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"Ultra-high risk" : exploring the prodrome to psychosis through cognitive and dialogic theoretical lenses : a project based upon an independent investigation

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ABSTRACT

This study is a theoretical exploration of the clinical phenomenon known as the prodrome to schizophrenia. The prodrome refers to a constellation of clinical symptoms that signal considerably high risk for the development of psychosis and/or schizophrenia. The prodrome is an area of high research interest, as the potential for early intervention with prodromal individuals to prevent or delay the onset of psychosis appears to be possible.

The clinical phenomena of the prodrome were explored, including a comprehensive review of the relevant literature and research. Case material is also presented. The prodrome is then conceptualized with a cognitive theoretical framework, including a discussion of research interventions using a cognitive or cognitive-behavioral approach and application to the case material with a cognitive theoretical perspective. The core cognitive components of cognitive distortions, automatic thoughts and core beliefs were examined and applied to the prodrome.

Next, the prodrome was explored using a postmodern approach, specifically utilizing a dialogic theoretical framework. A discussion of the Open Dialogue approach was applied to the prodrome and to the case material. The core postmodern and dialogical concepts of dialogical process, loss of agency/voice and sense of self were applied to the prodromal phenomena.

The two theoretical conceptualizations were then explored more in depth, including a discussion of the commonalities and divergences between the theories. I then used the core components of the two theories to formulate a synthesis in order to illuminate the prodrome in a new way. My findings from this process were indicative that, from both theoretical points of view, one of the defining features of the prodrome is a person's altered sense of self, which leads to a diminished self-experience. The prevalence of negative symptoms, apparent cognitive decline, "soft" or attenuated hallucinations and delusional beliefs and role or functional decline during the prodromal phase are often the result of an externalizing bias and core vulnerabilities based on a person's experience of the self as diminished. The thesis concludes with clinical practice implications and application to the case material.

“ULTRA-HIGH RISK”: EXPLORING THE PRODROME TO PSYCHOSIS THROUGH COGNITIVE AND DIALOGIC THEORETICAL LENSES

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CHAPTER ONE

INTRODUCTION

Schizophrenia and other disorders that include psychosis as the defining feature of the illness have long eluded comprehensive theoretical conceptualization. Many theories toward an etiology of the heterogeneous symptomatology encompassing schizophrenia have been proposed and researched. For many decades, there has existed a tension between the biological model and models that emphasize the significance of environmental and psychosocial stressors in the pathology of psychosis. While researchers, clinicians and academics cannot agree on the causation of psychosis, they certainly can agree on one thing: that psychotic disorders are ubiquitously debilitating and cause enormous suffering for patients and their families, as well as society at large. Research of late has focused predominantly on clinical trials for antipsychotic medication and its role in symptom abatement and management. With this suffering as motivation and a growing body of evidence in diagnostic accuracy and psychopharmacological efficacy, further research has delved into attempting to understand the phase or period preceding full-blown frank psychosis. This phase, period or constellation of symptoms has come to be known as the prodrome to schizophrenia. The prodrome refers to a set of risk factors that point to the potential onset of schizophrenia or psychotic disorders. This study will explore the phenomena of the prodrome and then will use two different theoretical frameworks to conceptualize this clinical entity.

While research in the area of understanding and identifying the prodrome with certainty has gained much interest over the last few decades, definitive knowledge of the nature of the prodrome does not yet exist. Intervening clinically with patients meeting the criteria for frank psychosis or schizophrenia has long been moving toward a bio-medical and neuro-developmental conceptualization, but the etiology of the full blown illness remains fundamentally elusive, further complicating attempts to understand the earliest manifestations of the illness. The *DSM-III-R* (American Psychological Association [APA], 1987) included nine symptoms of the putative prodrome; however, this category was eliminated from the *DSM-IV-R* (APA, 1994). As categorization and diagnostic certainty remain debatable among researchers, many clinicians see patients with sub-clinical manifestations of psychotic symptoms in a variety of settings. Schizophrenia is generally understood to be a highly debilitating chronic course of illness that exacts an enormous social cost on families, as well as long-term burdens on mental health delivery systems (Lavretsky, 2008). Therefore, prevention and early intervention are areas of high interest.

The predominant paradigm for conceptualizing schizophrenia has been the biomedical framework, which is represented by biological psychiatry and more specifically by the psychopharmological treatment of illnesses and clinical presentations classified as psychiatric disorders. This paradigm has become so prevalent in explaining the causes, conceptualizations and treatments for schizophrenia that psychosocial or environmental influences are most often considered secondary. The stress-diathesis model or stress-vulnerability model contends that a genetic, biological, or neurological marker predisposes an individual to developing schizophrenia, with environmental,

psychological, social, or developmental influences offering contributory impact to the onset of first the first episode of psychosis (Ellman & Cannon, 2008), as well as to the attenuated symptoms often observed in the prodromal state.

The primary preferred treatment for frank psychosis and for schizophrenia at this time is antipsychotic medication (Torrey, 1995). One of the first treatments considered successful in treating schizophrenia was chlorpromazine (Downar & Kapur, 2008). This and other major tranquilizers were used broadly during the 1950s, particularly in institutionalized patients with a schizophrenia diagnosis (Lavretsky, 2008). First generation, or typical, antipsychotics, also known as neuroleptic drugs, are generally believed to work on the positive symptoms of schizophrenia. Second generation, or atypical antipsychotics, work on negative symptoms, as well as positive symptoms (Downar & Kapur, 2008). Both clinicians and laypeople alike seem to be in agreement that schizophrenia is the result of a hereditary biochemical or neurological disorder that results in disordered thinking, perceptual and sensory abnormalities, social withdrawal and other depression-like symptoms (Torrey, 1995). Along with medication, psychosocial treatment modalities have and continue to include social skills training, cognitive behavioral therapy, clinical case management and supportive counseling (Downar & Kapur, 2008; Torrey, 1995). Therefore, it can be stated that the overarching paradigm for understanding psychotic illness, while dominated by a biomedical and neurodevelopmental conceptualization, also includes a strong psychosocial understanding of the clinical presentation of psychotic disorders. For example, it is commonly understood that psychosocial stressors like homelessness or social isolation can lead to the exacerbation of psychotic symptoms (Bebbington & Kuipers, 2008). Further, the

content of positive symptoms like delusions and hallucinations often include aspects of the individual's social network, family history and current circumstance. Thus, the dominant paradigm in which we find most understanding of psychosis, schizophrenia and the prodrome to psychosis is located firmly within the biopsychosocial model.

Expanding the understanding of schizophrenia to include psychological and social factors has led to less restrictive interventions, such as wraparound social supports in the community, rather than institutionalization or long-term hospitalization. However, it remains that intensive reliance on a biomedical understanding of the etiology of psychosis has led to very high rates of psychiatric medication prescription (Seikkula, 2002). Further, psychosocial theories have been seen as secondary, primarily as contributing to or triggering a pre-existent underlying genetic or other biological proclivity to a specific illness. This model parallels the stress-vulnerability model of risk for other medical illnesses, such as heart disease or diabetes, where environmental or psychosocial factors (e.g. diet or stress) are seen as bringing out an already present propensity for the full-blown disease. In such a model, the prodrome to schizophrenia can be understood as a constellation of factors that signal high risk for developing psychosis or schizophrenia. In the phenomenon chapter, I will provide a thorough concept of the current understanding of the prodrome. In this thesis I aim to examine the clinical phenomena that are known as the prodrome from both a modernist and postmodernist perspective. I then aim to take these two theoretical perspectives and draw significant elements of both to establish an understanding of what is happening during the prodrome. The topic of this thesis is of significance to clinical social work as it explores the earliest

manifestations of one of the most debilitating clinical presentations that social workers interface with, namely non-affective psychotic illnesses.

This thesis consists of six chapters. The first chapter serves to introduce the purpose of the study, the phenomenon to be explored and the relevance to clinical social work. The second chapter details the phenomenon of the prodrome, including a review of current relevant literature and research outlining the prodrome. The phenomenon chapter will include case material in order to orient the reader to the clinical presentation of the prodrome. The case of James is provided as a way of grounding the phenomena in practical and applicable ways. In the fourth chapter, I will discuss cognitive theory within the context of a biopsychosocial framework, including a review of the literature. In the first theory chapter, cognitive theory and cognitive-behavioral treatments will be explored. Cognitive-behavioral interventions have been studied more than any other psychological interventions in the treatment of first episode psychosis, full-blown schizophrenia and the prodrome. Several studies have indicated the use of CBT with the clinically high-risk population demonstrating attenuated psychotic symptoms. I will then use cognitive theory to conceptualize the case material from the second chapter. In the fifth chapter, I will discuss dialogic theory within the broader context of postmodern theory, including relevant research and literature. Dialogic theory is represented in this thesis by the Open Dialogue Approach, which is a clinical approach to psychiatric crisis that has gained widespread use and success in Northern Finland. I will use dialogism and the Open Dialogue approach to conceptualize the case material. In the final chapter, I will discuss cognitive theory and dialogic theory to explore the prodrome to psychotic illness.

Each theory explored has a clinical application, which I describe in relation to the case material.

CHAPTER TWO

METHODOLOGY

In this chapter, I will outline the theoretical framework for the subsequent chapters. I will also be developing and describing the analytical framework that will be used in the discussion chapter. As previously said, this paper will explore the concept of the prodrome of schizophrenia. The definition of the prodrome is as elusive as the clinical entity; researchers have, however, refined definitions that appear to be valid and reliable in prospective studies. Nonetheless, the period leading up to full-blown psychotic illness remains mysterious in many ways. Many theoretical lenses have been applied to the processes, symptoms and experiences that are known as schizophrenia or psychosis. This study will attempt to expand the current research literature base by extrapolating existent theory to the prodrome. This thesis will utilize current theoretical understandings of schizophrenia to investigate the applicability of such theories to the prodrome. The two theories that will be used are cognitive theory and dialogic theory. Each theory will be applied to the phenomena of the prodrome as well as to case material. Cognitive theory's application is understood in Cognitive Behavioral Therapy, while dialogism's is best represented in the Open Dialogue Approach.

It is important to compare the fundamental principles of each theory in order to understand what assumptions underlie the two theories. One way to access the fundamental principles of a theory related to human experience is to investigate the theory's assumptions of human nature and how individuals' experience their sense of

self. This is to ask, “how does this theory conceptualize self-experience?” I will access this question by outlining an individual’s self-experience from the two theoretical perspectives and case material. Self-experience is frequently used to match theoretical perspectives with subjective experience or practice (Lysacker & Lysacker, 2002). These explorations are important to clinical social workers because they underlie our foundational understanding of the self, which informs practice and interventions. Deviation from healthy manifestations of the self is a presentation of psychopathology that often accompanies those suffering from psychosis or the prodrome when seeking help from clinicians. Self-experience, a person’s subjective experience of himself or herself in the world, is of paramount importance in moving towards understanding the phenomena in the prodrome. In the discussion chapter, I will examine the fundamental conceptualization of self-experience in both cognitive theory and dialogism. This will then assist in the examination of how humans’ self-experience is impacted during the prodrome from each theoretical perspective.

Biopsychosocial Theory: Cognitive Theory and Cognitive-Behavioral Approach

The fundamental conception of self-experience in cognitive theory involves the processing of information. In cognitive theory, alterations to adaptive information processing are associated with general psychopathology. It is important to examine the different ways that information processing becomes maladaptive during the prodrome from a cognitive perspective. These maladaptive processes are exhibited in unhealthy or pathological ways of thinking, feeling or behaving. These psychological symptoms can be recognized, managed, corrected, or addressed, according to cognitive theory. Maladaptive information processing is acknowledged and corrected during cognitive-

behavioral therapy. Unhealthy ways of processing internal representations of external and internal stimuli are addressed by a therapist with the client. The client then replaces maladaptive beliefs and thoughts in order to manage the difficult patterns of feeling and behaving associated with the beliefs. Combating maladaptive beliefs appears to be beneficial in redressing the patterns of thought and subsequent distress associated with schizophrenia (see Chapter 4 for review of this research). Cognitive theory, as applied in cognitive-behavioral interventions, is rooted in a biopsychosocial model that includes the possibility that psychotic illness is the result of a confluence of biological, social and psychological factors. The cognitive approach focuses primarily on the psychological components of the onset in the prodrome, but also explains how these processes impact and are impacted by biological and social forces.

As will be discussed at length in this paper, the prodrome can be understood as the earliest manifestation of psychosis or schizophrenia. From a cognitive theoretical basis, the disorder of thought and information processing begins during the prodromal phase. This leads to the maladaptive patterns of thinking, feeling and behaving that can impact a person's self-experience. A prodromal individual's self-experience is diminished as the capacity for adaptive and coherent information processing is thwarted. Intervening early in this process may offset or possibly prevent conversion to psychosis, within a cognitive theoretical frame.

After exploring the fundamental principles of self- experience in cognitive theory, I will use the following cognitive theoretical components to structure the analysis: *core beliefs, automatic thoughts* and *cognitive distortions* as they relate to the clinical

presentation of the prodrome. The ways that the cognitive behavioral approaches address these components during psychosocial interventions will also be discussed.

Postmodern Theory: Dialogism and the Open Dialogue Approach

In postmodern theory and specifically dialogism, the fundamental conceptualization of human nature is the notion that each being occupies multiple selves or self-positions that are in constant internal dialogue with each other. As Lysacker and Lysacker, 2008, aptly describe, "we sense ourselves within and through encounters that are at once intra- and interpersonal, and that reflect complementary and dissonant facets of our being. [S]elf-positions are axes of self-world interaction, more a matter of who we are, than of whom we take ourselves to be" (p. 34). A continuous and ordered series of shifts in our multiple self-positions relative to relationships, situations and experiences reveals itself to us through the process of intra- and interpersonal dialogue. While this process is a complex and dynamic interplay, it remains ordered as a response to worldly interactions and coherent internal experience. The most basic concept of what a human being does is to be in constant dialogue with others and within the individual his or herself.

Self- experience in dialogic theory is emphasized as a coherent self-awareness that emerges out of a collection of voices or self-positions (Lysacker & Lysacker, 2002). Another foundational principle of humanity in dialogism is that human beings are innately relational and therefore must always be in dialogue with others. According to dialogism and other social constructivist post-modern theories, meaning is constructed as a relational activity (Seikkula & Trimble, 2005). Any utterance that is spoken is in response to another being and bears out its meaning as it is responded to. One of the

major components of post-modern thinking regarding schizophrenia is the diminishment of the dialogical process, both intra-personally and interpersonally. Subjective self-experience in the prodrome is marked by incoherence and the collapse or diminishment of the self's experience as dialogical (Lysacker & Lysacker, 2002).

This internal intrapersonal dialogue is interrupted and diminished in the prodrome to schizophrenia, as well. During the prodromal phase, it is not unusual for the dialogical nature of the self to be compromised in many ways. Firstly, the loss of agency and voice plays a major role in a prodromal individual's capacity to engage in the dialogical process. The individual's sense of self or subjectivity is also compromised during the prodromal phase. This frequently leads to withdrawal from interests and social contacts that usually have significance for the individual.

I will use the concepts of *dialogical process, sense of self* and *loss of agency/voice* to guide my analysis of the post-modern and dialogic theoretical lens applied to the prodrome. I will then explore the specific ways that the Open Dialogue approach addresses these concepts.

Methodology

In the discussion, I will compare and contrast the two theoretical perspectives on the prodrome, entering this discussion by each theory's concept of healthy self-experience. I will firstly explore the ways the two theories diverge and ways each individual theory could be used to critique the other. I will then move into an in depth exploration of the ways the two theories can be brought together to help us better understand the phenomena of the prodrome. This will be accomplished by examining the ways the components of *core beliefs*, *automatic thoughts* and *cognitive distortions* from

cognitive theory and *dialogical process*, *sense of self* and *loss of agency/voice* from dialogical theory correlate to each other and help to illuminate the prodrome in a new way. The synthesized theoretical approach will then be applied to the case of James. I will end with offering treatment and clinical practice implications and suggestions, based on this new understanding that develops from the theoretical synthesis.

CHAPTER THREE

THE PHENOMENON

The following chapter will outline and detail the clinical entity that has come to be known as the prodrome of schizophrenia. This particular area of research has gained prominence in the last two decades and is now at the forefront of prevention exploration for psychotic illness. As Yung and McGorry, pioneers in the research of prodromal schizophrenia, have noted in one of their earliest works, in clinical medicine, a prodrome refers to the early symptoms and signs of an illness that precede the characteristic manifestations of the acute, fully developed illness (1996). As such, the term "prodrome" in relation to psychotic illness originated as the concept of the pre-morbid phase of full-blown schizophrenia or psychosis.

History of the Prodrome

Many other diseases, syndromes or disorders have a prodromal phase, during which a constellation of symptoms are measureable and lead to the debut of an illness. The prodrome is more recently characterized as a set of clinical markers, including sub-clinical or attenuated symptoms, which are markers or risk factors signifying the phase that predates the full blown disease. A simple medical example can be found in the measles, where fever, coryzal symptoms, conjunctivitis, and cough signal the phase prior to the full-blown disease. These markers are then followed by a very specific rash, making definitive diagnosis possible (Yung & McGorry, 1996). Another notable example in the medical field, Alzheimer's disease, which is known to have a prodromal phase,

characterized by Mild Cognitive Impairment (MCI) and/or Mild Behavioral Impairment (MBI) (Taragano et al., 2009). MCI and MBI are known markers that can be measured and assessed as risk factors for dementia, the hallmark of Alzheimer's disease, much as attenuated psychotic symptoms have been the indicators of risk for psychosis, the hallmark of schizophrenia. Notably, the word "prodrome" itself has semantic connotations indicating that the development of the full-blown disorder is essentially inevitable. However, regarding the development of frank psychosis, the term "prodrome" is widely and nearly ubiquitously used to generally refer to increased clinical risk for psychosis, rather than an identifiable pre-illness phase after which psychosis will indeed onset. Efforts to prospectively identify the features of the prodrome to psychosis have been variably successful, which will be discussed at length later in this chapter.

One of the earliest motivations to spark research in the area of prodromal schizophrenia was to gain more exacting knowledge of the pathogenesis of psychosis. The early research on the prodrome was initiated in the early to mid- 1990's by several groups of researchers across the globe. McGlashan illuminates that increased efficacy of antipsychotic medication and an increasing understanding of the etiology and course of schizophrenia allowed for a reemphasizing the direction of research towards early identification (1996). It was hoped that researching the illness's earliest detectable signs would assist ongoing research in the origination of psychotic disorders. Researchers and treating clinicians believed they had advanced dramatically in knowledge of schizophrenia as a neuro-biological illness. More in-depth understanding of its pathogenesis was simultaneously a motivation for research on its earliest course, at the same time that this more current understanding of schizophrenia also served to make

further research into the prodrome possible. The phenomena of psychotic illness at its most nascent stage could be more clearly observed and understood in light of a clearer vision of chronic psychotic phenomena and diagnostics. Conceptualizing schizophrenia as a "brain disorder" of biological, genetic or neurochemical origin enabled researchers to search for causes and treatments within a more conventional medical research model. Despite advances in pharmacological treatments and promising evidence of genetic and biological origins of the illness, treating and working with patients diagnosed with schizophrenia, particularly chronic cases, was and remains notoriously difficult. The mystery of understanding and treating schizophrenia is summed up by Thomas McGlashan (1996), as he states "as a community of mental health providers and consumers we celebrate the advances of pharmacotherapy, family psychoeducation, and community-based care, but we also see treatment resistance and treatment failure. It is resistance and failure that I wish to address" (p. 202).

Historical Influences on Prodromal Identification

Emil Kraepelin was a German psychiatrist who is credited with formalizing the collection of symptoms known now as schizophrenia observed by many doctors, particularly in the 19th century. The constellation of symptoms, at that time, was believed to be an early form of dementia, leading to the nomenclature *dementia praecox*, or "precocious dementia" (Lavretsky, 2008). The symptoms included catatonia and hebrephenia. Kraepelin also recorded the presence of hallucinations in all five senses, but auditory hallucinations were prominently noted (Lavretsky, 2008). Kraepelin believed that dementia praecox was a disorder with specific neuropatholigcal origin. He also differentiated between dementia praecox and manic-depressive illness, the former having

a deteriorating course with marked disability in functioning and the latter a cyclical pattern or mania and depression. A Kraepelin characterization of schizophrenic illness has been highly influential in the direction of contemporary research, theory and psychiatry in the West. The categories that Kraepelin observed and recorded continue to guide our own diagnostic and clinical practice. Kraepelin noted in the late 1890s that over 70% of his patients suffering with dementia praecox had family history of psychosis (Lavretsky, 2008).

