993) have suggested that a pivotal task of therapy is, in the context of a safe therapy relationship, to increase awareness of emotion by focusing attention on emotional experiences, and the development of a narrative enabling symbolic self-reflection on the fundamental experiential meanings embedded in personal experience. In their process experiential approach to psychotherapy, Greenberg et al. (1993) have emphasised therapeutic tasks facilitating experiential rather than conceptual processing of events. The therapeutic narrative gives an indication of the levels of processing and understanding achieved by the client and can be used to focus therapeutic discourse. For example, when discussing trauma it is not unusual for narrative to become fragmented, difficult to follow and impoverished. This acts to signal to the therapist the presence of problematic or unresolved experiences.

Basic Elements of the Therapeutic Stance

Siegel (1999) proposes five basic elements of how caregivers can foster a secure attachment in the children under their care. These elements also form the basic elements of any therapeutic discourse.

Collaboration

Secure relationships are based on collaborative and carefully attuned communication. Collaboration is developed through the careful negotiation of clients' problems and goals within therapy, and the therapist's encouragement for the client to develop an active, enquiring and explorative approach to understanding and resolving emotional distress.

Reflective Dialogue

There is a focus on the person's internal experience, where the therapist attempts to make sense of client communications in their own mind and then communicate their understanding in a way that helps the client create new meanings and perspectives on their emotions, perceptions, thoughts, intentions, memories, ideas, beliefs and attitudes.

Repair

When attuned communication is disrupted, there is a focus on collaborative repair allowing the client to reflect upon misunderstandings and disconnections in their interpersonal experiences.

Coherent Narratives

The connection of past, present and future is central to the development of a person's autobiographical self-awareness. The development of coherent narratives within therapy aims to help foster the flexible capacity to integrate both internal and external experiences over time.

Emotional Communication

The therapist maintains close awareness not only of the contents of narratives but also clients' emotional communications. In focusing on negative or painful emotions within sessions the therapist communicates and encourages self reflection, understanding, acceptance and soothing.

General Outline of Therapy Sessions

Psychosis is a powerful event characterised by severe and distressing changes in thinking and experiences that are unified by a pervasive sense of powerful interpersonal threat, dominance and paranoia combined with a sense of personal vulnerability. Whilst psychosis, as a disorder, signifies stigmatising negative life trajectories generating feelings of hopelessness or triggering defensive denial and sealing over, the symptoms themselves have the potential to undermine basic assumptions of safety, interpersonal security, intimacy and attachment.

The therapist's orientation throughout therapy is the collaborative development of a coherent client narrative that optimises the evolution of their self-reflectiveness, the crafting of alternative helpful beliefs and appraisals, and the development of adaptive coping and interpersonal behaviours. Through the discourse of psychotherapy, the focus on narrative, and the use of cognitive and interpersonal techniques the therapist supports the client in meshing behavioural and cognitive change. Underpinning this process, the therapist carefully nurtures the therapeutic alliance and provides the client with a secure base from which to explore difficult issues.

Engagement and Formulation

The initial sessions over the first three months (sessions 1–10) focus on developing therapeutic alliance and bond, and mutual tasks and goals. During this phase the therapist and client collaboratively develop and prioritise a problem list from the client's perspective. The therapist needs to listen carefully and feedback their understanding of the client's experiences, interpretations and problems in their own words. During the early engagement sessions (sessions 1–4) the focus tends to be on the client's immediate problem list and goals before exploring more difficult and affect-laden experiences. Where relevant, negative experiences of treatment are explored sensitively, and the therapist encourages the client to reflect on the implications of these experiences for the therapeutic relationship. In this way the therapist can begin to develop an understanding of the synchrony between clients' specific autobiographical memories and their beliefs, attitudes and expectations of treatment. Negative experiences of psychosis are also explored. Again the therapist attempts to maintain a fresh and open dialogue by attending to specific examples of clients' descriptions. This process allows the therapist to develop further hypotheses about the nature of the clients' idiosyncratic appraisals of psychotic experiences and how these are likely to shape recovery and determine emotional and behavioural responses to the threat of relapse should early signs of relapse occur in the future. During narratives exploring experiences of treatment and psychosis the therapist needs to maintain sensitivity to the client's trauma by being aware of changes in voice tone, eye contact and body posture. These changes often signal changes in affect and the occurrence of intrusive thoughts or images.