Swiss psychiatrist Eugen Bleuler first used the term schizophrenia in 1911, which quickly replaced dementia praecox. The term literally meant "a mind torn asunder" (Lavretsky, 2008). Bleuler's conceptualization of schizophrenia included the idea that the illness incorporated a broad spectrum of disorders all sharing a psychological underpinning. While Bleuler's work in identifying and naming specific symptoms remains in large part intact in our current diagnostic practices, he has also been cited as bringing many heterogeneous clinical presentations under the same grouping of schizophrenic disorders. This can account for the complex and varied diagnostic categories included in most clinical manuals today.

First Episode Research and Early Identification of Prodromal Phenomena

Schizophrenia and psychotic disorders in general are known throughout psychiatry and by mental health providers to be some of the most difficult, resistant and costly illnesses to treat (Corcoran, 2008: Hafner, 2004). As long-term research on the onset, treatment, and diagnosis of schizophrenia was joined with increasing evidence that schizophrenia runs in families and appears to responds to medication especially in later stages of the illness, many researchers and clinicians attempted to outline the

vulnerability markers related to onset of schizophrenic illness (McGlashan, 1996). Research on the first episode of psychosis was underway when interest in the prodrome intensified, with qualitative and anecdotal retrospective evidence that the decline into the first psychotic break was heralded by warning signs that may have been traceable (McGlashan, 2001). Research revealed that there was a surprisingly long lag between the first psychotic episode and the first presentation for treatment. The period of time between first episode of psychosis and seeking of treatment is known and the Duration of Untreated Psychosis and is discussed below.

Hafner and his colleagues, also significant contributors to early understanding of prodromal syndromes, conceptualized early detection of the prodrome to psychotic illness as "secondary prevention", as it relies on the detection of subclinical symptoms and risk factors later in life (usually adolescence), rather than on prenatal detection through genetic testing (2004). Hafner further postulates that early intervention's goals are to prevent or postpone the onset of psychosis and to interrupt the course of the illness after onset, which is generally believed to be a declining course (Castle & Morgan, 2008; Lavretsky, 2008; Malla, 2004; McGlashan, 1996). Psychosis can and does frequently remit spontaneously with or without treatment. However, many researchers believe that it is rare that individuals experiencing psychosis and then remission ever return to their full functioning level prior to their first episode (Hafner & an der Heiden, 2008). Schizophrenia is generally understood to onset in late adolescence, with some variance, including some early onset (earlier in adolescence) and late onset (in adulthood). For the purposes of this study, most literature reviewed considered subjects between the ages of

13 and 30. Reference to difference in age, gender, race or ethnicity was explored minimally by researchers in the literature, but will be noted when relevant.

Alison Yung and Patrick McGorry, researchers and psychiatrists at the Early Psychosis Prevention and Intervention Centre in Melbourne, Australia, established a conceptualization of the initial prodrome in psychotic disorders, which has become the foundation for ongoing research in the field. Their definition of the initial prodrome in psychotic disorders refers to a period of disturbance which represents a deviation from a person's previous experience and behavior, occurring prior to the development of florid features of frank psychosis (1996). This is a very broad definition and represents some of the earliest understanding in the field of prodromal research. Yung and McGorry believed early on that the prodrome could be thought of as either a pre-psychotic form of an emergent psychotic disorder or as a syndrome that signals an increased risk or vulnerability to psychosis (1996). The second way of thinking of the prodrome eludes to the idea that psychosis is not an inevitable consequence of prodromal indicators. One of the challenges of early prodromal research was the necessity of retrospective identification of the hallmarks of the prodrome. This began at first with samples of patients who had already had a first episode of psychosis retrospectively reporting their experiences leading up to their first frank psychotic episode. The first episode marked the baseline by which pre-morbid functioning and subsequent symptomology could be measured.

Initial Instruments for Prodromal Assessment

In Yung and McGorry's pioneering work on retrospective analysis of prodromal features, instruments were designed specifically for interviewing patients about their past

prodromal experiences, as no tested measures existed at that time. Dr. Yung designed the Multidimensional Assessment of Psychotic Prodrome interview based on literature review and her own clinical experience. She further drew on the prodromal checklist from the Diagnostic and Statistical Manual III-R (1987), which is also discussed later in this chapter. The validity of her measures was not established, but her exploration of participants' retrospective experiences was significant, as these individuals had confirmed cases of psychosis at the time of inquiry. Twenty-one patients and/or their informants were interviewed regarding the prodromal period before they became floridly psychotic. According to this early study, a wide variance in prodromal features was discovered. However, sleep disturbance was universal among all participants. Anxiety, irritability depressed mood, impaired role functioning, social withdrawal, poor concentration, suspicion and lack of motivation were all noted in over two-thirds of the individuals. The authors summarize these early findings on the prodrome to include attenuated positive symptoms (i.e. perceptual changes, suspiciousness), non-specific neurotic and mood-related symptoms and behavioral changes (Yung & McGorry, 1996). Of note, many of the participants appeared to show signs of affective illness. Later research aimed to explore the phenomena of the prodrome to non-affective psychotic illness. Some of the import of the earliest research is found in the narrowing of the research populations and criteria, given the high diversity and variability of this and other studies' results.

Primarily basing features of the prodrome on DSM-III-R prodromal symptoms was not a successful diagnostic approach, as it failed to avoid the same high variance and broad categorization of "prodromal features," making narrowing down to actual

prospective identification difficult. In fact, the DSM-IV-R eliminated the prodromal symptoms checklist from the 1994 edition. However, researchers did not abandon attempts to develop prodromal identification measures based on the retrospective work begun by Hafner and Yung and McGorry.

Diagnostic Foundation

It should be noted that in order to define the prodrome to a disorder, the diagnostic criteria for the disorder itself must be examined. Therefore, it is certainly important to differentiate between psychosis and full-blown schizophrenia and to understand the phenomena of these clinical states in order to fully investigate the prodrome to these states. A thorough and exhaustive exploration of the diagnostic categories included in the spectrum of disorders under schizophrenia and psychotic illness is far beyond the scope of this study. Further, a critical analysis of current diagnostic trends is also not included, despite the fact that diagnostic trends and biases greatly influence the population addressed in this study. It is important to keep in mind that diagnostic categories and illnesses change over time, as research and social forces are applied. However, it is also important to understand the generally accepted categorically clinical manifestations of the entities being discussed. For the purposes of the current study, the Diagnostic and Statistical Manual of Mental Disorders (DSM) series will serve as the primary diagnostic tool for defining and categorizing symptomology. The DSM III-R states that schizophrenia always includes delusions, hallucinations, or certain characteristic disturbances in affect and the form of thought (APA, 1987). Diagnostically, psychotic symptoms, or "psychosis," are said to be the defining feature of schizophrenia and other psychotic illnesses. According to the 1994 edition of the

Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), that while psychosis may be present in other illnesses or may result from the onset of other disorders, it is understood to be a symptom and not the definitive diagnostic feature. For example, psychotic symptoms such as hallucinations and delusions may be present in Major Depressive Disorder, the major diagnostic differentiation is that major depressive symptoms are the prevailing clinical presentation (APA, 1994). Psychosis in the 1994 manual was most specifically defined as the presence of delusions or hallucinations, occurring in the absence of insight into the pathological etiology of these symptoms. More broadly, psychotic symptoms could include hallucinations that were recognized as such. Other understandings included more positive symptoms of schizophrenia such as disorganized speech or impaired behaviorally functioning. Overall, psychosis was characterized as the "loss of ego boundaries" or "gross impairment in reality testing," which were earlier conceptualizations also included in the DSM-III. Most editions of the manual include some minimal criteria for duration of symptoms.

More recent criteria for full-blown schizophrenia include both "positive" and "negative" symptoms. Generally, positive symptoms are defined as "an excess or distortion of normal functions", while negative symptoms "reflect a diminution or loss of normal functions" (APA, 2000). Distortions of thought (delusions), perception (hallucinations), language and thought processes (disorganized speech), and impaired behavior (disorganized or catatonic) are included in positive symptom categories. Negative symptoms include restrictive emotional expression and intensity (affective flattening), restricted thought and speech patterns (alogia), restriction of goal-directed behavior (avolition) and restriction of experiencing pleasure (anhedonia) (2000).

Declining Course of Illness Framework

Another important piece of groundwork for understanding psychosis that has influenced how prodromal research has progressed is the "duration of untreated illness" model. The length of time that psychosis is not treated is believed to contribute greatly to the course and long-term outcomes of the illness; the longer treatment is postponed after the first episode of clinically significant symptoms the more negative the outcomes have been noted (Hafner & an der Heiden, 2008). The period between when even slight behavioral or functioning changes are first noticed, known as pre-morbid functioning, and the first episode of florid or frank psychosis is of special importance, as it appears to have implications for long-term recovery and/or relapse. Based on a neuro-developmental model of psychosis and schizophrenia, psychosis is understood to be a declining course illness that if left untreated would only result in less favorable outcomes. While florid positive psychotic symptoms may remit with little or no intervention, rarely do individuals retain their previous levels of functioning, particularly in social interaction, work and role functioning and affect expression (Addington & Addington, 2008). Malla et al. conducted a study in which they reported that the Duration of Untreated Psychosis (DUP) was predictive of less favorable indicator measurements in level of remission, positive, negative, depression and anxiety symptoms in short to mid-term patient outcomes (at least a year after seeking treatment) (2001). Later studies focused on longer-term outcomes. Harris et al., researchers located at the University of Melbourne and associated with ORYGEN, a specialized early psychosis service facility where the original first episode psychosis (EPPIC) and prodromal early intervention treatment center, the Personal Assessment and Crisis Evaluation (PACE) clinic, conducted a large

scale prospective study of first episode psychosis patients over an eight year period. The study revealed that shorter DUP is significantly associated with decreased severity of positive symptoms, and enhanced social and occupational functioning and quality of life (Harris et al., 2005). This study also indicated that DUP was not associated with negative symptoms, which were more likely to be impacted by premorbid adjustment (2005). Other long-term studies have corroborated the DUP theory that outcomes in patients tend to be less favorable the longer the duration before first psychiatric treatment is sought (Bottlender & Moller, 2003). As a body of literature, these studies have been used as evidence in support of further investigation into early detection, identification and intervention for psychosis and schizophrenia-spectrum disorders, namely to move forward in identifying the prodrome prospectively. As Barnaby Nelson and Alison Yung summarize from their research and anecdotal experience as clinicians serving patients suffering with psychosis, early intervention is crucial as individuals experiencing early phases of psychosis or the prodrome may be more like to engage in treatment before psychotic symptoms are entrenched, social networks are dissolved or disrupted and functioning has deteriorated significantly (2008).

Narrowing Measures for Identification of the Prodrome

As secondary prevention, as Hafner described it, became the emphasis of prodromal researchers, it was incumbent on researchers to identify the features prodrome objectively. In order to develop consistent and reliable measures for identification of this clinical state, clinical trials were arranged with the goal of measuring the rate of conversion to psychosis among the sample. This population could then be identified and

diagnosed as pre-psychotic or at risk for developing psychosis. Ultimately, researchers goal was the development of interventions that were justifiable clinically, ethically, and economically. As motivation became focused on the potential for preventative treatment and early intervention before full blown-psychosis onsets, research quickly shifted towards the development and testing of clinical measures that can be used to identify patients who are prodromal.

Vulnerability to psychosis has long been thought to apply to more people than ever become fully psychotic, a concept supported in early Kraepelian theory of schizophrenia. The belief that psychosis could appear among individuals who were already at specific risk and who were exposed to particular acute stressors was long held by both doctors and the public in general. This led to the notion that a "nervous breakdown" or "psychotic break" was the result of environmental factors conflated with a pre-existing capacity for psychosis. Researchers set about attempting to identify what placed an individual at risk for such a break.

Genetic predisposition to schizophrenia was accepted as scientific fact as early as the mid-1990s and marked a clear direction in research, since isolating a genotype that carried the illness seemed quite possible at that time (McGlashan, 1996). Since then, many researchers have searched for a schizophrenic phenotype. Despite this certainty, a purely genetic cause of psychotic illness has not been made clear. However, genetic risk remains one of the biggest markers for prediction of psychosis as definitive measures for identifying the prodrome have tested. The hereditary, or at least, the familial nature of schizophrenia and other psychotic disorders is still considered to be one of the most widely accepted theories of causality and prospective risk identification.

Other vulnerability markers that were identified through retrospective research included brief psychotic symptoms, sub-clinical or attenuated psychotic symptoms and decline in role functioning (McGlashan 1996). Some studies also indicated that neurocognitive abnormalities and behavioral signs are markers of the prodrome or of clinical high-risk states. Subtle neurocognitive deficits may predate the onset of attenuated psychotic symptoms (Cornblatt, 2001).

According to the North American Prodrome Longitudinal Study research teams, five features appeared uniquely connected to the prediction of psychosis from baseline presentation. Participants were help-seeking prodromal or at-risk individuals. These five features were: genetic risk with recent deterioration in functioning, higher levels of unusual thought content, higher levels of suspicion/paranoia, greater social impairment and a history of substance abuse (Cannon et al., 2008). Retrospective recording of pre-morbid presentation of these vulnerability markers were the focus of creation of diagnostic measures for the prodrome.

Regarding specifiable diagnostic categories for the identification of the prodromal phase of psychotic disorders, including schizophrenia, only the DSM-III-R is notable for including prodromal symptomology. Although this DSM version was completed and published in 1987, long before the bulk of prodromal research began in the late 1990s, it is indicative of the direction clinical research and retrospective identification of risk factors were headed. The DSM-III-R's broadly defined list of prodromal symptoms are marked by a "clear deterioration from a previous level of functioning" and is characterized by "social withdrawal, impairment in role functioning, peculiar behavior, neglect of personal hygiene and grooming, blunted or inappropriate affect, disturbances

in communication, bizarre ideation, unusual perceptual experiences, and lack of initiative, interests and energy" (1987). The manual recognizes both the retrospective nature of this diagnostic criteria and the variability in length and nature of the prodromal phase.

Diagnosing the prodrome, therefore, rests heavily on our diagnostic categories, criteria and concepts of psychosis and schizophrenic disorders as defined in the most current diagnostic manual. The most reliable way to define the prodrome was initially to identify it as a retrospective entity relative to conversion to psychosis. In other words, individuals who had developed frank psychosis and who themselves could or had relatives who assisted in reporting their functioning and clinical issues prior to onset were asked to discuss the pre-psychotic phase of their illness. In one such retrospective study, researchers interviewed subjects who were in the recovery phase after their acute first episode of psychosis. Participants were asked about the period leading up to the psychosis, using a combination of unstructured and semi-structured techniques. Symptoms identified retrospectively were a varied mixture of attenuated psychotic symptoms, neurotic and mood-related symptoms, and behavioral changes. Symptoms were often disabling and some, such as suicidal thoughts, potentially life-threatening. (Yung & McGorry, 1996).

Patients who are considered Ultra High Risk (UHR) or potentially prodromal are being screened by a number of different measures, all primarily based on the three syndromes retrospectively identified by Alison Yung and Patrick McGorry, both based out of the ORYGEN Youth Health facility in Melbourne, Australia. Yung and McGorry (1996) pioneered three distinct prodromal syndromes that are thought to all potentially lead to full-blown psychotic illness. The first syndrome, as well as the most common

among prodromal patients, is the Attenuated Positive Symptoms category (APS), which accounts for sub-clinical or prodromal, positive symptoms that have begun in the last year but have not met the criteria for severity. The second syndrome is Brief Intermittent Psychotic Symptoms (BIPS) syndrome, which involves the presence of recent-onset, psychotic-level syptoms that occur for less than one week and spontaneously remit. Lastly, the third syndrome identified by Yung and McGorry's research is the Genetic Risk and Deterioration (GRD) category, which is determined if the patient has schizotypal personality disorder or a first degree relative with a psychotic disorder, in addition to a 30 % decline in functioning over the last month. It is possible for patients to be categorized in two different syndromes. Based on the above three syndromes, it is clear that biological, psychological and social forces are currently understood to impact the onset of putative psychosis. Meeting the criteria for the prodrome is a diagnosis that describes individuals who are at "ultra-high" clinical risk for developing psychosis.

The PACE clinic (Personal Assessment and Crisis Evaluation) in Melbourne, Australia was one of the first sites devoted to the assessment, diagnosis and treatment of the prodrome. The researchers located at this clinic in Melbourne established the reliable measure, the Comprehensive Assessment of At Risk Mental States (CAARMS), which is a semi-structured interview designed to identify and assess the UHR criteria in individuals presenting with potentially prodromal symptoms (Yung, 2005). The CAARMS is generally used in European and Australian studies and clinics. The Comprehensive Assessment of At-Risk Mental States (CAARMS) measure includes recent onset of functional decline, genetic risk, and attenuated (subclinical) or brief threshold psychosis (Bota, 2008; Yung, 2008). The CAARMS were used in several

studies to assess three separate trait groups of at-risk individuals. The first group includes Attenuated (sub-threshold) Psychotic Symptoms (APS). This group experiences symptoms of thought disorder, particularly the presence of hallucinations or delusional beliefs that do not meet the full criteria for psychosis in either severity or conviction (Yung, 2005; Yung et al., 2008). For example, a threshold level delusion might be that an individual believed that the U.S. government had launched a satellite with the specific intent of following that individual's whereabouts and tracking their thoughts. In contrast, a sub-threshold level of this delusion might be that a government satellite was indeed launched and the individual worried with regularity that the satellite perhaps was being used to track him. In the sub-threshold case, the individual was still able to identify the feelings and thoughts as his own cognitions that he could believe or not. The difference in the two levels in this case is in the conviction of the belief and its origin. The second trait group identifiable through the CAARMS is the Brief Limited Intermittent Psychotic Symptoms group (BLIPS). The BLIPS group includes individuals whose symptoms spontaneously remit within twelve months. The third group assessed with the CAARMS is the presumed genetic vulnerability group. This group is also assessed using another measure- the Family Interview for Genetic Studies (FIGS)- and includes a family history of psychotic disorder in a first degree relative or a diagnosis of Schizotypal Personality Disorder in the at-risk individual (Yung et al., 2008).

The above definition of the three syndromes of the prodrome has also been operationalized by McGlashan et al. at the PRIME Clinic at Yale's Department of Psychiatry in the SIPS/SOPS measure. The SIPS/SOPS is currently the leading measure used in North American Studies and clinics. The Structured Interview for Prodromal

Symptoms (SIPS) measure includes assessment of onset or worsening of subclinical positive symptoms in five categories, including unusual thought content, suspicion/paranoia, perceptual anomalies, grandiosity, and disorganized communication and was found to be a valid measure (Miller et al., 2003), with a conversion rate of 50% (7 of the 14 of individuals identified as prodromal using SIPS were psychotic at after twelve months). This is in comparison to other studies where conversion to psychosis has been predicted with varying success. Further, the above study also examined the interrater reliability of administering the SIPS/SOPS interviews. The measures were shown to have excellent inter-rater reliability, meaning that once trained in assessment using the SIPS/SOPS, clinicians were nearly always in agreement in diagnosing the prodrome (Miller et al., 2003).

Generally, in combined studies of the predictive power of assessment measures, the SIPS and CAARMS have been recorded as identifying patients who will convert to psychosis at rates between 40%-60% (Bota, 2008; Yung et al., 2003).

Between 2000 and 2003, the National Institute for Mental Health (NIMH) funded a multisite collaborative study called “Prevention and Early Intervention in Psychotic Disorders,” which focused on refining prodromal diagnostic criteria and improving the predictive power of these measures. This North American Prodrome Longitudinal Study (NAPLS) involved collaboration by eight individual research sites. The SIPS/SOPS criteria were universally used in assessing whether participants met prodromal criteria. Once diagnosed as prodromal in relation to one of the three prodromal syndromes, participants were followed for two and a half years. The results were a 35.3% conversion

rate, meaning that about 35 % of participants identified on the basis of recent onset or worsening of subsyndromal psychotic symptoms experienced conversion to psychosis after two and a half year follow-up (Cannon et al., 2008). The NAPLS data set was more broadly used to establish a common set of diagnostic characteristics for examining the prodrome, namely the SIPS approach, when applied to help-seeking individuals, those at genetic/familial risk and a normal comparison group (Addington, 2007).

In order to successfully create the above measures, it was necessary to recruit potentially prodromal individuals, assess them using the most current version of the instrument in question, follow the individual for a period of time and then reassess the individual to see if they have indeed converted to psychosis, as meeting prodromal criteria might suggest. A wide variance in the conversion prediction rates is noted, as discussed above. Further, the nature of the sample and recruitment strategies should briefly be reflected upon, as it is helpful in understanding the nature of early intervention in psychosis. Firstly, most studies in the literature enlist individuals who are help-seeking and screened for psychosis risk indicators, so many of the conversion rates can not be applied to general population samples as a way of screening for psychosis risk (Cannon et al., 2008). Another consideration is the possibility of "false-positive" diagnosis, which is certainly of concern if treatment interventions are to be explored.

CASE MATERIAL

The following case is drawn from the casework of Dr. Cheryl Corcoran, who is a psychiatrist and researcher of note in the field of prodromal schizophrenia identification and treatment (Corcoran, 2009). The case is a good illustration of how complex

diagnosing the prodrome can be, particularly regarding differential diagnosis, cultural relevance and theoretical framework.

Identifying Information

James is a 15-year-old adolescent boy who was referred for social withdrawal, declining school function, some depressive symptoms and school refusal. He lives with his mother and older brother. He was referred by his school counselor.

Chief Complaint

"I don't know why my school wanted me to come here today."

History of Present Illness

James has always been somewhat shy and awkward, although he has had some close friends and has maintained an A-B average in school until recently. His mother, who accompanied him to the initial interview, reports that during his recent summer vacation, he spent a few weeks in July visiting extended family in South Carolina, where he spent time with his cousins, hanging out and playing basketball. When he returned home to New York City, his local friends called to invite him to go to the movies, to play basketball, etc. He usually declined, saying it was too hot to go outside. Instead, James stayed in his room for up to ten hours at a time, watching cartoon channel episodes and playing multiplayer online games. Rather than joining his family for dinner, he would take food up to his room and eat alone. James began to stay up all night and sleep during the day. His room became increasingly messy, he changed his clothes less often and showered every other day, only after his began nagging him to do so. For his birthday, his mother offered to take him to his favorite restaurant, but he was resistant to do this. She

coaxed him to go and he reluctantly agreed. In the car on the way to dinner, he slumped in the backseat, covering his face with his hand. At the restaurant, he kept his menu throughout the meal, hiding his face by holding it upright. He ate all of the shrimp in his favorite dish, but without his usual delight.

With the start of the new school year, James' mother was optimistic that he would improve. In the first few weeks of September, he went to school daily and did most of his homework. When he returned home from school he went straight to his room, where he remained on his computer for hours. His room was still quite messy and he showered and changed clothes only with repeated prodding.

By October, he had become somewhat irritable, especially with a younger niece who wanted to spend more time with him. His clear preference was to be alone. His friends had stopped calling him. His mother said it was like he had become a stranger, unlike himself, and she worried he might be using drugs or if this was just adolescence. His first report card revealed almost all C's. His teachers reported he was very quiet in class, typically looking out the window or doodling and drawing. His English teacher saw his drawings and reported they were full of nihilistic themes, including images of explosions and violence. Although James could generally complete other types of assignments, he had particular difficulty with writing assignments. He would write a first sentence and then stop, saying he was not sure what else to add. At school, the janitor found him sitting alone in the bathroom after hours; James could not or would not say why he was there.

By December, James refused to go to school, and again would not say why. Resorting to desperate measures, his mother locked him out of the apartment during the day so that he would go to school. When she returned from work, she found him just sitting quietly on the porch of their home. At the school's urging, James' mother brought him in for a psychiatric evaluation.

Past Psychiatric History

In the past, James reportedly had a diagnosis of "inattention without hyperactivity."

Medical History

James was the product of a full-term, normal vaginal delivery. He had mild asthma as a young boy, for which he was prescribed albuterol inhalers. He has not received steroids, required emergency room admission or been intubated as a result of his asthma.

Developmental History

As an infant and toddler, James was a much easier baby than his brother, who had been colicky. His mother reports that when she took him shopping, he would sit in the cart quietly. James began walking at 14 months. His mother thinks he may have started speaking a little later than his brother, but she is not sure. James responded well to cuddling and played with other children. He has always been a little clumsy and less athletic and outgoing than his brother.

When James went to preschool and then kindergarten, he separated easily from his mother, but his teachers noted he was a little shy and needed to be drawn out. He rarely initiated play with other children but joined in when invited. His mother describes him as being more compliant and less mischievous than his brother.

James was referred for evaluation in the second grade for inattention without hyperactivity. The reports were lost, but his mother recalls that James was prescribed a stimulant of unknown dose for a brief period, which was not particularly helpful. Of note, James was taller than the other boys in his class- “like a gentle giant”- and other children provoked and teased him to see if he would respond. His teachers all liked him immensely and tried to protect him, as they perceived him to be somewhat vulnerable.

James’ school performance over several years was marked by A’s and B’s, compliance, and the development of friendships, although he was somewhat shy and awkward.

Social History

James lives in a one-bedroom apartment in northern Manhattan with his mother and older brother, with whom he shares a bedroom. James has never known his father. When was age 3, he was in foster care for a few months with his brother when his mother was hospitalized (see below). He has no history of abuse or neglect. The family is supported by his mother’s salary as a secretary and some income from his older brother.

Family History

James' mother was hospitalized 25 years ago for an episode of psychosis, which has never recurred. James' mother said that she thought she was hearing the voice of an older uncle, named Jimmy Carter, who had recently died. She said the doctors mistakenly thought she was having auditory hallucinations of the U.S. president. She was given chlorpromazine briefly and discharged within a few weeks. The symptoms have not recurred, and she has not taken any additional psychiatric medications or received any care since the hospitalization.

Mental Status Examination

James appeared younger than his stated age ad was quite slender. He wore age-appropriate clothing, including a basketball jersey and jeans, and a baseball hat on backwards. He appeared awkward and shy and sat quietly while his mother described the course of events leading up to the evaluation.

When interviewed alone, James was compliant with the interview, answering all questions. He maintained fair eye contact and spoke softly, smiling occasionally while tapping his foot. He described his mood as "OK". His thought pattern was a bit tangential and at times odd.

When asked about the past few months, James acknowledged that he did prefer to be by himself. He felt uncomfortable around others. He was not sure how to act with his friends and he did not think they liked him much anymore. In crowds, he felt like people looked at him and thought he was weird or menacing, especially as a young, tall black male. He was not sure whether he should make eye contact with others. His

neighborhood felt increasingly dangerous, and he felt like he had to look over his shoulder. On the other hand, he did not feel like anyone had singled him out or was plotting against him in any way.

James also reported that he had been thinking a lot about politics, and he thought U.S. society as a whole was controlled by television and mass marketing. He thought George Bush was a "jerk" and wondered if George Bush had something to do with the 9/11 attacks so he could get a lot of power. James acknowledged a lot of fantasizing about blowing up the world- building a tube to the center of the earth and dropping a nuclear bomb- so that all the mistakes and problems would be erased. On the other hand, James has considered that a better approach would be to become a rap star and spread the message of God and love and peace instead.

James also described having feelings of déjà vu every few months, and also wondering if he had dreamed about things before they happened, such as a teacher's being absent from school. He also felt sometimes that if he saw a white car drive by, something bad might happen. He though these were strange ideas that did not make much sense, and he was not sure why he thought them. He confirmed that his thoughts were clearly his own and he did not feel controlled by anyone or anything else.

When asked about sensory perceptions, James acknowledged that when he returned to New York City from South Carolina in the summer, the city seemed much louder and smellier and dirtier than before. Therefore, he preferred to stay in the apartment. Sometimes, he thought he heard his name in the wind. Late at night, when he was in his bedroom, he sometimes thought he saw a black object moving briefly in the periphery of his vision. However, he denied any voices or any other type of hallucination.

As this case material demonstrates, diagnostic work on the prodrome is complex and requires in-depth exploration of clinical phenomena. Many different theoretical frameworks could be applied to this case in order to understand the patient and his experience. The implications for treatment are also riddled with complexity. For instance, if James was not actually at risk for developing psychosis, yet he and his mother were informed that this was a possibility, it may have deleterious effects because of increased stigma and shame associated with serious mental illness. Treatment with psychotropic medication in a false positive case is certainly an ethical concern, as the side effects of both conventional neuroleptics and atypical antipsychotics are serious and must be weighed with the benefits of the medication.

CHAPTER FOUR

COGNITIVE THEORY

In this chapter I will first outline the broad biopsychosocial framework before introducing cognitive theory and the closely related approach of cognitive-behavioral therapy. I will then use this lens to examine the case of James once again.

The Primacy of the Medical Model of Psychiatry

Schizophrenia is a disorder for which myriad theories have been developed. As a spectrum of illnesses, it is remarkably complex and not well understood, despite intensive investment in formulating research to discern its etiology. Traditionally, there has been tension between biological and environmental causal understandings of psychosis and schizophrenia. Medical psychiatry has dominated the field in treatment and research for the last several decades, thereby also dominating the narrative of the disorder's origin. By holding the claim that schizophrenia and psychosis have purely biological roots, broad implications follow for understanding and treating the prodrome of the illness. Conceiving schizophrenia as a "brain disease" over which the sufferer has little or no control has come to be the predominant framework of schizophrenia that psychiatrists, families, clinicians, patients and the general public understand. Thus, the prodrome has been highlighted recently, as it appears to give clinicians the opportunity to interrupt the natural biological course of psychosis with a more advanced knowledge of schizophrenia and its onset and treatment. In fact, the National Alliance for the Mentally Ill (NAMI) has adopted the "brain disease" narrative as a way of supporting families, patients and the

public in their understanding of this complicated and confusing group of illnesses (Torrey, 1995). The biological "brain disease" theory of schizophrenia has been widely publicized and lauded by psychiatrists. As E. Fuller Torrey (1995) writes in his seminal work, *Surviving Schizophrenia*, read broadly by families and professionals, states, "there is no evidence whatsoever that schizophrenia is caused by how people have been treated either as children or as adults; it is a biological disease of the brain, unrelated to interpersonal events of childhood or adulthood" (p. 142).

It is from this backdrop that I approach our first theoretical perspective on the prodrome. The biological disease model for psychotic illness has many limits, despite its primacy as the dominant narrative in the popular and clinical understandings of psychosis. The biological model has been broadened by many researchers and clinicians in order to incorporate the complexity of clinical presentation of psychotic illness and subsequently, the prodrome. In this chapter, I will lay out the broad framework of the biopsychosocial model of schizophrenia. I will then move into an in-depth exploration of cognitive theory and its correlate, cognitive-behavioral theory. These theories will be discussed and then will be used to frame an understanding of schizophrenia and psychotic disorders in general. Cognitive theory and its close relative, cognitive-behavioral theory, will then be used to examine and broaden our understanding of the prodrome to schizophrenia. Research and literature related to the theory's application to both psychotic illness and the prodrome will be reviewed. Lastly, the case of James will be considered with a broad biopsychosocial and specifically cognitive theoretical lens.

Biopsychosocial Model

Biological explanations for schizophrenic illness have more recently been adjusted to account for the lack of specificity in narrowing in on any one biological theory. For instance, researchers have spent many years attempting to isolate a gene or to identify a specific neurotransmitter that can explain the symptoms and etiology of schizophrenia. Further, the notion that "stress", psychological, social and other types, does in fact preempt most relapses of psychosis, as well as first episodes of psychosis is more widely accepted currently. Environmental influences on this spectrum of presentations have been noted in many studies. For instance, schizophrenia has a higher incidence in urban areas (Castle & Morgan, 2008). It has also been evidenced that dark-skinned emigrants who immigrate to areas where the population is primarily light-skinned have a higher rate of developing schizophrenia (Shean, 2004). This evidence has lead many researchers to expand the knowledge base regarding the cause and onset of psychotic illness to include risk factors beyond genetic vulnerability. Therefore, it has now become quite commonplace for clinicians, psychiatrists and researchers alike to call upon a biopsychosocial model in understanding the etiology and development of schizophrenia and more specifically the prodrome to schizophrenia. This chapter will outline the relevant biological, psychological and social theoretical models of psychotic illness and its prodrome, in order to orient the reader to the broader context of the cognitive theoretical approach. This chapter will then explore in depth one specific theoretical model from within the broader biospsychosocial context, specifically the cognitive-behavioral approach, which originates in cognitive theory, as it applies to prodromal schizophrenia.

Most research aimed at understanding psychotic illness, its cause, onset and outcomes emanates from the fundamental acceptance of the biopsychosocial model of schizophrenic illness. By accepting this theoretical orientation, research conclusions accept many assumptions about the nature of the phenomena being researched. Many of these factors will be discussed below. However, I find it important to make the reader aware of these theoretical assumptions and how they overlay the following factors of the biopsychosocial model and cognitive theory. First, it is assumed that schizophrenia is a clinical entity with psychosis its core clinical manifestation. There has been research suggesting the notion that schizophrenia is spectrum of illnesses or not a clear diagnostic category as it is laid out in diagnostic manuals. The research reviewed below, particularly regarding the diagnosis of schizophrenia, assumes that the diagnostic criteria in the *DSM IV-R* are correct. These underlying assumptions greatly influence the way prodromal research is conducted. Identification is based on current diagnostic categories and a biospychosocial model of disease.

Genetic Factors

It is generally accepted that schizophrenia runs in families. For many years, geneticists insisted that a gene could be identified that carried the heritable pathology for schizophrenia. However, endeavors to narrow to this gene have been unsuccessful and it is now more generally accepted that many genes have the capacity to carry the latent illness, but such genetic predisposition plays only a small part in the actually advent of the disease (Beck et al., 2009; Glatt, 2008). Genetic factors may be considered necessary, sufficient or contributing to risk for schizophrenia spectrum disorders (Shean, 2004). There are some researchers who insist that genetic factors are primary in the causation of

schizophrenia. However, this has not been substantiated in the research and most cases of schizophrenia disorders are considered to have other contributing environmental factors that "trigger" any underlying genetic vulnerability (Glatt, 2008).

Gene studies, including twin studies and adoption studies, have helped to confirm that there is a higher occurrence of schizophrenia in those with relatives with this diagnosis. In fact, having a first-degree relative with the illness does increase the rate of schizophrenia prevalence by a factor of at least 10 (from 1% to 9-13%) (Gottesman & Erlenmeyer-Kimling, 2001). Generally speaking, the closer in degree relation an individual is to a relative with schizophrenia, the higher that individual's risk for developing the disorder (Glatt, 2008).

As discussed in the last chapter, identifying the prodrome to psychosis has been most easily predicted when genetic risk is considered among other assessment tools. Thus, it is clear that the role of a familial or heritable condition plays a significant role in the earliest notable expressions of psychotic illness. Those at highest risk have a first-degree relative with psychotic illness as well as recent deterioration in functioning, comprising the prodromal syndrome group of Genetic Risk plus Deterioration (GRD; Miller et al., 2003).

Neurodevelopmental Factors

Schizophrenia has, of late, been broadly understood to be a neurodevelopmental disorder. This view of the illness purports that schizophrenia or psychotic illness is the result of the confluence of a basic biological error (likely prenatal injury or illness) and genetic influence or risk, all of which combine to create "structural, functional, and/or biochemical abnormalities in the developing brain" (Cornblatt, 2001). These

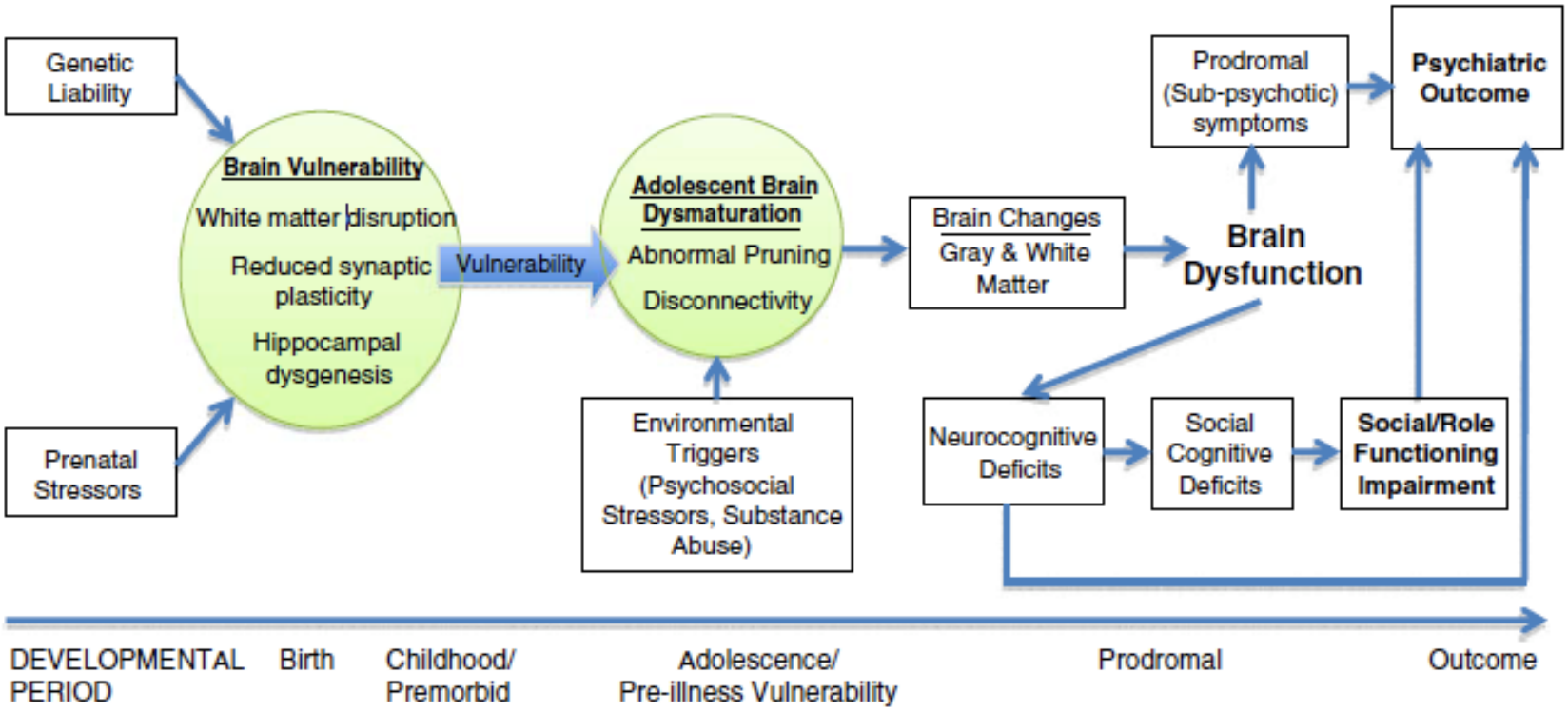
abnormalities amount to a biological predisposition or vulnerability to psychotic illness later in life. This vulnerability may be triggered by stressors in adolescence, as onset usually occurs in late-adolescence/early adulthood (Cornblatt, 2008). As schizophrenia is an illness with typical onset in adolescence or early adulthood, it is widely believed that part of its course is connected with brain development and neural "paring" that occurs in adolescence (Shean, 2004; Stewart & Davis, 2008).

Stress-Diathesis or Stress-Vulnerability Model

As discussed in the previous chapter, researchers have agreed on three distinct prodromal syndromes; the Genetic Risk with Deterioration (GRD) syndrome, the Attenuated Positive Symptoms syndrome (APS), and the Brief Limited Psychotic Symptoms (BLIPS) syndrome. One of the most helpful ways to conceive of the biopsychosocial model broadly is to approach the entirety of the model not as a specific theoretical perspective, but as an integration of many varying theories and etiological frameworks. Thus, the stress-diathesis, or stress-vulnerability, model essentially is the title given to any collection of biological, social and psychological theories for schizophrenia. When conceived in this way, it is certainly a model underpinning much of prodromal research and intervention. Of the three prodromal syndromes outlined in the previous chapter and mentioned about, the GRD syndrome appears to be most predictive of ultra high risk for psychosis. The two other syndromes require at least the presence of subclinical or brief positive psychotic symptoms, thereby indicating that psychotic processes may have begun. Vulnerability, however, can refer generally to any inborn or acquired traits that may predispose one for developing schizophrenia. It has been established that many more people in the general population develop psychotic-like

symptoms and never develop frank psychosis or schizophrenia (Sass, 1999; Davidson, 2003). Further, other psychiatric states include the presence of psychotic symptomatology, but are not defined by the presence of psychotic symptoms in the way that schizophrenia is. Thus, the presence of attenuated symptoms is not seemingly as strong an indicator for risk for psychosis as genetic risk is.