Such changes are thus important opportunities to help develop the client's own self-reflectiveness and their awareness of the importance of their experiences and interpretations in mediating their adaptation and adjustment to the experience of psychosis. However, in doing this, the therapist needs to be careful to support clients in regulating the affect within sessions by carefully timing

exploration of these sensitive areas. The therapist can calibrate their timing by reflecting on the strength of therapeutic alliance, and the client's resilience and access to coping skills and interpersonal resources. In addition, the therapist can structure sessions in a way that enable exploration of more difficult issues during the middle phase of sessions, thus allowing the session to shift focus onto other matters towards the end. The use of agenda setting and item prioritisation can support this process. Formulation during this phase is tailored to the person's recovery style, the level of alliance, and the nature of goals and tasks which have been agreed upon. Therapists often make errors in using a formulation to explain clients' problems at a level that is important to the therapist (in terms of guiding treatment, looking for barriers etc), but has less relevance for the client. For example, it is often important for the therapist to understand how beliefs have evolved from very early childhood experiences. However, the client may see such an approach to formulation as a stereotypical attribution of adult problems to childhood experiences (e.g. you mean it's all to do with my childhood!'). The client may connect problems to experiences in a way that activates strong negative (and potentially overwhelming) negative affect, or the client may be attempting to seal over and isolate their psychotic experiences from other aspects of their life history. This latter strategy may be an attempt (consciously or otherwise) to avoid strong affect or to prevent contamination of the traumatic experiences into other aspects of their life. The formulation emphasises those core components of therapeutic alliance, bonding, mutual goals and shared tasks. The engagement phase determines that the function of formulation at this stage is to support the development of alliance, client self-reflectiveness, and accurate mentalisation of the therapists' beliefs and intentions.

Transforming Beliefs and Problematic Interpersonal Strategies

This middle phase of therapy tends to be conducted over sessions 11 to 20 and focuses upon the development of a more careful understanding of how clients' experiences have led to the development of their negative beliefs about the self, others, the world, and the future. Within a compassionate framework (Gilbert, 2005) the therapist explores with the client how helpful (and unhelpful) their specific beliefs and appraisals are in terms of achieving their specific goals. For example, a client may describe feeling lonely and isolated and wanting to develop more meaningful relationships with others. However, based on their experiences prior to their first episode of psychosis they believe other people are intrinsically untrustworthy. Often individuals also have an extremely limited experience of confiding and trusting peer relationships. Furthermore, in many cases they might not have had a chance to develop these, as their first episode of psychosis interrupted the development of appropriate interpersonal skills and social integration. Therefore in order to reduce their sense of vulnerability they often avoid contact with others. In this scenario, the functional significance of avoidance can be validated, and the negative consequences for the person explored.

In addition, the therapist maintains a mindful awareness of a number of key dimensions or themes relevant to staying well after psychosis, including (a) emotional distress, (b) interpersonal trust and intimacy (encompassing the ability to interpret and predict the responses of others), (c) feelings of entrapment, shame or humiliation in psychosis, (d) clients' sense of hope and optimism for recovery, and (e) help-seeking in the context of distress and self-experienced vulnerability to relapse.