The graphic flow chart below is one way of conceptualizing the stress-diathesis model in relation to the prodrome. While the visual aid might suggest that psychiatric outcome is inevitable, the pathways represented below refer to possible outcomes given certain vulnerabilities. Further, what the chart does not clarify are protective, mediating or resiliency factors (Chart drawn from Niendam, Jalbrzikowski & Bearden, 2009)


Genetic Liability
Prenatal Stressors
Brain Vulnerability
White matter disruption
Reduced synaptic plasticity
Hippocampal dysgenesis
Vulnerability
Adolescent Brain Dysmaturation
Abnormal Pruning
Disconnectivity
Environmental Triggers (Psychosocial Stressors, Substance Abuse)
Brain Changes Gray & White Matter
Brain Dysfunction
Prodromal (Sub-psychotic) symptoms
Psychiatric Outcome
Neurocognitive Deficits
Social Cognitive Deficits
Social/Role Functioning Impairment
DEVELOPMENTAL PERIOD
Birth
Childhood/ Premorbid
Adolescence/ Pre-illness Vulnerability
Prodromal
Outcome

Research does indicate that other vulnerabilities may be indicative of predisposition to schizophrenia. As discussed above, these include prenatal and perinatal injuries or illnesses, neurodevelopmental irregularities or functional or structural brain abnormalities may exist in neo-natal or early childhood, well prior to the onset of the prodrome. While the presence of the anomalies is widespread and detectable, it is not entirely ubiquitous and homogeneous, once again pointing to the notion that schizophrenia is perhaps not a single clinical entity, nor is its cause.

The stress-vulnerability model allows for a broad range of interaction between biological and environmental factors. Most researchers and clinicians have focused on the interaction between genetic and experiential factors. As these factors collide and interact, it is important to be mindful that this is not a passive process. The process of the collision of vulnerability to psychosis and the experiential "stressors" is most readily observed in the clinical presentation of the prodrome, where psychotic processes are nascent but not fully developed or entrenched. The hope of intervening in this process has led many to research methods of treatment in this phase, as will be discuss later in this chapter. One theoretical perspective that lays out a framework for understanding the very process by which the vulnerability towards psychosis and stressors in the environment or in experiential phenomena interact is cognitive theory. Cognitive theory not only can be used to explicate the very course of psychotic symptomatology from the prodromal phase into chronic psychotic illness, but also offers treatment intervention in the form of cognitive-behavioral therapy. Cognitive theory is explored below.

Cognitive Theory

Cognitive theory is often understood most readily in relation to its clinical implementation in cognitive therapy (CT) and cognitive behavioral therapy (CBT). CT emerged as an alternative to strict behavioral therapies and to insight-oriented psychodynamic therapy. CBT emerged as a confluence of cognitive theory and earlier applications of behavioral treatments.

Cognitive theory is based on the fundamental principle that information processing is the defining feature of human life. Cognition, the act of processing information and forming meaning through thoughts and representations, is the primary way that humans make sense of their world, both internal and external (Clark, 2009). According to cognitive theory, then, humans respond to their mental representations of their internal and external environment, rather than directly responding to the environment. Just as the environment can change and shift mental representations in the form of beliefs, attitudes, cognitions, thoughts and interpretations, so too can the mental representations be changed, altered or evaluated. Cognitive theory allows us to describe and make sense of the various cognitions and processes that characterize acute psychiatric symptomatology. It also is useful in proposing certain pre-existing states or vulnerability markers that can be predictive of future psychopathology (Clark, 2009). In this way, it is certainly in line with early intervention efforts in prodomal psychotic illness, particularly within the biopsychosocial, or stress-diathesis, framework. As Clark states, the underlying cognitive vulnerability "remains latent and inactive until triggered by a relevant life experience" (2009).

One of the important concepts within cognitive theory is that of schemas, which refer to cognitive structures that are persistent. Schemas are long-term internal representations of "stimuli, ideas or experience that organize and integrate new information in a meaningful manner" (Clark, 2009). For those predisposed to psychopathology, cognitive theorists propose that maladaptive schemas exist as a result of genetic, biological, developmental, learning and many other factors and experiences. These experiences lead people to come to meta-conclusions that form "core beliefs," which are fixed, global and over generalized convictions about the self, others, the world and the self in relation to external stimuli (Clark, 2009; Beck, et al., 2009). These convictions have global consequences as a backdrop to psychiatric disorders.

CT postulates that many difficulties associated with psychopathology, including depression, anxiety and psychosis, can be traced to cognitive distortions. It is commonplace to accept the beliefs of those who suffer with anxiety, depression or other psychiatric disorders as meaningful within the context of anxious or depressive thought processes and therefore crucial to the recovery process. Distorted or maladaptive thought patterns are examined and challenged in cognitive-behavioral therapy as a way of helping sufferers to redress these pathological ways of thinking. The distorted thought processes are believed to influence behavioral and feeling, thereby comprising the constellation of pathological symptoms.

In the case of psychotic symptoms, particularly delusions, hallucinations and disordered thought, however, it is commonplace to place the content *and* process of these phenomena outside human comprehension. Cognitive theorists believe that, on the contrary, these symptoms are understandable within the same conceptual framework that

we understand thought distortions in other clinical disorders and therefore workable or responsive as a part of the treatment process (Beck, 2004). As one explanation of cognitively oriented understandings of prodromal psychosis put it, “like all people, those at risk of psychosis attempt to make sense of their experiences in the light of their earlier development and the meaning they attach to events will influence symptoms, emotional responses and behavior” (Bechdolf, 2005). In its most basic form, the cognitive model posits that events stimulate “automatic thoughts” (based on schemas and loaded with psychological meaning for individuals), which then trigger emotional and behavioral responses (Beck, 1979, as cited in Beck et al., 2009).

The experience of prodromal or emerging psychotic symptoms, whether attenuated, brief or intermittent, is subject to the ongoing interpretation, dependent on the person’s pre-existent schema and the nature of the symptoms. Another significant assumption of cognitive theory is the notion that there is a continuum from “normality” to psychosis. Rather than postulate that psychosis is located outside the realm of typical experience, cognitive theory asserts that experiences that have psychotic themes are much more common and exist along a spectrum of severity. This also fits well within the conceptualization of the prodrome, as it is often characterized by attenuated symptoms that do not meet the criteria for frank psychosis in severity or conviction. The researchers who developed and train other clinicians in the SIPS/SOPS diagnostic measures state, “one of the key determinants of a symptom being considered attenuated and not at a fully psychotic level of intensity is the lack of conviction regarding the externally generated, “real” nature of the symptom as well as the maintenance of insight” (Miller et al., 2003). Therefore we can see that, for example suspicion is a relatively common experience, a

person in the prodromal state may say, “I am fairly sure they watch me everyday”, a person with psychosis states, “I know they are watching me everyday.” The degree to which a person locates their experience of distress in externalized sources is a main component of differentially diagnosing the prodrome versus frank psychosis. Such a phenomenon is known as “externalizing bias” in CT and is discussed ore below.

In schizophrenia, an individual’s fundamental orientation is a reflection of their distorted internal representations, according to cognitive theory. These representations, in the case of psychotic illness, often predate the full expression of psychosis and thought disorder. For instance, a person who has a cognitive vulnerability to schizophrenia may have a fundamental belief or orientation of “me against them,” which is a precursor to and foundation for externalized delusions and hallucinations with persecutory themes. Cognitive distortions are in and of themselves seen as a vulnerability marker for schizophrenic illness. Many of the distorted ways of thinking become solidified and permanent during the highly stressful time period of the prodrome. As Beck describes it, these “representation makes patients vulnerable to experiencing non-psychotic reactions such as suspiciousness, depression, and anxiety, and they provide the substrate for the formation of delusions” (2009). Frequently, the dysfunctional thinking process whereby these distorted representations are manifest occurs at a time where life situations (rejection, isolation, major life change) are targets of a person’s cognitive vulnerabilities. When thinking about the nature of prodromal symptoms, we know that often what distinguishes the prodrome from frank psychosis is the severity, frequency and conviction of a person’s suspicious, bizarre or delusional thinking. In fact, the ideas a person has at the prodromal stage may be more open to reality checking. As an example, in the case of

James, he believed that there was a possibility that George Bush was involved in 9/11, but was not absolutely convinced of it and was certainly not driven to act on these beliefs or ideas. This belief could have been probed and possibly tested against evidence to the contrary. This would then allow James to learn the coping skill of reality testing intrusive and disturbing thoughts, rather than continue to perseverate on the, potentially further deepening the beliefs toward delusion.

Cognitive Theory of Delusions and Hallucinations

Many of the positive symptoms of psychosis are conceptualized within the cognitive theoretical outline as reflections of biased thinking (Beck, 2004). Biases in thinking are seen in the individual's highly selective attention to their misinterpreted experience. These experiences are highlighted and become "hypersalient" (Beck et al., 2009) to the individual.

One of the most distinct differences between the prodrome and frank psychosis in the cognitive model is the notion that core beliefs meet with experience in a way that is a progressive continuum from maladaptive interpretations to psychotic experience. The paranoid beliefs run from "soft", or open to influence, in the prodrome to "hard," or fixed, in frank psychosis. Each symptom typically arises from distinct sensory domains, but all stem from the fundamental core schema underlying an individual's proclivity to particular biases. One such bias is an "externalizing bias," which refers to the tendency of cognitively at-risk individuals to believe that other people are dangerous or contemptuous of them. These individuals are not able to acknowledge that these interpretations arise from their own cognitive sensitivities and orientation, rather than from external sources

(Beck, 2004). This externalizing bias leads those at risk to have the sense that the input they are detecting has come from an external source, rather than from their own thoughts.

Individuals at risk also tend to have an egocentric bias, referring to thinking in psychosis where irrelevant events are attributed to have personal meaning (Beck, 2004). This is especially salient given that this referential thinking is often solidified during the course of the prodrome by a process that could be deemed a "self-fulfilling prophesy." An individual at risk for psychosis holds core beliefs that his environment is hostile and that he is at the center of this hostility. These foundational thoughts form a basis for the individual to over-attend to experiences that are perceived as hostile. The individual becomes hyperattentive as a way of managing the feelings of vulnerability and fear of danger associated with this perceived hostility. Any perceived threat is then collected as "evidence" of this hostility aimed at the individual, feeding the belief that the individual is the center of his environment. This cycle continues, forming the "self-fulfilling prophesy" as described above.

Cognitive Theory of Negative Symptoms

Similar to cognitive conceptions of positive symptoms, cognitive theory posits that many individuals predisposed to psychotic illness have latent and inherent cognitive vulnerabilities that lend well to the development of hallmark negative symptoms. While positive symptoms have been seen has the defining features of schizophrenia and psychosis, negative symptoms like alogia, paucity of speech, thought blocking, social withdrawal and avolition have often been given less attention, especially within the medical model, as negative symptoms are less likely to respond to psychopharmacology (Beck et al., 2009). These symptoms, however, are important features of schizophrenia

and have been since the time of Kraepelin and Bleuler. Beck et al. explain that prominent negative symptoms, which are quite obvious in many patients with schizophrenia, mark the absence of healthy behavioral and internal responses to stimuli (2009). They further explicate that reduced verbal and nonverbal expression and lack of engagement in constructive, pleasurable or social activities are outward reflections of internal working models, likely established because of neurocognitive impairment. These factors lead to emotional and behavioral deficits. Dysfunctional and negative belief schemas further exacerbate distorted thought processes, creating expectations that are negative or maladaptive. Research has shown that people suffering from schizophrenic illness are especially prone to having expectations of self-defeat, poor performance, and social ineptness (Beck et al., 2009). These beliefs, according to cognitive theorists and practitioners, feed into social aversion, avoidance, apathy and social withdrawal, independent of levels of depression, anxiety, positive symptoms, and disordered thought (Beck et al., 2009). This entire process summarizes the presentation of negative psychotic symptoms.

Research on Cognitively-Oriented Treatments

Dysfunctional cognitive functioning is not considered sufficient or even necessary to cause a psychiatric disorder. Rather, cognitive theorists insist on the confluence of biological, genetic, social, developmental, emotional and psychological factors in explaining psychopathology broadly, schizophrenia and its prodrome more precisely. The following is a review of the literature and research describing cognitive aspects of the prodrome.

Extensive research has been done in identifying cognitive vulnerabilities in putatively prodromal individuals. One study administered a comprehensive neurocognitive battery and clinical assessment on 37 participants who met Criteria for Prodromal States (COPS) and compared the data to 47 healthy subjects and 59 first episode of psychosis individuals. The results revealed that high-risk individuals performed more poorly compared to the healthy control group, but better than the first-episode group (Keefe et al., 2006). Several studies have essentially replicated this design and found similar results, that at-risk individuals performed between healthy controls and first-episode subjects on neurocognitive tests (Eastvold, 2007; McGlashan et al., 2010). The researchers also discovered that the high-risk subjects struggled with processing speed and measures of vigilance, memory and attention, among many other global measures of cognitive proficiency.These studies help to corroborate evidence that neurocognitive deficits are indeed present during the prodromal phase and deteriorate further after the first episode of frank psychosis.

A double-blind study randomly assigned putatively prodromal individuals (using SOPS criteria) to take olanzapine or to the control placebo group. Neuropsychological tests were administered to each group and were repeated at 6 months and 12 months. The results showed that neruocognitive deficits were present in each group and that olanzapine had no effect on these deficits, also suggesting that cognitive vulnerability is a pre-morbid state in individuals at risk for developing psychosis (Hawkins et al., 2008). Once again, this asserts that cognitive vulnerability does indeed pre-date the onset of psychosis and is perhaps not responsive to antipsychotic medication, thereby implying the need for more psychologically based cognitive treatment approaches.

As biopsychosocial perspectives on schizophrenia have become more pervasive, alternative treatment modalities to antipsychotic medication have been explored. While the primary treatment of choice for psychosis remains psychotropic medication, the limits of these drugs have been recognized. Side effects of both first and second-generation antipsychotics have been well documented and many patients must balance out the risks of using such drugs with the short and long-term benefits (Nelson & Yung, 2008). It is also well-documented that outcomes for patients with schizophrenia are much worse in developed nations, where higher doses of antipsychotic medication is the norm, than in the third world, where patients with schizophrenia are not given antipsychotic drugs in such high doses, frequency and duration (Seikkula & Olsen, 2003). Further, a great majority of patients who are prescribed antipsychotic medication and take them as directed continue to have residual refractory symptoms that do not respond to psychopharmacology (Serruya & Grant, 2009) The need for supportive housing, vocational support, case management, family support, crisis intervention and general clinical support, including supportive counseling has long been accepted as the gold standard of treatment for psychotic illness, particularly in chronic and severe cases. These approaches have also been transferred generally to prodromal populations (Nelson & Barnaby, 2008). The genesis of more psychologically oriented treatment interventions has primarily focused on either supportive psychotherapy or cognitively oriented psychotherapy. Nelson and Yung openly recognize the need for more research on the use of psychopharmacological treatment in the Ultra-High-Risk population (2008).

Research is limited on medication treatment in the prodrome, side effects can be serious and long term treatment with such antipsychotic medication is not ideal,

especially for patients who are not yet fully psychotic. However, the narrowing of predictive diagnostic measures seems to introduce the imperative to look for other safer treatment models.

Beck made early hypotheses in 1979 about the malleability of psychotic delusional thinking, postulating that schizophrenic delusions were indeed open to reality testing and were therefore representative of inherent cognitive misinterpretation (Beck, 1979 as cited in Beck et al., 2009). This paved the way for specific cognitive treatments of schizophrenia, such as Cognitive Behavioral Therapy for Psychosis.

Cognitive Behavioral Therapy for Psychosis (CBTp) is a modified version of CBT that has broadly influenced treatment of schizophrenia. CBT is a very popular treatment in general at this time, given the motivation for evidence-based treatment modalities that work on specific symptoms that can be measured pre- and post-treatment. CBT has been applied to many different symptom clusters in schizophrenia: anxiety, reality testing, negative symptoms like social withdrawal and avolition, positive symptoms like delusions and hallucinations, depressive symptoms and symptoms of thought disorder. CBT has also been applied in group settings, as well as directed individual psychotherapy. For these reasons, it is difficult to summarize the totality of CBT's impact in treating psychosis, as comparison across the literature is thwarted because of different measurement use, milieu, and target symptoms.

One study showed that after thirteen sessions of group CBT, there was a significant reduction in the delusional conviction and distress related to the delusion (Landa et al., 2006). Tarrier et al. conducted a randomized control study and 18-month follow-up with acutely psychotic patients measuring positive symptoms, time between

relapse and re-hospitalization that showed that there was a significant benefit to CBT versus treatment as usual, as measured using the Positive and Negative Syndrome Scale (PANSS) instrument (2004). The results of this study also supported significant improvement in the intensity and frequency of hallucinations with the use of CBT.

According to a randomized controlled trial conducted at the PACE clinic that compared cognitive therapy with treatment as usual in 58 patients at ultra high risk of developing a first episode of psychosis, UHR patients tolerated CBT, which appeared to be efficacious in preventing conversion to psychosis. Participants were screened using the PANSS instrument, which considers subclinical symptoms or brief psychotic symptoms (Morrison et al., 2004). Therapy was provided over 6 months, and all patients were monitored on a monthly basis for 12 months. The CBT group was significantly less likely to develop frank psychosis over the twelve-month period. Positive symptoms, if present, were also significantly reduced (Morrison, 2004)

Cognitive-Behavioral Paradigm

Cognitive therapy and cognitive behavioral therapy are collaborative, problem-solving oriented, and educational interventions that are time-limited and involve structured and directed sessions with the client and therapist (Morrison, 2008). The client is assessed based on the presenting disorder and homework is given that targets specific symptomotalogy (Morrison, 2008). In the CBT paradigm, automatic thoughts are addressed by examining the relationship between the event, thoughts, feelings and behaviors.

CBT for psychosis has been shown, as stated above, to be effective in treating many difficulties due to psychotic symtoms. The efficacy of these treatment methods,

cognitive theory's relatively easy applicability to the prodrome and the seemingly safe and gentle effects of CBT have led many researchers to approach the prodrome from a cognitive-behavioral treatment standpoint. While CBT may be an appropriate theoretical lens for the prodrome, studies have not been altogether conclusive of its effectiveness in treating specific symptoms of the prodrome, including attenuated positive symptoms and over all social and role functioning adjustment. For instance, in one study, supportive counseling treatment and CBT were compared in efficacy for increasing social adjustment scores in subjects at high risk. Interestingly, both treatments were effective and there was no significant difference between the CBT and supportive counseling (Bechdolf, 2007). However, in a frequently cited study by Morrison et al. in the United Kingdom, cognitive therapy significantly reduced the likelihood of making progression to psychosis as defined on the Positive and Negative Syndrome Scale over 12 months and also significantly improved positive symptoms over the course of the research (Morrison, 2004). This study measured different aspects of the prodrome, because it was measured by a different instrument (the PANNS), rather than the COPS/SOPS measures.

There remains a lot of interest and research on the application of CBT and cognitively oriented treatments to the prodromal phase. There may in fact be evidence to suggest that CBT is appropriate for certain individuals with certain prodromal symptomatology, while CBT could be inappropriate, less effective or triggering to some prodromal patients (Grazebrooke, 2004). Below, I will explore the case of James as an example of cognitive case conceptualization.

Application to Case Material

The case of James is a complex and at times perplexing case. When looked at from a biopsychosocial model, specifically within a cognitive theoretical, many variables must be considered. Firstly, it would be important to tease out the symptom picture more fully. James presents with what appear to be depressive symptoms- avolition, anhedonia, and loss of interest in previous activities. Some of these characteristics could also be classified as neurovegetative and also include sleep-wake reversal and difficulty concentrating (in school). Also of note, James has isolated himself from his family and friends, he has a notable decline in school functioning, ultimately leading to school refusal. His self-care has diminished. He shows signs of unusual thought content- including violent and nihilistic thoughts. He has had some suspicion (i.e. people looking at him menacingly), grandiosity (becoming a rap star) and perceptual abnormalities (hearing his name in the wind). The presence of these symptoms is certainly sub-psychotic. Likely, if evaluated with the SIPS/SOPS semi-structured interview, James would meet criteria for the prodromal state, especially if his mother's episode is considered as a family history of psychosis, placing him in the genetic risk plus recent decline in functioning group (GRD). However, his attenuated positive symptoms are also of interest, along with his cognitive decline- specifically his inability to complete unstructured tasks, difficulty with memory and confusion. He is also experiencing perceptual abnormalities that fall below clinical symptomology, but that include hearing his voice in the wind and having the vague sense of déjà vu. As will be explored from a cognitive perspective, the connection between James' core beliefs about himself and the

world and how he interprets his experience would play a significant role in the attributions he makes about these difficulties.