The therapist helps the client mesh their negative beliefs with functional aspects of their coping and interpersonal behaviours in order to create opportunities for the client to consider developing new or underdeveloped interpersonal strategies. For example, a client may describe their parents as critical and intrusive and feel angry when they complain about his behaviour at home. In response to this the client shouts at his parents, leaves the room, and avoids speaking to them. Whilst it is

important for this client to maintain his sense of autonomy and independence and to avoid been treated in a childlike manner, the costs of this strategy for the client are increased distress, rumination, negative reactions from parents, and an increase in feelings of suspiciousness and paranoia. The therapist might work with the client to develop alternative strategies including assertiveness and anger regulation combined with developing a compassionate mentalisation of his parents' anxieties, worries and concerns for his well being. This latter strategy allowed him to develop a reassuring communicative style with his parents. The development of new or underdeveloped interpersonal strategies provides an important opportunity for therapist and client to craft alternative accounts of the client's experiences enabling the development of alternative beliefs. For example, on reflecting on his parents' behaviour this client considered how their anxiety and worry reflected their parental feelings towards him, and how they had valued his development. This was particularly so given their harsh upbringing in amongst the shipbuilding areas of Glasgow. Their expectations had been devastated by his first psychotic episode, and they had thought that he would never work again. This client valued his independence and autonomy, and saw an important aspect of this transition as reducing their anxiety about his well-being.

The therapist further fosters clients' recognition of the presence of existing strengths and skills that enable them to survive and endure of traumatic and distressing experiences and adverse life circumstances. It is important that a formulation at this stage incorporates both negative and positive aspects of existing strategies in order to develop meaning-making that incorporates both positive life experiences without minimisation of negative life events. In this sense the therapist encourages a model of complex affect encouraging integration of both positive and painful emotions. In this way the therapist helps the client not to disregard or avoid negative emotions in association with their psychotic experiences.

End Phase and Closure

The end phase of therapy from sessions 21 to 30 focuses on the continued meshing interpersonal and cognitive change, on issues arising from closure and ending of therapy, and the rehearsal of a formulation-driven approach to detection and response to at risk mental states for relapse. In order to address issues of separation and dependency that may have arisen during therapy, the frequency of sessions is increased during this phase to once per week. Therapist and client collaborate on the development of both a narrative based and diagrammatical formulation of relapse. This formulation lays down the basis for planned interventions in the event of an at risk mental state for relapse. These interventions may involve targeted cognitive behavioural therapy (Gumley et al., 2003), key worker interventions or changes in prescribed medication (depending on the client's choice). It is vitally important that the end phase of treatment acknowledges the ending of the therapeutic relationship and the negative emotions associated with this. Often individuals in this client group are socially isolated and have had a number of negative interpersonal experiences. They therefore can be particularly vulnerable to feelings of loss and perceived rejection. It is essential therefore for the feelings and attributions associated with this loss to be recognised and dealt with within the therapeutic discourse.

Service Model

A co-ordinated multidisciplinary response to clients' needs is important in relation to recovery, relapse detection and relapse prevention. It also seems to be unreasonable to work with clients to encourage

and develop their help- seeking behaviours if the help that they receive isn't the help that they were seeking in the first instance. Designing services to best meet the needs of emotional recovery and staying well is an important but complex task. An important characteristic of this treatment protocol is that it is incorporated into a multidisciplinary context. This requires a coherent and co-ordinated approach supporting clients' recovery and importantly to responding to crises.

In relation to this, Goodwin et al. (2003) propose that a key function of multidisciplinary teams is to facilitate a secure base' through providing continuity and consistency of care during acute and recovery phases, by providing sensitive and appropriate responses to affective distress and by providing emotional containment during times of crisis. It is important to strike a balance between providing a reassuring supportive environment with encouragement to explore. Desynchronous approaches to recovery, relapse detection and prevention have the potential to produce ruptures in therapeutic alliance. For example, the basic approach of staying well is the development of an accepting compassionate model of psychotic experiences. Catastrophic or anxiogenic responses by staff to the re-emergence of low level psychotic experiences are therefore considered desynchronous within this approach to staying well therapy.