James has a history of clumsiness, awkwardness and social difficulties, all of which are vague in nature. He has a history of "inattention without hyperactivity", indicating the possibility of early cognitive deficiencies, which have been shown to frequently proceed prodromal onset. While the case cites a family history of psychosis, upon closer inspection, this episode does not appear to meet criteria for a full-blown frank psychotic episode. Firstly, his mother reports a distinct misunderstanding between her experience and what the treatment providers understood to be happening. Mother reported that she heard the voice of her uncle, recently deceased at the time, whose name happened to be Jimmy Carter. James' mother reports she was hearing the voice of this uncle, which was interpreted as psychotic hallucinations, but may have been a culturally appropriate response to the death of a loved family member. As we do not have much background from the case material, other than a brief passing mention that James is "a young black man", it would have been helpful for the interviewing clinician to inquire about James' background, cultural beliefs and values. This may have then provided the information necessary to better understand his mother's experience of audio hallucinations. For instance, in many cultures around the world, it is not unusual for surviving family members to have audio or visual hallucinations or visions of dead family members (Whaley & Hall, 2009). In the case material, we hear James' mother clarify that there was confusion about the nature of her audio hallucinations, namely that her dead relative shared a name with a past president. Since psychotic hallucinations and delusions often contain ideas of reference or bizarre references to figures in authority, it

would be cause for suspicion if she had claimed to be hearing President Jimmy Carter's voice. However, this was not the case, rather, it was her uncle Jimmy Carter she was hearing. Because there are culturally sanctioned experiences that mimic psychosis, it would be vital to understanding James' family history to look further into the cultural relevance of psychotic-like experiences. As I explore more in depth in the next chapter, psychotic-like experience is not as rare as many people believe it is.

Cognitive theory has many interesting implications, given the potential for prodromal psychosis within the case material presented above. Beck et al. indicate that cognitive abnormalities predate the onset of psychotic symptoms in many patients who go on to develop schizophrenia. These cognitive insufficiencies or vulnerabilities can have a significant impact on an individual's functioning in social and academic settings. These vulnerabilities, along with other biopsychosocial sensitivities, meet with stress and can set up conditions that are prime for the development of psychosis. Neurocognitive difficulties, along with socialization problems and psychological problems contribute to lowered motivation and interfere with young people's ability to develop appropriate skills for managing social situations (Beck et al., 2009). This can frequently reiterate or support any fundamental core beliefs the person may have in their schematic understanding, particularly beliefs about other people being dangerous, a "me vs. them" schema. Quite typically, "these individuals either voluntarily withdraw from social interactions or experience social isolation from others" (Beck, 2009). This is evident in James' extreme social withdrawal starting after his trip to South Carolina in the summer.

Beck et al. note that dysfunctional cognitive schemas are crucial in the onset of hallucinations and delusions, as discussed above relative to frank psychosis. These

maladaptive beliefs are often the result of stressful conditions or experiences that lead to conclusions like “I’m inferior” or “People are against me” (Beck et al., 2009). These core beliefs, as revealed in automatic thoughts, are the result of life experiences. In the case of James, he has come to the belief that people in his neighborhood are dangerous and are looking at him strangely. While few articles have discussed the significant of sociocultural variables in the development of cognitive schema or prodromal psychosis, these factors have likely loomed large and probably largely unconsciously in the life of this young man. As a Black adolescent male in an urban setting, he may actually be experiencing racial microaggressions in his community and perceiving them as personal attacks. Given that he grew up in this community, this stress would have been enduring and insidious. Now that he has sought help from highly privileged psychiatrists, who are indeed white (given that we know who the authors of the article are). His suspicion, a natural reaction under racially tense circumstances in which one is simultaneously perceived as and perceives a threat, has become embedded as an internalized cognitive structure. James’ sense that George Bush might have had something to do with 9/11, which referential and perhaps paranoid in nature, was actually a relatively widespread idea in New York after the terrorist attacks on the World Trade towers, another example of a “symptom” that may seem to be evidence of paranoia out of context. Many people living in New York shared similar beliefs, as many “conspiracy theories” were swirling around the frightening terrorist attacks on American soil. However, given the other surrounding difficulties James is experiencing, it would make sense to explore this belief or notion further within the context of cognitive psychotic vulnerability.

There is evidence from the case material that suggests that James had cognitive and social vulnerabilities from a young age. This could have led to internalized representations of the world, his sense of self and other people that were maladaptive. For instance, if he struggled with social interactions and spontaneous skills in interpersonal relationships (such as with schoolmates), this may have contributed to an internal cognitive structure that led him to conclude that he was different and others were not easy to relate to. When his schoolmates perhaps teased him or did not readily associate with him, as is suggested by the report that his teachers perceived him as vulnerable and tried to protect him, this may have reinforced the burgeoning schematic structure. This underlying cognitive vulnerability impacted his ability to modulate stressful situations as they arose and as his development proceeded through adolescence.

James is exhibiting signs that he has externalized his core beliefs of himself as perhaps powerless and inferior, as evidence by his sense that people in his neighborhood are viewing him as menacing and his community is dangerous. He also has a sense that he might be able to prove himself by becoming a famous rap star and passing God's message of peace and love. Beck et al. hypothesize in their cognitive conception of psychosis that often times an inflated sense of one's own power, as is observed in grandiose thoughts and delusions, is indicative of a core view of the self as inadequate and others as superior. This is then defended against by portraying oneself as much more important and others has inferior. James also has notions of blowing up the earth by planting a bomb at the center of the planet. This thought or cognition displays not only grandiosity, but also magical thinking, which is also reflective of a similar core schema of feeling powerless (Beck et al., 2009).

Based on the cognitive interpretation above, James' impaired intellectual or cognitive functioning from an early age has made him quite prone to the fundamental attribution error, causing him to automatically attribute many life experiences, particularly thoughts, to external causes (Beck et al., 2009). These attributional errors are often concerned with threat in high-risk individuals, who often accumulate evidence that supports their sense of externalization. While he does not state openly what he attributes his difficulties to, it is clear from the ensuing interview that he has concerns about threats outside of himself.

In cognitive theory, the prodrome is marked by the collision of vulnerability factors with stressors in the person's life experience. The schemas that make up core negative or maladaptive belief representations become "hypersalient" (Beck et al., 2009) and go unchecked by healthy reality testing processes. If continued without intervention, automatic thoughts and hypersalient beliefs can become more solidified by emotional and behavioral reactions to these disturbing thoughts in the form of social aversion and emotional withdrawal. As these beliefs move from "soft" to "hard" through the process of attributing internal processes to externalized entities, subclinical symptoms may become more crystallized and prominent. For these reasons, motivation to identify and treat the prodrome is high, particularly for individuals like James, whose family history of psychosis is unclear and whose functioning has significantly declined.

CHAPTER FIVE

DIALOGIC THEORY

The second theoretical perspective that will be explored and applied to the clinical phenomena of prodromal schizophrenia is the postmodern perspective, specifically dialogic theory and the Open Dialogue Approach. This chapter will outline the fundamental principles of the broad contextual stance of postmodern theory, then will apply the postmodern stance generally to schizophrenia and the prodrome. I will then explore in depth dialogism and the Open Dialogue Approach. Dialogism and Open Dialogue will be applied to the case of James and will be used to understand the prodrome to schizophrenia from a postmodern lens.

Postmodernism: A Response to Modernism

It is important to understand the larger context of postmodern theory as it applies to mental health and illness before delving deeper into one specific theory from within this framework. In this section, I will broadly explore postmodernist theory as it applies to psychiatric illness concepts. It will be first necessary to explore the notion of modernism, to which postmodernism is a response.

Postmodernism, as it were, is a sweeping term referring to a philosophical or paradigmatic shift in how we view ourselves and the world. The postmodernist paradigm arose in response to the modernist paradigm that had dominated our worldview since the time of the Enlightenment. The focus that characterized the Enlightenment period of the 18th Century was on truth by way of reason. Modernist or Enlightenment thinkers were

responding to the medieval paradigm, which was dominated by superstition, fear, and dogmatic religious belief. The notion that humans were superior among all living beings inhabiting the earth became paramount during the Enlightenment. According to this philosophical perspective, what set humans apart from other beings was their ability to reason and to objectively know truth. That an objectively *knowable* truth existed and this truth was not ruled by superstition, supernatural belief or religious faith led to a belief that the world was "ordered according to the dictates of reason; a world shaped by science, technology and the primacy of efficiency" (Bracken & Thomas, 2005). For this reason, scientific inquiry became of primary significance, as modernism asserts that the objective truth can only be ascertained by rigorous and scientific methods, such as medicine and research.

Psychiatry and much of the mental health field has been dominated by a highly modernist approach. In fact, the biopsychosocial perspective is indeed a modernist framework, albeit a broadly encompassing and less reductionist one. The biospsychosocial perspective seeks to identify and understand the causes, courses and treatments for human suffering, taking into consideration a confluence of various factors. The very pursuit of valid and reliable measures for diagnosing individuals with mental disorders is an entirely modernist agenda. Effective treatments imply cause and effect, reflecting an objective state of human wellbeing and thereby knowable categories of illness. Therefore, our typical conceptions of diagnosis, such as the *DSM-IV* (and other diagnostic manuals), and treatment, such as Cognitive-Behavioral Therapy, are examples of modernist practices based on modernist theories. Modernist theories are also often referred to as the positivist position. Positivism refers to the approach to knowledge as

objectively, positively identified sensory experience, which is considered the preferred way of knowing. This position is explored more in depth below.

In this section, I will explain the broad context for postmodern theory and use Foucault's philosophy to ground the theory. Postmodern thinking is not an outright rejection of modernism, but involves bringing awareness to its limitations. One theorist that has exemplified a postmodern response to modernism is Michel Foucault. The application of a postmodern paradigm to mental health and mental illness is well captured by Foucault, who was a dominant postmodernist dissenter to our traditional conceptions of psychiatry, mental illness, mental health and psychology. While the preceding terms, including psychiatry and psychology, are by no means synonymous, nor do they encapsulate the entirety of the modernist enterprise, the terms will be used as entre to more a grounded grasp the postmodern critique of modernism. The following paragraph will outline Foucault's influential critique of the modern position in mental health.

Foucault is particularly critical of psychiatry and psychology's claims to objectively knowable categories of illness of the mind. He records a history of how madness became known to be an illness and then a specific mental illness. As he states in *Mental Illness and Psychology* (1976), "it was only the arrival of the calm, objective, scientific gaze of modern medicine that what had previously been regarded as supernatural perversion was seen as the deterioration of nature" (p. 65). Foucault identifies the "calm, objective gaze" as one of modern society's preeminent social controls and believes that this gaze is present in clinics, hospitals, and prisons among other professional settings. According to modernists, there is an objective notion of what man's "nature" should be and this is the standard by which all beings are measured. The

scientific gaze is used to judge and categorize abnormality in relation to these "natural" categories of normality. When the gaze falls upon "atypical" or disturbing behavior, thoughts or ways of relating, individuals exhibiting these attributes are given labels describing their deviation from the norm. Foucault also calls to attention the way that we are invested in the "dividing up of social space according to the lines of valuation and exclusion" (1976). Each culture has a different configuration of this divide and this shifts over time. The practices each society implements to define the life of the "madman" indicate that culture's comfort with the deviation from "nature." I would be remiss to not mention that Foucault's postmodern approach to mental illness if often critiqued for its somewhat romanticized vision of mental illness; that illness is defined from outside of the individual by professionals as a way of social control. This approach does indeed appear to neglect the very real subjective pain of people suffering from mental anguish. This is one reason that postmodern writers have begun to give such attention to subjective experiences of those suffering from such anguish, which is discussed below.

Diagnosing madness, or more precisely mental illnesses, then is a project of modernity. This project has to do with describing what constitutes "abnormality." Many postmodern thinkers have critiqued this project as inherently flawed. They criticize that rather than identifying why and what exactly defines and causes abnormality, modern psychiatry locates the problem within the person. In other words, defining mental illness is about defending conceptualizations of normality. The postmodern critique maintains that categories of deviation from this notion of normality are not pre-existing forms of nature, but rather are constantly redefined in relation to social values. Each diagnosis is a social construction that we honor based on our system of values. Our system of values is

expressed in what Foucault calls “discourse,” which is a how language expresses formal discussion, usually referring to social boundaries (1976). The discourse in relation to psychiatric illness and suffering (and subsequent treatment) is subject to what Foucault calls the “clinical discourse.” Foucault and many other social theorists believe that madness or deviant human behavior has moved towards medicalization as a method of social control. This in turn has a dramatic effect on individuals’ behavior and experience. Many social theorists posit that discourses are extremely important because the do impact peoples’ real lived experience. The available theories of knowledge and current discourse act like blueprints for experience. For example, a person having unusual perception or sensory experiences may feel quite distressed, not only by the actual experiences themselves, but also by what the person knows might be signs of “becoming crazy,” based on the prevailing discourse on what “crazy” means.

Critique of Positivism

In this section, I will further explicate the modernist perspective of positivism in relation to postmodern critiques of this position. Positivism, part of the philosophical foundation of modern psychiatry, is a position that claims that our objective observable sensory experience is the only valid source of knowledge about reality (Nelson et al., 2007). Positivism claims that operational definitions describe objects in terms of the “specific processes or tests used to determine its presence of quantity” (Nelson et al., 2007). For instance, in psychiatric diagnosis, this process is reflected in the descriptive categories of symptoms, which are collected and organized by professionals, but understood to be descriptions of already existent natural categories. A simpler example is the notion of measuring an object’s length, whereby the tool for measurement must be

objectively tested and publicly agreed upon. Such is also the case with measures for diagnosing clinical entities, including the prodrome to psychosis; the measures must be tested and agreed upon by the psychiatric community. While most researchers and clinicians acknowledge the constructive aspects of their diagnostic tools, as evidenced by the constant redefinition of diagnostic assessment tools, modern psychiatry generally claims to be in pursuit of fully defining phenomena that exist clinically; ultimately moving closer to objective truth.

Postmodernism in general objects to the aforementioned approach, given that it is indeed replete with presuppositions, theoretical biases and assumptions that allow psychiatry to make claims to objective knowledge. Instead of coming closer to objectively knowable truth, positivism only serves to privilege one set of beliefs over other beliefs, often known as narratives. The notion of narratives is grounded in postmodernism and refers to the idea that rather than the existence of a singular truth that must be ascertained through scientific rigor, human experience is actually much more multidimensional. The story of biological psychiatry and the medical model of mental illness is merely one way of explaining or understanding schizophrenia or psychosis as part of human experience. When we give preference to this modernist perspective, we tend to silence or ignore other ways of conceptualizing these phenomena. This is especially evident in the neglect of individuals' subjective experiences of schizophrenia or psychosis, which are almost always missing in research, diagnosis and treatment of such disorders. A researcher's position in examining schizophrenia often speaks to his or her underlying assumptions about the nature of the illness and subjects diagnosed with schizophrenia. It is often stated that individuals with schizophrenia lack insight into their

illness. This could partly explain the general avoidance of subjective interviews or surveys of patients' psychotic experience. Researchers' positions regarding schizophrenia are often colored by the theoretical presuppositions inherent in their understanding of the clinical phenomena. Subjective experiences of individuals experiencing mental illness will be examined more at length below.

Critique of Modernist Concept of Schizophrenia

In examining the diagnostic category that has subsumed experiences called schizophrenia, postmodern theorists are critical of many assumptions that precede these categorizations. Taking up the *Diagnostic and Statistical Manual*, as it is seen as a guidebook for practitioners, researchers and diagnosticians, and has become inextricably linked with our understanding of mental illness, Irene Harvey indicates that this manual only serves to describe categories or symptoms (referring to DSM III-R; 1987). Describing categories of illness is a task that does not benefit most patients, as it does not probe precipitating factors or causation. It is also fraught with assumptions about normality. For instance, Harvey illuminates one aspect of diagnostics in schizophrenia- the absurd nature of delusions. Referring to utter lack of grounding in reality, "absurdity" is not diagnosed or defined in the DSM, rather it is simply pre-understood. In other words, any "healthy" individual would be well aware and grounded in reality enough to recognize absurdity when confronted with such (1987). Further, the DSM III includes symptom check-lists for the presence of such phenomena as "content of thought," which in schizophrenia so defined can include "overvalued ideas" and "markedly illogical thinking" (i.e. clear internal contradictions or clearly erroneous conclusions). What is overvalued or markedly illogical is once again based on a subjective assumptive position,

a position of “normality,” which “has its history just as madness does, and it is a result of a product, not a pure natural origin that might fall into madness- or, in this case schizophrenia (Harvey, 1987). Harvey also criticizes the manual’s writers’ foregone conclusion that speech is the best way to know thought content and therefore mental state (1987). She argues that relying on spoken language to ascertain an individual’s mental state is also an act of assumption.

Further, the arbiter of defining the assumption we come to call “normal” is almost always a person in a position of power; a clinician, doctor, judge, prison guard, researcher, etcetera. The application of the clinical gaze is a way of sorting out the social categories of normal and abnormal. As Kovel puts it, psychiatry’s effort towards raising mental disorders to the conceptual level of disease gives a certain “grandeur” (1987) to diagnosis of mental anguish or suffering. Disease, in modernist theory, is a pure, real thing- in-itself (Kovel, 1987) that can be objectively known, studied, quantified. While there are widely variant, highly technical and specific critiques by myriad postmodern thinkers, the preceding examples are provided as a jumping off point for the general flavor of postmodern theoretical approaches. In fact, as Bracken and Thomas (2005) state, “postmodern thought represents a struggle to free ourselves from the idea that there is only one path to the truth, one way of using reason, one form that science and serious reflection should take” (p. 95). There are many postmodern theories, thus ongoing critique of positivist or modernist psychiatry could be made *ad nauseum*. Postmodernism can broadly be seen as a perspective that does not privilege any single method, paradigm, or authority but rather seeks to hold a multiplicity of possible truths in response to the single narrative of scientific modernism claim to truth.

Subjective Narratives

One way to move from the broad theoretical base and to dig more fully into the phenomena of schizophrenia and its prodrome is to explore subjective narratives of individuals with these experiences. In order to more deeply understand the postmodern position on schizophrenic experience and its prodrome, I will use phenomenological and narrative approaches to explore and ground the fate and lived experience of these individuals. By way of including marginalized narratives, many postmodern critics have sought to provide a space for the voices of those diagnosed with schizophrenia, those experiencing their first psychotic episode and those at risk. In the section below, I will discuss and explore how phenomenology uses first-person narratives not to explain the etiology of psychosis and psychotic risk, but as a descriptive practice that is intended to bring out essential features or characteristics of schizophrenic experience.

In this paragraph, I will look at the notion of the self as it emerges from narratives of those having from psychotic experiences. Phenomenological critiques of modern psychiatry have described the subjective experiences of people suffering from experiences labeled psychosis or schizophrenia, as discussed above. The relevance of subjective experience is crucial from a postmodern perspective, given that the experience of psychosis is so alienating, isolating, unbearably frightening and difficult to describe (Seikkula, 2003). Further, these individuals are experiencing a crisis or disturbance of their fundamental sense of self (Lysacker & Lysacker, 2008; Nelson et al., 2007). While notions of the "self" vary among theorists, part of the postmodern and phenomenological pursuit is to give voice through language and discourse to previously silenced voices. Expressions of psychotic disturbance and the close examination of subjective experience

shed light on the distortion of the self and subjectivity in psychotic disorder, but do not define the self objectively. This is especially the case in ultra-high-risk cases, where the onset of symptoms may be signaling a serious disturbance of the self and a crisis of meaning-making. Sass states that the descent into psychosis leads to the loss of an individual's sense of active intentionality and integrated sense of self (1999).

Phenomenology of Schizophrenia and the Self

Nelson et al. explore the subjective dimensions of individuals at risk for psychosis, stating, "what brings a patient to the psychiatrist is a disturbance in their experience of self, others and world, not a complaint about abnormal activity of neurotransmitters" (2007). Nelson and colleagues discuss descriptions of anomalous subjective events in ultra-high risk individuals. These descriptions of unusual subjective events include anomalies of self-identity, awareness, affect, perception, etcetera (2007). The lack of these descriptions in the literature have been foregone in preference for reliable and valid measures, which Nelson et al. critique. The existing criteria for diagnosing Ultra High Risk (UHR) patients does not include subjective experience, which includes anomalies of affect, cognition, perception and body-motor experience (2007). In an in-depth study of self-disturbance in psychosis conducted in Denmark, analysis of the data revealed that self-disturbance is highly specific to schizophrenic illness. This research group also discovered that pre-schizophrenic prodromes were marked by the significance of self-disturbance. Marked self-disturbance, as measured by the Examination of Anomalous Self- Experience instrument (EASE), was strongly indicative of the development of a schizophrenia spectrum disorder (Parnas et al., 2005; Parnas & Handest, 2003). From this research, we can conclude that a disturbance of self-experience or sense of self is a

fundamental hallmark of schizophrenic illness, more so that in any other psychopathology, and that this disturbance predates the onset of full-blown psychosis. Therefore, the significance of subjective experience of the self is of paramount concern in understanding the prodrome.

The exclusion of subjective experience of an individual's altered sense of self in psychosis has long been problematic for postmodern thinkers. In this section, I will discuss some of the ways that self-disturbance can occur in psychosis and the prodrome and outline how these have been generally excluded from the literature. As Sass outlines, many schizophrenic patients lose their sense of an integrated self and active intentionality (1999). As described in the phenomenon chapter, many patients experience their thoughts and experiences as coming from an external entity, as being controlled or powerless. Simultaneously, it is not unusual for patients to also have the sense as the self as all-powerful and all-knowing. The self seems to be "dispersed outwards, where it fragments into parts that float among the things of the world: even one's most intimate thoughts and inclinations may appear to emanate from some external source or mysterious foreign soul" (Sass, 1999). At the same time, the self may seem to have pre-eminent power to influence events and others. Sass illuminates the duality of this experience as paradoxical and incredibly mystifying, causing a chasm in the sense of self.

Sass invokes Foucault when discussing the resulting awareness or "hyper-reflexivity" on one's own consciousness becomes a preoccupation for the person (Sass, 1999). The tendency to be hyper-reflexive leads to intense self-consciousness and alienation, in the form of turning inward and away from social life, practical activity and emotion (Sass, 1999). This is done, as least in large part, in response to the objective gaze

of psychiatry. This view of the schizophrenic condition moves away from modernist notions of schizophrenia as a brain disorder, whereby the brain's function in essentially in decline. Madness is frequently associated with irrationality, idiosyncratic behavior, disordered thought and incorrect or inferior functioning in general. Schizophrenia can indeed display marked obscurity and contradiction, but this profound alienation, turning inward and anomalous thought processes are not indicative of abnormality or of a "broken brain" in this framework.

Medical and biological psychiatry has minimized our ability to hear the multiple narratives of those suffering from these experiences and how the sense of self shifts in these people. The move towards medicalization has often been coined "reductionism", which is the belief that many different events can be attributed to (or reduced down to) one main type of knowledge, namely positivism (Bracken & Thomas, 2005). In psychiatry, almost all aspects of human behavior, including aspects that have meaning, can be reduced to, attributed to, or explained by "non-meaningful" causes (Bracken & Thomas, 2005). For example, anxiety, worry, fears, hopes or loves can be attributed to genes, neurotransmitters, atoms or neurons. While it is certainly admirable that biopsychosocial approaches have broadened the scope of causal entities (genes *and* social environment *and* ego functioning, for example), it is still a practice of categorizing in relation to normality. As Nelson et al. discuss, the attenuated symptoms of the prodrome do not place an individual at risk, rather, the underlying core of psychotic vulnerability signals an increased risk (2007). This vulnerability is not *describable*, although researchers have attempted to describe the phenomena of symptomology of risk, but

instead the expression of subjective disturbance is the crux of understanding the vulnerability to psychotic experience.

Postmodern Theory of Mental Illness, Schizophrenia and the Prodrome

What, then, are we to make of individuals suffering from what has come to be called mental illness, specifically schizophrenia and its prodrome? If *these* are not categorical illnesses with biological, psychological and social causes, triggers and components, then how shall individuals so suffering be assisted when seeking help? Postmodern theorists have indeed themselves been critiqued for speaking of philosophy and theory of mind when human beings are dealing with real and unspeakable conflict, suffering and pain due to the conditions or experiences that have been gathered under the heading of schizophrenia. To add to the confusion, it does appear that researchers have been successful in narrowing down the phenomena that signal the risk of developing such a conflicted experience (and so named the prodrome to schizophrenia). If these are only conceived as socially constructed categories, then are we not less compelled to intervene and possibly prevent such suffering?

Ultimately, postmodern theory is a constructionist theory, proposing that indeed our understandings of meaning are created in practice through interpretation and discourse, not necessarily expressions of *a priori* natural conditions. This allows for many, multiple meanings and truths to emerge, simultaneously. One of the primary concerns in constructionist postmodern theory broadly is giving dominance or preference to any one discourse over another (Bracken & Thomas, 2005). Modernist positivism's tendency to give primacy and preference to one narrative as truth is of particular concern, as it ignores and marginalizes other narratives. In this case, the narrative of psychosis as a

biological brain disorder with environmental influences is preferred to the more marginalized narrative of psychosis as a profound alteration of self-experience with little or no known etiolgy. These critiques are helpful in understanding the way that we have come to define and treat major mental illnesses like schizophrenia. The critiques allow us to conceptualize these experiences as phenomena that often arise in personal and familial crises and that these crises represent the individuals' attempt to make meaning out of their experience. However, many postmodern or social construction approaches are rebuffed for being impractical and lacking in actual perspectives from those with such experiences. For this reason, the inclusion of subjective narratives from individuals themselves suffering from psychotic experience is invaluable.

Giving space for exploring the sense of self as described by beings suffering from psychotic experience is an endeavor that can help to bring these neglected narratives forward and into the mainstream. Most diagnostic, treatment or etiological narratives ignore the perceptions of the sufferer. Schizophrenia, psychosis and the onset of symptoms interrupt "the lives of people struggling to find and create security and meaning in a world of contingency" (Lysacker & Lysacker, 2008). Symptoms are yet another contingency; a "threat to human well-being that must in interpreted and constructively engaged" (Lysacker & Lysacker, 2008). Many clinicians and researchers believe that people suffering from schizophrenia are doubly beset with difficulty because, whether a function of the illness or the person's capacity for reflection, they often lack insight into their symptoms. However, such an assumption has in fact been reputed by many first-person narratives in which it is revealed that a person's suffering is in fact exacerbated by her all-too acute self-awareness of the losses, difficulty and

disappointment she is experiencing as a result of her disorder (Davidson, 2003). Sass's concept of "hyper-reflexivity" also endorses this notion that rather than being utterly unaware of their predicament, people suffering from psychosis are in fact much more acutely aware of the difficulty they find themselves mired in.

Postmodern Approach to the Prodrome of Schizophrenia

From a social constructionist perspective, psychosis can be conceived of a temporary, radical and alienating experience that isolates one from shared communication. The person experiencing psychosis feels they are in a 'no-man's land' where unbearable experience has no words, and therefore no voice and no authentic, real agency in their lives (Seikkula, 2003). Lysacker and Lysacker are clear in pointing out that individuals with psychosis do not completely lose their sense of self, nor do they collapse entirely into self-referentiality (2008). This is apparent in their intersubjective experiences of being occasionally overwhelmed by experiences with other people and their own subjective experiences (Lysacker & Lysacker, 2008). For instance, an individual experiencing psychosis may become distressed by an interaction with another person that they perceive to be threatening, in turn causing paranoia or frightening thoughts about the person's intentions. They also may have subjective experiences that can be distressing as well, indicating that the self is maintained and is subject to experiences that are interpreted and perceivable.

Davidson conducted interviews with over one hundred individuals in different stages of schizophrenia or psychosis (2003). Those who were able to describe the very first hint of the onset of the illness described the experience in varying ways. Some experienced the presence of classical "positive" symptoms, namely hearing voices,

although this often started off in subtle forms, such as whispering or vague noises. Others experienced subtler changes before any hallucinations were present. However, Davidson concludes that nearly all the participants experienced "cognitive changes," such as memory loss and confusion, concentration problems and loss of interest or ability to focus on things that used to interest them. They also reported increases in sensitivity to everyday phenomena. This sensitivity along with changes in perception, cognition, and attention gave participants an overwhelming sense of being distracted (2003). This further led to social withdrawal and isolation. Participants attempting to makes sense of these experiences of themselves were left so confused that they often lost their own sense of agency (Davidson, 2003). This process served to externalize the distressing phenomena of the disorder, but also continued to alienate the person from their own sense of agency and self (Davidson, 2003; Lysacker & Lysacker, 2008). When a person feels she is not in control of her own thoughts (many say hallucinations seem to come and go as they please), experiences of the self can feel less integrated.

One possible way that delusions develop in this model is that the sense of one's own agency being usurped by an illness or disorder of unknown origins leaves a vacuum or space to be filled with some other, usually demonized and externalized being. The lack of personal agency is then explained by the usurping of this control by this other agent. Examples of such external agents vary from each individual; God, the devil, the police, the government, an unfriendly neighbor (Davidson, 2003). Lysacker and Lysacker further explicate that many reports of those having complex verbal hallucinations overwhelmingly have the sense that these "voices" cannot be responded to or engaged with (2008), once again contributing to a sense of "voicelessness." Intrapersonal dialogue

is interrupted incessantly by anomalous sensory or misperceived mental phenomena, further disabling the person's foundational process of self as dialogical. Hallucinations are essentially monologues (Lysacker & Lysacker, 2008).

Many voices of first person narratives examine retrospectively the earliest signs of the struggles associated with the illness. Many of these narratives include themes of confusion and silence around the earliest onset of the illness. The earliest signs are often troubling and distressing, but a solidified language is lacking in order to give voice to these experiences. This silence and lack of language is incredibly alienating for the individual who is already struggling with a crisis of meaning in an attempt to make sense of what is happening. As the person's dialogical processes are interrupted, their ability to clearly conceptualize self-positions deteriorates. Without this clarity, it can become more difficult for a person to coherently present the appropriate self-position in interpersonal interactions. Further, as subclinical positive symptoms become more frequent and intense, the person's ongoing intrapersonal dialogue is increasingly overwhelmed by the monologue of hallucinatory voices (Davidson, 2003).

Open Dialogue Approach to Psychiatric Crisis

The Open Dialogue Approach is one example of clinical work with firm roots in postmodern theory. In this section I will discuss the history of the approach and its fundamental principles. This approach can be broadly applied to any psychiatric crisis or difficulty, but has been shown to be particularly helpful in working with families affected by the first psychotic episode. The Open Dialogue Approach is an example of postmodern theoretical approach applied to real clinical work. Philosophically, Open Dialogue is grounded in narrative and phenomenological frameworks. Its ultimate goal is

not to change, cure, diagnose or even educate people, but to provide a space where many voices can be heard simultaneously speaking of the same problem.

Roots of the Open Dialogue Approach

The Open Dialogue (OD) approach has its clinical roots in Northern Finland, where the local psychiatric hospital team noticed that recidivism was high and that engagement levels were low in cases where a patient was experiencing psychiatric crisis, often the first episode of psychotic symptoms. The clinical team there found that the "linguistic turn" of postmodernism and social constructionism was especially applicable to families in crisis, who often found themselves separated from the process of "treatment" and then referred to other providers, bouncing in and out of hospitals and acute crises. This seemingly unending process of alienation left the family more and more confused. The team acknowledged the discontinuity of the traditional approach, which in many ways reflected the families' experience; treatment professionals were constantly in flux, each with different professional diagnoses and interventions (Seikkula et al., 2003). As the team members bounced in and out of the families' lives, the families' parallel process built mounting confusion about what could be helpful and consistent. This confusion, the team in Finland found, was related to the lack of language to describe the family's experience.

As dialogism is firmly rooted in postmodern thought, it posits that intrapersonal and interpersonal dialogues are the core of self-experience. Open Dialogue approach, specifically, also owes a debt to the broad context of the double-bind theorists and family therapists who pioneered a communication based approach to understanding psychotic problems (Seikkula & Olsen, 2003). A full review of the double-bind theory and a

comprehensive history of family therapy's contribution to understanding psychotic problems are well beyond the scope of this thesis, but these two theoretical and practical approaches are important to acknowledge. Double-bind theory asserts that psychotic problems have their origin in relational context (typically families) and begin with communication contexts where hallucinations and delusions are adaptive (Seikkula & Olsen, 2003). According to double-bind theory, conflicting and complex communication patterns within families can lead to the development of psychotic symptoms as a way of coping. For example, a family member may tell the identified patient that he is loved and valued, but may maintain a facial expression that communicates repulsion. Over time, the conflicting verbal and/or non-verbal patterns of communication can lead the person to respond with psychotic expressions, such as hallucinations and delusions, as a way of coping (Bateson et al., 1963). Expanding from this theoretical model, many models of family therapy attempted to untangle the paradoxes of communication and relational interactions contributing to psychotic problems in one family member (Seikkula & Olsen, 2003). Open Dialogue approach, however, directly attempts to open double bind interactions. In Open Dialogue, psychotic expressions are seen as adaptive ways of coping with unbearable experiences. As we see in dialogism, often the person's inability to shift among self-positions and to maintain internal and external dialogue. Social networks are no longer sources of dialogic shifting, but rather monologic or silenced communications. Beyond just solely looking at communications, the Open Dialogue approach to addressing double-bind interactions also examines the relationship context in which these communications are held, specifically by including the social network.

Theoretical principles of Open Dialogue

The theoretical principles of the Open Dialogue approach are "tolerance of uncertainty," "dialogism," and "polyphony in social networks" (Seikkula & Olson, 2003). Tolerance of uncertainty and dialogism are practices of language that allow many different narratives and perspectives to emerge. Rather than implicating one theory, diagnosis or treatment plan over another, this allows for open collective dialogue to progress. "Immediate advice, rapid conclusions and traditional interventions make it less likely that safety and trust will be established" (Seikkula & Olson, 2003). Safety and trust are of paramount importance and great attunement is given to therapeutic trust and safety. This often requires that treatment meetings are held on consecutive days for upwards of ten to twelve days following the initial meeting or crisis.

Theoretically, dialogism evolved from Bakhtin's conception that human beings are polyphonic beings composed of distinct voices in dialogue with one another (Bakhtin, 1984). At times these voices can be complementary, contradictory and contrary (Lysacker & Lysacker, 2008). As with the phenomenological view, dialogism asserts that one's sense of self is observed in feelings, thoughts, behavior and beliefs which are not a singular essential entity, but a multiplicity or ensemble of "selves" (Lysacker & Lysacker, 2008). Thus, dialogism offers a theory of the self as a complex, interactive collection of parts that are in constant dialogue with each other and thereby can be in contradiction or seeming disconnection with other parts. According to this postmodern position of dialogism, the self can be conceived as an ensemble of "self-positions" that are not organized or controlled by any overarching entity or "ego."

In this theoretical position, both the self and the world of experience are conceived in parallel ways as collections of multiple narratives and positions. During schizophrenic overwhelm, both the sense of self and the narrative of an individual's experience becomes disrupted. The experience of the self and its many positions is distorted by the compromise in dialogism. The ability of the individual to maintain a relational narrative with those in his or her network is also disrupted, leading to a deeply isolating and alienating experience. When the individual's dialogical relations with significant others and those with whom they continually have contact with are disrupted during psychotic experience, the individual's capacity to experience himself as autonomous and having agency and voice is impaired. Both the intrapersonal and interpersonal experience of the self is diminished (Lysacker & Lysacker, 2008).

If the self arises as both a dialogue between multiple self-positions (intrapersonal) and between the self and others (interpersonal), this is inherently a polyphonic and dialogical continuum of experience. Many individuals suffering from the onset of schizophrenia and ongoing psychosis have expressed that they experience diminishment and fragmentation of dialogism and polyphony. It is hypothesized that organization of the multiple selves or self-positions is impaired when schizophrenic disordering appears.

Practice Principles

The following are the seven main principles of the Open Dialogue Approach in practice:

Immediate help/intervention

Immediate intervention is a key concept in the OD approach. The clinician receiving the first contact with the family arranges the first meeting within twenty- four hours. Twenty-four hour crisis services are available in the Western Lapland and have

been in existence since 1992. The team may meet many times during the initial crisis; the team frequently anticipates meeting daily for ten to twelve days during the acute crisis period (Seikkula, 2003).

Social-network perspective

Social networks refer to caring personal communities for support and collaboration, reflecting the way people really live their lives in a postmodern society (Seikkula et al., 2003). People's subjective experiences are encompassed in their social networks, not merely within a framework of symptomology in contrast to normality. Families and networks are greatly impacted by the subjective psychotic experience of one of their members. These social networks are made up of people from a clients' personal network, which can pose a challenge to traditional or conventional expertise of clinical professionals. This challenge is precisely the move that OD intends, as the gaze of professionals and the acts of identifying the problem within the family or network and seeking to change the problem is one that is alienating and shows preference for the metanarrative of the professionals. As Seikkula (2003) and his colleagues state,

> opening doors for families to participate in analyzing the problem, preparing a treatment plan, and participating in treatment meetings throughout the entire treatment sequence were the first steps in seeing all the problems as problems in the actual social situation of the patient (p. 190).

Flexibility and mobility

The treatment response is adapted to the needs and presenting concerns of the family. For instance, treatment meetings may be scheduled at the family's home, if consented by the family (Seikkula et al., 2003). During a crisis phase or acute presentation, no exact plans for future treatment are made by the clinicians, rather the

team is focused on opening the dialogue with the family on a continuous basis. After the crisis has calmed, treatment methods and interventions are chosen based on the family's values and input and on the patient's problems, preconditions and needs (Seikkula, 2003).

Responsibility

The first staff member that receives contact regarding the referral, whether it is with the patient, a family member or relative or another referring agency, is responsible for scheduling the first team meeting. The entire treatment team takes charge and participates in the whole treatment process (Seikkula, 2003; Seikkula et al., 2003).

Psychological continuity

The team of clinicians present at the first team meeting remains involved with the case for the entire duration of treatment. This team takes responsibility for treatment as long as necessary in both inpatient and outpatient settings. Members of the patient's social network are also invited to participate in every meeting. The team also anticipates that the treatment of an acute psychotic crisis can require between two and three years and the team commits to this time period with the patient with his or her social network (Seikkula, 2003).

Tolerance of uncertainty

One of the unique elements of the OD approach is the intentional avoidance of hasty decisions, premature treatment choices and diagnoses. This is part of inviting a sense of safety and security, which in turn allows for a dialogue to form. As a routine part of each team meeting, participants discuss whether and when the next meeting will take place. Tolerating uncertainty in diagnosis, treatment and interventions is an active attitude of the therapists who attempt to engage with the family and network to form a

joint process (Seikkula, 2003). This is a departure from many treatment team decisions in inpatient or crisis interventions where the focus is on the professionals rapidly deciding on a diagnosis and treatment plan, which is then presented to the patient and the family.

Dialogism

The principle of dialogism, which is discussed at length above, when put into clinical practice maintains that the focus of the treatment team is to promote dialogue with the family. Focusing on change in the patient or the family is of secondary concern. The dialogic conversation is a forum where families and patients have the chance to increase and voice their sense of agency. The primary focus is on allowing a new understanding of the problem to be built by holding a dialogue in following the themes, language and way of speaking that the family is used to (Seikkula, 2003).