An integral component of staying well is the provision of team based multidisciplinary training aimed at encouraging staff to reflect on their own beliefs, attributions and assumptions about recovery and relapse. Training focuses on helping staff identify and reflect on their own beliefs about psychosis, how they make attributions about clients particularly during periods of high stress, how these attributions influence their own emotional and behavioural responses to relapse, and how these attributions interact with clients' beliefs, expectations and responses during periods of crisis. Training also focuses on providing key workers with the basic techniques and strategies described in this treatment manual. In particular, the aim here is to support key-workers' role in supporting the client, particularly in the context of crises or at-risk mental states for relapse.

Conclusions

There remains a major challenge to researchers and clinicians alike. The evidence for cognitive behavioural therapy in the prevention of relapse is limited unless the therapy is dedicated to relapse prevention (Tarrier & Wykes, 2004). There is therefore an urgent need to develop psychological therapies that can specifically target relapse. Relapse following first episode is high and acceptance of routine treatment is low, indicated by high rates of non-adherence in the first two years of psychosis (Robinson et al., 1999). Recent evidence suggests that unplanned discontinuation of antipsychotic medication due to treatment side effects is a major contributor to relapse following a first episode of schizophrenia or schizoaffective disorder (Robinson et al., 2002). Treatment acceptability appears to be low even for atypical antipsychotics with 70 % discontinuing from maintenance treatment after a first episode (Keefe, 2005). Cognitive interpersonal relapse prevention is a psychological treatment approach that is dedicated to relapse prevention. In addition, building on earlier experience (Gumley et al., 2003) that explicitly aims to enhance service engagement and help seeking, reduce relapse vulnerability, and facilitate emotional recovery and personal re-organisation in early psychosis (Gumley & Schwannauer, 2006). Therefore this approach explicitly is concerned with a primary task focus on affect, drawing upon an interpersonally based developmental understanding of affect regulation as a means of promoting emotional recovery and relapse prevention.

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Dr Andrew Gumley, B.A. (Hons), M.App.Sci., PhD, CPsychol, AFBPsS, is a clinical psychologist working as Senior Lecturer in Clinical Psychology in the Section of Psychological Medicine, University of Glasgow. He is also Honorary Consultant Clinical Psychologist at ESTEEM: North Glasgow First Episode Psychosis Service. His clinical and research interests concern working with emotional recovery and staying well after psychosis. He is particularly interested in the developmental and interpersonal origins of affect regulation in psychosis and how these factors help us develop an understanding of resilience, help-seeking, engagement and recovery in the context of first episode psychosis.

Key publications

Gumley, A. I., Karatzias, A., Power, K. G., Reilly, J., McNay, L., & O'Grady, M. (2006). Early inter-vention for relapse in schizophrenia: Impact of cognitive behavioural therapy on negative beliefs about psychosis and self-esteem. *British Journal of Clinical Psychology, 45*, 247–260.

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This paper outlines a Cognitive Interpersonal psychotherapeutic approach staying well after psychosis. It is proposed that emotional recovery and relapse prevention are dual interlinked outcomes unified by a conceptual framework that places affect regulation at the core of psychotherapeutic change. The paper describes the empirical basis for the relationship between affect dysregulation and relapse; the developmental and interpersonal origins of affect (dys)regulation; and the link between relapse prevention and emotional recovery. Cognitive Interpersonal Therapy is designed as a 25 to 30-session intervention, which is conducted over nine months. It is divided into three distinct but overlapping phases: engagement and formulation; transforming beliefs and problematic interpersonal strategies; end phase and closure. Based on client problem lists, priorities and goals the therapist systematically identifies barriers to emotional recovery, relapse detection and relapse prevention and works with the client to develop productive coping, self soothing and helpful affect regulation strategies are identified, developed and strengthened.

Keywords: relapse prevention, psychosis, affect regulation, cognitive therapy