Research on the Open Dialogue approach indicates that it greatly decreases the need for long-term and repeated hospitalizations, as well as decreases the need for the use of neuroleptic medication. In an initial study of first episode psychosis, the model was shown to improve outcomes by reducing recidivism, use of medication and the incidence of hospitalization (Seikkula & Olsen, 2003). In a two-year follow up study of the OD approach in outpatient settings for first-episode psychosis in Northern Finland, the OD group had few relapses, shorter hospital stays, few residual psychotic symptoms and few cases of neuroleptic medication prescription (Seikkula et al., 2003). This study was not a randomly assigned, double blind study, so there are methodological limitations. But compared to treatment as usual, better outcomes were noted and the Finnish program continues to be employed as a first-line approach to first episode psychosis. The model is also being used in acute care settings in much of Scandinavia and Russia (Seikkula &

Olsen, 2003). The studies done in Finland have samples that are quite small and homogenous, which the researchers concede is a limitation. Seikkula notes that while the sample size and makeup are limitations, the strength of this systemic shift in the Western Lapland region of Northern Finland has been a comprehensive, flexible and responsive mental health response to psychiatric crisis. Duration of untreated psychosis declined to 3.6 months (Seikkula, 2003).

Application to the Case of James

From a broad postmodern perspective, it is helpful to conceptualize the case as James' narrative. Immediately, we find ourselves in the predicament that the story is written in the third person past tense. Furthermore, the narrative is recorded by a clinical researcher, who is attempting to distill James' experience into a diagnostic framework for the purpose of educating other researchers and clinicians. She asks James questions and takes his history from his mother. This serves to distance the reader from the subjective narrative and also diminishes our sense of James' voice. If we were to only take what first person statements James is recorded making, we would have almost no coherent narrative at all.

Despite the flawed nature of the case's recording, I will first take up the project of the specific ways we are shown that James' narrative is silenced and his sense of self disrupted by his anomalous sensory and perceptual experiences. At first, we discover that James initial difficulty appears to have begun over the summer when he was 15 years old. However, we quickly learn, apparently from his mother, that he has always been somewhat shy and awkward, although he was "an easier baby" than his brother. We find that James was affectionate and loving. Also, we learn that James was assessed to have

difficulty with inattention, but this is vaguely described. Since we know from dialogical and narrative theories that the self develops in dialogic relation to others and as a narrative between the multiple self positions we occupy, we can assume that part of James interpersonal dialogue between himself and others (mother, teachers, sibling) would have included this sense that he was shy, awkward and inattentive. Therefore it is likely that James developed the self-positions of self-as-shy, self-as-awkward, self-as-inattentive. These self-positions likely interacted with other varying self-positions and possibly contradicted his positions as self-as-loving, self-as-affectionate. Other possible self-positions, which we do not have the privilege of exploring because we do not hear directly from James regarding his sense of self, include, self-as-son-of-psychotic or self-as-different.

When describing his experience more recently, James states to the interviewer that he perceives others to be looking at him as though he is "weird or menacing." This could signal James' sense of himself as including these self positions of weird and menacing, but could also be related to his self-position and identity as a black male in an inner city. The very real experiences of people of color being marginalized in their communities frequently occurs in subtle ways such as glances, looks, comments and other microaggressions. In many cases, people of color experience "paranoia" that is warranted, as they are the target of these microaggressions. Since people from the dominant culture are seldom consciously aware of these microaggressions, the person of color could be labeled as paranoid. To internalize this experience is to have an intrapersonal dialogue that is quite disparate from one's interpersonal dialogue, causing

rifts in one's self-position and clarity of one's own capacity to choose and have agency over sense of self.

James is also having anomalous sensory and perceptual experiences. These profoundly frightening and alienating experiences have left him feeling diminished and different from his peers. He acknowledged that he prefers to be by himself, feeling uncomfortable around others. His sense of himself as different from his friends has led him to the conclusion that they do not like him anymore. When he returns from South Carolina to New York City, he states the city seems smellier, louder and dirtier than before. James may be hypersensitive to sensory experiences as a result of his nascent sense that he is different and becoming more disconnected with that which was familiar. It is not likely that NYC is any different, but it could be part of James' growing sense of isolation and alienation- the city he grew up in and calls home is now even rejecting him, while he feels disgusted by it. It may be especially evident that the city that he has lived in his whole life is much dirtier, louder and smellier relative to his experience in South Carolina.

James' profound sense of isolation, alienation and confusion about his own agency is vividly captured when he describes sitting alone and being found by a janitor, unable to explain why he was there. This image of him, alone, silent and motionless is a visual and experiential entryway into how James' sense of self has been impaired by his psychological, social and emotional experiences. The Open Dialogue approach would point to this experience as the crux of a psychiatric emergency. The patient is having such an utterly frightening and unbearably isolating event happen to them that they feel and experience a very real loss of agency. We see this again captured in James' difficulty in

school; he cannot write an essay. He can barely get past the first sentence. In order to be the author of a written work, one must have a sense of oneself as an agent with voice and some narrative to tell. We see James' ongoing sense that he has lost his voice and agency in his own life symbolized by his near paralysis in attempting to author a written narrative.

James attempts to make some sense of his frightening sensory events and his own loss of power, voice and agency. He begins to react to this by withdrawing from settings where interpersonal dialogue is necessary, such as school and with peer, social situations and his family. He questions whether his friends even like him anymore. It is widely know that stigma strongly impacts people's perceptions of those with "mental illness" and those suffering with these illnesses feel demoralized, as these stereotypes are internalized (Lysacker & Lysacker, 2008).

Firstly, in a conventional modernist model of treatment or assessment, it may be that James and his family would have to be on a waiting list in order to get into a clinic for consultation. In most traditional medical models, after presenting for psychiatric consultation, the clinicians involved would make diagnosing and assessment the immediate goal. Many questions would be asked in order to illicit from James and his mother whether James has symptoms that fit into any of the categories that these clinicians diagnose and treat. These questions would often be specific and close-ended, as the clinicians attempt to narrow James' presenting concerns into categories; does he have anxiety, depressive symptom, negative symptoms of psychosis, how strong are his convictions about his perceptual and sensory experiences? Does James have cognitive disabilities? During this process, James would be subjected to the calm, objective gaze of

the assessing clinicians. Once a diagnosis was agreed upon by the clinicians, they would present this to the family, along with treatment recommendations. Typically, first –line treatment for any of the conditions in question in James' case would include psychoeducation for James and his family, psychotherapy, likely from a cognitive behavioral framework and medication to address anxiety symptoms, depressive symptoms and psychotic symptoms.

In contrast, using dialogical theory as the framework would understand James' predicament in terms of dialogical compromises leading to experiences of self-diminishment (Lysacker & Lysacker, 2008). In Open Dialogue, one of the ways to understand and redress these compromises is to provide a structured yet safe space for dialogue to re-emerge and to mend interpersonal dialogism. This is initiated by providing immediate help in the form of the first team meeting. The patient and his family do not get put on a waiting list, rather the initial meeting is schedule as soon after the first contact is made as possible. Further, the patient's social network is invited to this and every meeting thereafter. In the instance of James, his mother, brother, teachers, friends and any other relatives or people involved in his life would be asked to attend. During the first meeting, the clinicians would invoke a sense of safety by establishing that meetings will be held as frequently as necessary during the initial emergency. The focus of the team meetings is not to rapidly diagnose and treat, but rather to establish rapport and dialogue with the family. This is done by listening to the family and using their own language to communicate about the problem as they see it. Each family member is invited to speak about his or her sense of the problem.

James' social network would also experience the clinical team's tolerance of uncertainty. Rather than jumping to conclusions and making assessments and presenting them to the family and patient, the clinicians become fully immersed in the task of developing dialogue with the network. While uncertainty can indeed cause anxiety when safety is of concern or when family members are highly distressed, this is often assuaged by meeting every day until the initial crisis calms. This can greatly increase the networks' sense that they are being heard and the patient's sense that he is not alone. Allowing for a polyphony of voices can be comforting to the patient, as it increases the likelihood of dialogue and invites agency on the part of the patient. Further, since the polyphony takes place in a safe environment and within the patient's own network, it is much less disturbing that the "caucophony" that many patients with psychosis abhor and become overwhelmed by (Lysacker & Lysacker, 2008).

As the OD approach is network and language based, it is also need-adapted (Seikkula & Olsen, 2003), which means that James' need within the context of his social network would be constantly and flexibly addressed. Therefore, all of the dialogical aspects are met in this model; the need for voice, agency, response to a person's changing sense of self and needs and the interpersonal context that a person's sense of self develops.

The Open Dialogue approach can strike us as unusual or unstructured because it does not seem to imply a systematic treatment intervention. However, the team meetings serve as the ongoing treatment. The treatment principles outlined above continue to guide the team's approach with the family. This does not bar members of the team or the social

network from requesting or implementing other treatment methods, including the use of psychotropic medication and individual therapy.

CHAPTER SIX

DISCUSSION

In this chapter, I will begin by grounding the discussion of the two theoretical perspectives relative to the prodrome in each theory's concept of humanity and self-experience. I will then discuss the core components of *automatic thoughts, core beliefs* and *cognitive distortions* from cognitive theory as they apply to the prodrome. Next, I will discuss the components of *dialogical process, sense of self* and *loss of agency/voice* from postmodern dialogical theory applied to the prodrome. I will provide an in depth discussion of the contrasting elements of the two theoretical approaches to the prodrome, and will then move into the ways the two theories can be taken together to give us a new understanding of the phenomenon of the prodrome.

Cognitive Theoretical Concept of Self-Experience

Cognitive theory begins with the assumption that human beings' primary function is to process information (Beck, 2009). Information is processed by making internal representations of sensory experience of both external and internal events. Humans make mental representations of all of their experiences. Accordingly, when formulating responses to their experiences, people do not respond directly to the actual experience, rather they respond to their mental representation of it (Clark, 2009). Human beings are constantly involved and engaged in a perception-interpretation process. The result of this process is affective, behavioral and physiological responses, which can either be positive and adaptive, or negative and maladaptive (Clark, 2009). Thus, human beings experience

themselves as well adapted and as coping well when their information processing is unencumbered by cognitive distortions and maladaptive beliefs.

If we begin with this position on self-experience, according to cognitive theory, it then follows that healthy humans process information with efficiency and functionality allowing them to progress without undue distress or suffering in relation to their mental representations. As can be the case when examining the essence of humanity in the context of psychopathology, we often understand what health is in comparison to disease. In cognitive theory, psychological disease or pathology is related almost ubiquitously to disturbances to the information processing system for an individual. Psychological disturbances can be characterized by excessive or deficient stimulation of the systems responsible for beliefs or attitudes (Clark, 2009).

The cognitive model of the prodrome asserts that the core symptoms are derived from basic disturbances in information processing causing vulnerable individuals to slip into decline that is difficult to halt. These disturbances lead to perceptual abnormalities and disturbances of the experience of the self (Nelson & Yung, 2008). These perceptions lead to interpretations that have consequences in the ways individuals behave and feel. Cognitively oriented interventions are aimed at redressing and restructuring the information processing system. Overly maladaptive or negative perception-interpretation processes are examined and ultimately challenged in favor of more positive or adaptive ones.

Schemas and Cognitive Distortions

The foundational components of cognitive structures are called *schemas.* Schemas are pervasive internal representations of stimuli, ideas, and sensory experiences that

organize, filter and integrate information so that a person can find meaning in phenomena (Clark, 2009). Schemas are essentially the cognitive bridge between perception of an event and the interpretation of the event. Schemas are activated by any life event, regardless of its origin (pathological or otherwise). When a person's foundational schemas are maladaptive or negative, information processing is biased from the outset. This results in *cognitive distortions.*

Beck and many cognitive theorists believe that a great deal of psychopathology is based on cognitive distortions. Distortions of thought are based on erroneous thinking that is often derived from early learning experiences. These erroneous thought patterns create long-term cognitive biases and inaccurate appraisals of both external and internal stimuli, leading to the development of schemas. Schemas are long running patterns of thought. Our interpretations of experiences are greatly influenced by our schemas because schemas are unconscious foundational filters through which information is processed. Part of cognitive-behavioral therapy is illuminating this process and challenging beliefs that are maladaptive or unhelpful. In this capacity, cognitively oriented therapy does involve giving language to previously unstated parts of human experience, namely unconscious thought patterns, schemas and beliefs. Schematic organization in prodromal individuals is thought to contain enduring representations of the self, others and the world that are "negative." This is the foundation for cognitive vulnerability to prodromal syndromes.

Core Beliefs

Schematic orientations lead to core beliefs. An underlying schematic orientation with tendencies towards externalization and views of the self as helpless or easily

compromised lead to core beliefs such as “I am vulnerable” or “Others cannot be trusted” (Morrison, 2008). Cognitive researchers maintain that *core beliefs* play a significant role in the onset and escalation of psychotic symptoms. Negative beliefs about the self, the world and others are associated with psychosis (Morrison, 2008). How a person appraises psychotic phenomena tremendously impacts how the person responds to these experiences. People appraise situations based on their schematic orientation. When an individual interprets mental representations with core beliefs, they often come up with thoughts to characterize the core belief. For example, if the prodromal experience is subclinical audio hallucinations and the core belief is “others cannot be trusted,” the thought associated may be “people at work are gossiping about me.” This thought can lead to a feeling of paranoia, distress, anxiety, and anger, etcetera. It can also lead to behavioral changes, such as social isolation. Delusional thinking in Ultra-High Risk (UHR) individuals can be understood as an attempt to explain unusual internal psychological states. As the person continues to have unusual internal experiences, they continue to gather evidence aligned with the belief they have chosen to understand these experiences.

In cognitively oriented treatment, core beliefs can be evaluated and changed through cognitive-behavioral techniques such as gathering evidence for and against the belief, generating a list of advantages and disadvantages to a particular belief, and generating alternative beliefs (Morrison, 2008). It should also be mentioned that core beliefs may not always be negative. For instance, many people whose schemas include self-vulnerability and fear of others conclude that paranoia is a positive experience, because it serves to keep them safe. Therefore, paranoia (i.e. “I must always be on

guard") as a core belief can be a positive reinforcing cognitive experience for some (Morrison, 2008). Another example of positive psychotic-like experiences is social withdrawal. Based on their core beliefs, many people are lead to paucity of speech, social withdrawal and disengagement (Beck, 2004). The belief that disengaging with social interaction (i.e. negative symptomatology) can assuage difficulty based distorted beliefs about the self, others or the world. This can contribute to the cycle of information processing and schizophrenic-like behavior and feeling patterns.

In prodromal syndromes, delusions are often not entirely or fully formed, hence they are deemed subclinical, attenuated or brief. This makes sense within a cognitive paradigm, given that a prodromal person can begin to have suspicions that are not grounded in reality, but these thoughts or beliefs may not be entirely "hard." This can mean that the beliefs are open to reality testing or malleable. During the prodromal phase, a process whereby individuals undergo psychosocial stress in combination with already present cognitive vulnerabilities combine to cause symptoms that range from well below psychotic level to brief periods of fully psychotic symptoms (Bebbington & Kuipers, 2008). Adverse experiences can combine with pre-existing core beliefs about the self, the world and other people in the world to form delusional beliefs. As stated by Bebbington & Kuipeers (2008), pre-existing vulnerabilities

> triggered by stresses such as negative life events or negative relationships, individuals may experience and increasing cascade of cognitive and perceptual anomalies that, together with emotional reactions, lead them to conclude not that this is a 'bad day,' but that external agents are conspiring against them. (p. 78)

Recovering from episodes of psychosocial stress activating cognitive schemas and core beliefs that are prone towards externalizing of adverse events is highly dependent on the

individuals' capacities for cognitive coping. Often, in individuals who are prodromal, such coping skills are absent. As we will see in the following section on automatic thoughts, this is intertwined with an externalizing bias.

Automatic Thoughts

According to cognitive theory, *automatic thoughts* are the products of a biased information-processing system (Clark, 2009). This information processing system rests on the foundation of schema and core beliefs about the self and others. All experiences and stimuli are filtered through these unconscious or rarely noticed cognitive structures. The results are almost always automatic thoughts. Automatic thoughts (or images) are specific to current circumstances and are involuntary and temporary mental representations of a person's current affective state. These thoughts or images are typically plausible or realistic in current circumstances, meaning that they are not frequently so bizarre that they cannot be reconciled with the person's current concerns and schemas (Beck, 2009; Clark, 2009). However, in people who are cognitively vulnerable, perceptions may be biased, which can in turn cause highly biased negative automatic thoughts. Most often, an individual is not acutely aware of their automatic thoughts. Automatic thoughts are usually a primary object of cognitive interventions. Repeatedly illuminating automatic thoughts and their impact on behavioral, affective and physiological responses is a way that cognitive therapists attempt to modify dysfunctional underlying schemas and core beliefs (Clark, 2009).

Cognitive theory posits that hallucinations are in fact an externalized version of the "inner voice" stream of thoughts that are present for most people (Beck et al., 2009). In cognitive theory, *thoughts* are first person experiences (e.g. "I am a loser"). These

thoughts can translate into a *voice*, which is a second person representation of the *thought* (e.g. "You are a loser"). Often in psychosis, these translated thoughts are heard as third person accusations directed at the individual suffering from psychotic experience (Beck et al., 2009). For those who are cognitively vulnerable to psychotic patterns of experience, automatic thoughts play a very salient role in the development of prodromal symptoms. Individuals prone to prodromal syndromes have cognitive structures such that they perceive intrusive thoughts to be personally relevant and therefore requiring response (Clark, 2009).

Beck et al. assert that the content of automatic thoughts play a significant role in the exacerbation of hallucinations (2009). The process of the inner dialogue being externalized into voices, hallucinations or delusions is related to a specific cognitive vulnerability known as an externalizing bias (Beck et al., 2009; Clark, 2004). UHR individuals are often prone to an externalizing bias. This externalizing bias leads those at risk to have the sense that the input they are detecting has come from an external source, rather than from their own thoughts or internal processes. It is typical of prodromal individuals to have a pre-existing attributional style that tends to attribute negative experiences to an external cause (Beck et al., 2009). This fundamental bias contributes to the development of prodromal symptomatology, as many young adolescents have negative automatic thoughts and psychotic-like experiences, but UHR individuals are more prone to externalizing these thoughts (Beck et al., 2009).

Postmodern Theory's Concept of Self-Experience

Postmodernist thought is, generally speaking, suspicious of what can be called "meta-narratives." As mentioned in the previous chapter, meta-narratives are theories or

ways of knowing that make claims to truth above other ways of knowing. This is often referred to as the linguistic or narrative "turn", which refers to the paradigmatic shift in the way we conceptualize our experience of the world, our selves and other beings. This shift has at its root the idea that our lives and experiences cannot be distilled down to biological, genetic, neurological, psychological or any other singular theory.

Based on the linguistic or narrative turn, dialogism honors that people are comprised of multiple different parts all in continual dialogue with each other. Further, the theory also brings to light that all forms of communication, spoken or unspoken, are always a response to interpersonal and or intrapersonal interactions. The fundamental conceptualization of human nature is the notion that each being occupies multiple selves or self-positions that are in constant internal dialogue with each other. As Lysacker and Lysacker, 2008, aptly describe, "we sense ourselves within and through encounters that are at once intra- and interpersonal, and that reflect complementary and dissonant facets of our being. [S]elf-positions are axes of self-world interaction, more a matter of who we are, than of whom we take ourselves to be" (p.34). A continuous and ordered series of shifts in our multiple self-positions relative to relationships, situations and experiences reveals itself to us through the process of intra- and interpersonal dialogue. While this process is a complex and dynamic interplay, it remains ordered as a response to worldly interactions and coherent internal experience. The most basic concept of self-experience is that people are in constant dialogue with others and within the individual his or herself.

An ordered and comprehensible process is necessary for the above to occur, which of course presumes a person has the capacity for such order. While all humans, according to dialogism, must engage in the dialogical process (both inter- and

intrapersonal), the theory also assumes that this process will be mostly unencumbered. Dialogism does allow for dissonance, contradiction, confusion and complexity among self-positions. However, the process of dialogue is still the crux of self-experience and this must be a relatively uninterrupted and ordered process in order for a healthy sense of oneself. This theoretical perspective, while much less apt to label interrupted dialogical processes as "diseased" or "disordered" and to diagnose this as mental illness, still has at its root a notion of health and order in self-experience.

Dialogical Process

Dialogism offers a theory of the self as a complex, interactive collection of parts that are in constant dialogue with each other. Because human experience is a complex multiplicity of many different experiences, the parts that make up a person can be in contradiction or seeming disconnection with each other. According to the postmodern position of dialogism, the self can be conceived as an ensemble of "self-positions" that are not organized or controlled by any overarching entity or "ego" (Bahktin,1984; Lysacker & Lysacker, 2008). The self can be conceived as a continuous flux of self-positions; for example, self-as-brother, self-as-African-American, self-as-anxious. Each "part" of the self can be conceived of as a different self-position that constantly is in intra-personal communication with other self-positions, depending on various life events and interpersonal communications. The self-positions shift in relation to each other as well. Every person's self-positions flux in and out of prominence in the person's overall sense of himself. Further, a person's multiple self-positions are in dialogue with each other, which allows for even contradicting self-positions to co-exist (Lysacker & Lysacker, 2008).

Open Dialogue addresses the disruption of interpersonal and intrapersonal dialogue by utilizing a language-based intervention for families with psychotic problems. The person suffering from psychotic symptoms is invited to speak about their experiences without judgment, hasty diagnoses or professional opinions. This is all accomplished within the context of the person's social network. The inclusion of the network serves to address the disruption in the interpersonal dialogical process by bringing the individuals' closest relationships into a communication-based setting and providing permission for each person to conceptualize the nature of the problem in his own words.

Sense of Self

It is widely known that psychosis and schizophrenia changes how people think about and experience themselves as individual human beings in the world (Davidson, 2003; Lysacker, Glynn, Wilkniss, & Silverstein, 2010; Lysacker & Lysacker, 2002). In fact, even the earliest pioneers in schizophrenia research and literature, Eugen Bleuler and Emil Kraeplin, acknowledged that a fundamental alteration of the self-experience was a hallmark of schizophrenic experience (Lysacker et al., 2001). The changes in process of making meaning, activities and processes that order the multiple selves face diminishment during the prodrome. Changes in the processes that order the self were cited as some of the primary difficulties in schizophrenia as early as the beginning of the last century (Lysacker & Lysacker, 2002). The changes in these processes have largely been ignored or conceptualized as secondary to biological and neurological disorder within the biopsychosocial model.

There is evidence to suggest that the sense of self is diminished in a similar way during the prodrome as it is during psychosis (Nelson et al., 2007). We also know that

self-esteem is greatly impacted during most experiences with psychopathology and negative experience of the self can contribute to ongoing difficulty in a number of psychological problems (Beck, 2009). The collapse of coherent self-experience during the prodrome may in fact signal the very first experience of sense of self being altered, yet negative self-concept and an underlying sense of vulnerability may contribute to the increasing sense of altered self (Nelson et al., 2007). From a narrative postmodern perspective, this collapse of self-awareness or altered sense of one's own self reflects an impoverished self-narrative (Lysacker, Glynn, Wilkniss, & Silverstein, 2010), which in turn leads prodromal individuals to continue to experience themselves as diminished. The self-narrative or self in dialogue with itself and others can be disrupted in potentially three ways during the prodrome.

First, instead of experiencing the self as a coherent dialogue, ongoing conversations within the self and others can be drowned out by one or two dominant and loud self-positions of voices (Lysacker & Lysacker, 2002; Lysacker & Lysacker, 2008). It is typical for a self-position to shift into dominance and for one to experience open and continuous dialogues between separate and often opposing elements. These elements do flow in a hierarchical fashion, the order and dominance of the self-positions routinely shifting, allowing for the dialogue to consistently continue. During the prodrome, it is indeed possible that the ordering and reordering of the hierarchy is disrupted in such a way that internal dialogue is captured or dominated by one or two self-positions. It is possible that the ever-shifting hierarchy ceases its shifting and becomes rigid (Lysacker & Lysacker, 2002). This experience in the prodrome can be known as the monological self, whereby the prodromal individual comes to only experience himself in one or two

fixed self-positions. This self-experience can be correlated to those with significant positive symptoms, whereby the "voices" of hallucinations and delusions are the overriding and dominant self-positions.

The second possible disruption of self-experience in the prodrome is known as the cacophonous self. This involves the break down of the hierarchy of self-positions in such a way where no coherent dialogue can be perceived, leaving the prodromal to embrace a cacophony of self-positions. The internal dialogue of the cacophonous self is rich with voices and self-positions, however, they lack coherence, connection and hierarchy of any kind, which in turn leads to inaccessibility of dialogue with others (Lysacker & Lysacker, 2002). This can also lead to anguish with the prodromal person, given that the self appears to be dissolved into an incoherent, disorderly and unsettling collection of unrelated self-positions. This self-experience could be associated with individuals who have disorganized thought patterns, difficulty with concentration or decline in social functioning.

Thirdly, an empty or "barren" sense of self could be capitulated if dialogue itself became suspended. With only the bare minimum of self-positions available, the person feels virtually useless to develop or continue intrapersonal or interpersonal dialogue. The lack of or suspension of the self-narrative can lead to a prodromal individual's sense that they lack any capacity for dialogism at all. This could be associated with negative symptoms, social withdrawal, avolition and anhedonia.

The sense of self or self-experienced is almost always altered or changed in some way during the prodrome. Above, I have explored a few ways this might occur. Below I will discuss the ways that these self-experiences relates to the clinical presentation of

prodromal phenomena and how this relates to the cognitive understanding of the prodrome.

Loss of Agency/Voice

Conceptually, psychosis and schizophrenic-like illness in dialogic theory is a profoundly frightening experience during which a person loses her ability to describe the experience and feels a distinct inability to act in response to this experience (Seikkula, 2003). As we know from dialogic theory, a person experiences themselves most fully when he or she is able to engage in an ever-shifting internal dialogue between multiple selves and external dialogue between other people and experiences in their world. During psychosis, the person loses the ability to respond quite frequently within the context of relational dialogues, both within social networks and internally (Bateson et al., 1963; Seikkula, 2003). The self is experienced at its fullest when the capacity for dialogic response is present. It has been theorized by some postmodern thinkers and Open Dialogue researchers and practitioners that loss of the ability to respond is a primary hallmark of the psychotic experience. As described above, the internal dialogue is thwarted in any number of ways during the prodrome; by the barren, monological or cacophonous self-experiences characteristic of the prodrome. One of the consequences of the self-experience being diminished in the prodromal phase is that a prodromal individual experiences a real loss of agency. Loss of agency can be characterized by a loss of the capacity to act, speak and/or respond to the events and experiences of one's own life. In the prodromal phase this is often experienced as a loss of voice. The loss of voice is characterized by the lack of everyday language to describe what is happening to the person. As Seikkula et al. describe it, psychosis can be seen as "one way to deal with

experiences so terrifying they can only be expressed though the language of hallucinations and delusions" (p. 191). In many ways, hallucinatory and delusional communications and utterances are a person's active attempt to make sense of what is happening to them. During the prodrome, these first frightening experiences are often understated, intermittent or overshadowed by a decline in social functioning. Nevertheless, changes occur during this period, most of which are outside of previous experience and words.

The main task of the dialogue in OD is to construct a new language for the difficult experiences of the patient and those in his or her network (Seikkula et al., 2003). These experiences typically have not yet been given language or words that the patient and the social network can use to make meaning and comprehend the incredible frightening experiences occurring in the prodrome. OD is a language-based approach (Seikkula & Olsen, 2003), which is a reflection of the crucial necessity of language in order for prodromal to recapture a sense of agency. Within the dialogic framework, rebuilding the capacity for voice and responsiveness to internal and external dialogue can be the best way to address this aspect of the prodrome.

Contrasting principles: Critiques Using Dialogism and Cognitive Theories

When returning to the clinical phenomena of the prodrome based on the review of the literature, it is crucial to realize that research has shifted over time. The prodrome is conceived now to be a set of factors that signals increased risk for the onset of psychosis. When these risk factors are present and an individual experiences stress or other events that may cause psychotic symptoms in a more general population sample, prodromal individuals are more likely to remain in a pervasive psychotic state. As discussed above,

cognitive theorists often cite the fact that psychotic experiences are actually more common than widely believed (Clark, 2009; Beck, 2004). Cognitive theory asserts, based on the stress-diathesis model, that under circumstances that may cause severe stress, underlying cognitive vulnerabilities will be triggered and maladaptive patterns will emerge. This in fact fits nicely with the prodrome's phenomena; that it can be a time of attenuated symptoms, but more accurately reflects an underlying proclivity towards pervasive psychotic patterns of thinking, acting, feeling and interacting. These patterns emerge as subclinical symptoms, brief symptoms, social or functional decline in the prodrome. Cognitively oriented therapy interventions have the goals of; 1) managing existing symptoms, psychotic, depressive, anxiety and any other co-occurring psychopathology, including substance abuse and 2) preventing the possible conversion into frank psychosis (Auther et al.,2008; Jackson, McGorry, & Edwards, 2001).

We can conceive of the prodrome as both a clinical phenomenon unto itself and yet inextricably connected to psychosis. The prodrome is a distinct clinical entity, as it is a different set of symptoms and clinical presentations than frank psychosis of schizophrenia. However, without definitions or common understandings of psychosis and schizophrenic illness, it is impossible to conceive the prodrome as separate entirely from these phenomena. The prodrome signals risk for psychosis and also shares features, symptoms and patterns with psychosis. In general, prodromal research has been dominated by the medical psychiatry and biopsychosocial models.

One critique that dialogic theory would have of cognitive theory would be in the fundamental idea that a person's thoughts can be "erroneous." This notion implies the modernist conception of "health versus disease" or "right versus wrong"; namely that

there is a healthy way to think or a right way to think and this is contrasted with unhealthy or maladaptive ways of thinking. This is particularly poignant in examining the long-term existent schemas of individuals who suffer from prodromal experiences. Many of these experiences are profoundly disturbing and frightening; however, a person's premorbid functioning often plays a significant role in how they are able to cope with such experiences (Jackson, McGorry, & Edwards, 2001). Cognitive theory offers that a person's distress in the face of psychotic symptoms and experience is real and often exacerbated by their pre-existing schemas, thoughts, and self-references. Dialogism would add that because these thoughts and schemas are automatic and rarely discussed in everyday life, there is a lack of language with which to describe and relate to these experiences. Describing and relating our experiences to others and to all of our multiple self-positions is crucial in the dialogical process. It is also crucial to the dialogic principle of polyphony and tolerance of uncertainty, in which labeling ways of being as "maladaptive" would be seen as unhelpful, stigmatizing and disruptive of dialogic processes. There is growing evidence the supports the idea that stigma and negative expectations themselves are enough to contribute to worse outcomes in psychotic clients and those attempting to recover from the first psychotic episode (Lysacker, Glynn, Wilkniss, & Silverstein, 2010).

OD addresses the dialogical nature of human beings by utilizing a social network perspective. The social network includes those who are nearest to the patient (Seikkula et al., 2003). OD openly acknowledges that the self is a polyphony of self-positions and voices from those in our social network. While tolerance of uncertainty and the social network are believed to be highly helpful in developing a new language-based solution to

the problem of prodromal psychosis, cognitive theory would critique this on the grounds that OD does not go far enough to mend the foundational vulnerabilities that led to the onset of the problem. For instance, redressing cognitive distortions and underlying schema that led a person like James to believe that he was be glanced at menacingly by folks in his neighborhood might include exploring his experience of internalized racism, leading to feelings of vulnerability and fear. CBT would work with James to address the underlying beliefs and choose beliefs that were more in line with healthier functioning. As stated above, management of active symptoms during the prodrome would be crucial in a cognitive paradigm.

In many cognitively oriented treatments, the clients' explanatory model for their own problems or difficulties is explored (Jackson, McGorry, & Edwards, 2001). In cognitive therapy, this serves to build the therapeutic alliance and collaborative approach. Beyond this, from a dialogic perspective, conceptualizing a person's own internal representation of the problem allows for the patient's voice to be heard and to be truly accepted as one possible explanation for ongoing difficulty. The ultimate goal of cognitive therapy is to redress or challenge maladaptive core beliefs and cognitive distortions (Clark, 2009). From a dialogic perspective, this can pose a problem, as it directly challenges the principle of tolerating uncertainty. As we know from dialogism and the Open Dialogue approach, diagnosing or coming to rapid clinical conclusions is something that OD attempts to avoid. In CT, labeling one set of cognitions as "maladaptive" and another "adaptive" and favoring the more adaptive set is an example of striving for certainty. Diaologism would also critique the goal of redressing "maladaptive" core beliefs and cognitions during the prodrome, as this task would be

incredibly challenging when an altered internal dialogue and diminished sense of self are present for the client. Further, such redressing or cognitive "restructuring" requires the capacity to reflect on one's own thinking and self-experience. This capacity, often known as metacognition, is often greatly impaired during psychosis and in the presence of the prodrome (Lysacker, Glynn, Wilkniss, & Silverstein, 2010). CT does implore that building engagement and the therapeutic alliance is crucial to providing safety in order to challenge these beliefs. However, the very notion that one person has the authority or power to privilege thoughts as more adaptive is problematic from a postmodern position. Cognitive restructuring, utilized during cognitively oriented therapy, including Cognitive Behavioral Therapy, is also problematic because it does not address the underlying problems related to diminished capacity for meta-cognition and self-experience.

Commonalities Between Dialogism and Cognitive theory

Cognitive theory and dialogism have several commonalities, despite their divergent origins. These commonalities include the fundamental understanding that psychotic-like experience is more typical among the general population than commonly asserted. Further, both theories assert that disturbance of the sense of self is a primary feature of the prodromal phase. Neither theory attempts to fully explain the cause or fundamental origin of psychosis or its prodrome, but rather explains the way psychotic-like experience comes about, can be adaptive, what vulnerabilities might be present in prodromal individuals and the ways that these vulnerabilities are manifest in situations ripe for psychosis.

Cognitive theory helps us to understand some of the core vulnerabilities underlying the onset of the prodrome. In fact, cognitive theorists and dialogic theorists

assert that psychotic-like or frankly psychotic experiences are more common among the entire population than is generally acknowledged (Beck, 2004; Davidson, 2003; Morrison, 2008). However, most people have these experiences only rarely or under severe stress. Those vulnerable to psychosis or already in the prodromal phase have far more devastating and prolonged experiences that often lead to frank psychosis or schizophrenic illness (Beck, 2004) The cognitive structure in these individuals that is prone to core beliefs about the self such as "different, inept, inferior" (Beck, 2004). Dialogism furthers this conceptualization by acknowledging the different self-experiences in the prodrome that correlate with these descriptions; monologic, barren or cacophonous. Symptoms associated with the prodromal phase are not unlike more common experiences, but only when these experiences become pervasive and intense, causing distress, changes in behavior and cause some decrease in "insight" is a diagnosis of psychosis made (Beck, 2004).

Both cognitive theory and dialogism cite disturbance of the sense of self as one of the most significant experiential difficulties for prodromal individuals (Lysacker & Lysacker, 2009; Nelson et al., 2007; Nelson & Yung, 2008;). As discussed earlier, there are three potential ways that self-experience can be disrupted, altered or diminished in the prodrome. These three ways include the barren, monologic and cacophonous self-experiences. Dialogic theory does help us to conceive of many of the ways that self-experience can be disrupted and how this manifests into prodromal presentations. However, dialogism does not explain the exact mechanism by which self-positions, dialogues and sense of self become hallucinations, delusions, negative symptoms and

social decline. Cognitive theory can work within the dialogic framework to explain in more detail how these self-experiences come about.

Frequently in cognitively oriented therapies, challenging distorted, maladaptive or unhealthy cognitions is part of the symptom management process. If a person has core beliefs that are negative or vulnerable, it is likely these beliefs are not verbalized and a great deal of shame is experienced when these beliefs are brought to light through behaviors or expression of language. During the process of cognitive behavioral therapy, inductive and Socratic questioning is used in a collaborative and safe manner as a way of peeling back the layers of information processing (Morrison, 2008). This is a way of giving voice and language to a previously silenced part of a person's life, which mirrors the significance of a language-based intervention that is also relational and dialogic from dialogism. It is also done within the safety and containment of a relational dyad or group. One of the first principles of CBT in general and specifically for psychosis or first-episode psychosis has been to establish therapeutic alliance (Jackson, McGorry, & Edwards, 2001). This is also aligned with the dialogic idea of social network. In the Open Dialogue approach, the patient is invited to include their social network in the team meeting. The network can include family, friends, teachers, mentors and any other people that are significant in the person's life. This is done as a way of visibly bringing the prodromal person's interpersonal relationships to the forefront in order to address the disruption in interpersonal dialogue. As we know from dialogism, providing opportunity for interpersonal or external dialogue is a way of reawakening the person's capacity for intrapersonal or internal dialogue.

One of the other most salient common factors in dialogic and cognitive theories is that neither theory offers a comprehensive causal explanation for schizophrenia, psychosis or the prodrome. Instead, the theories each help us to conceive of what is occurring during psychotic or prodromal experiences. While cognitive theory is much more rooted in a biopsychosocial perspective, it does offer a refreshing conceptualization of psychotic symptoms. Instead of using the "diseased brain" explanatory model for understanding so-called incomprehensible psychotic symptom content, cognitive theory actually asserts that symptom content can be used to understand a person's circumstances and cognitive vulnerabilities. Dialogic theory, firmly rooted in postmodern theory, asserts that psychotic symptoms are in fact a person's attempt to make meaning out of intensely disturbing and disparate internal experiences. Both theories allow that psychotic-like experience is on the spectrum of reasonable expectable human responses under certain circumstances. The prodrome, therefore, both separate from frank psychosis and yet inexorably linked, also lies on this spectrum of experience.

Understanding the Phenomena in a New Way

In this section I will use components of both theories to provide a synthesis of theoretical understanding. I will end the chapter with a re-assessment of the case material utilizing the synthesized theoretical framework.

The dominance of one or two self-positions can be known as a monological self. As we know, a dialogical self where continual dialogical process occurs inter- and intra-personally. During the prodrome, the hierarchy of self-positions can become fixed in such a way that one or two self-positions become dominant. The resultant difficulty in the intrapersonal dialogical process is significant, as a prodromal person's sense of self is

significantly diminished without prior experience modeling how to return to a full dialogical self. Above, I stated that this could be associated with positive symptoms and emergent delusional thinking. A "monological" self, one dominated by one self-position correlates to the cognitive model of the process by which a person's "inner voice" is externalized, creating auditory hallucinations (Beck, 2009). The inner voice of cognitive theory is actually a multiplicity of voices in healthy individuals. In prodromal individuals, a cognitive structure that favors externalizing adverse events and automatic thoughts that are indicative of vulnerable schemas can lead to the dominance of one or two self-positions. The self-positions are "louder" and can drown out the other self-positions. In this way, self-positions are manifest from inner voices representative of a fixed dialogical process. These one or two voices are externalized outside agents through the process of automatic thought development. As we know, many prodromal individuals begin to fixate on a few beliefs that have bizarre or delusional content. The above process can also help to explain how the preseverative thought and belief system begins to form in the prodrome.

Another possibility in the prodrome is that a caucophony of voices presents itself, whereby an individual feels overwhelmed by a flood of self-positions with no apparent organization (Lysacker & Lysacker, 2008). The lack of relationship between self-positions signals a clear disruption of the intrapersonal dialogic, which leads to disturbance in interpersonal dialogue and the coherent sense of self. This disorganized presentation could manifest itself in loosening of associations, reports of voices or lack of coherence in language, as is frequently seen in the prodrome either as subclinical hallucinations and delusions, as well as disorganized thinking, difficulty in concentration

and social and functional decline. Cognitively, the prodromal person is unable to properly process information as it enters the person's perception.

Yet another presentation in prodromal individuals appears to be what most clinicians would deem "negative" symptomatology. This is characterized by undeveloped or fragmented self-positions. In this case, an individuals' dialogue with others is likely to be limited and discontinuous. James' case is a good example of this kind of experience of self-diminishment based on disrupted dialogical processes. In cognitive theory, the "barren" or more silent presentation is in fact an active coping skill. The disengagement in communication and social skills is a way of managing intensely disturbing affect associated with such dialogue. We can conceive of the barren or empty self as correlated to negative symptomatology. The cognitive conception of the negative symptoms of the prodrome (i.e. social withdrawal, avoidance of social contact, avolition) are seen as active coping skills used to assist the individual in mitigating the disturbing content of his thoughts and the associated negative affect (Clark, 2009). The person also often searches for evidence to support the beliefs she has chosen to explain her unusual internal experiences. Rather than characterizing this as evidence of lack of insight, as is traditionally done with refractory delusions, it is much more helpful to see this as the person's struggle for meaning.

Application to Case of James

The case of James reveals what could be called negative symptomatology and a self-experience that appears to be barren or perhaps monological. When asked what brings him in for an evaluation, James states that he doesn't know why he is there, which can lead us to assume that he has little awareness of the problems that have caused his

social network to have concern for him. He has retreated from his friends and other social activities, such as playing basketball. He shows little enjoyment or motivation in the activities he once engaged in. He has also begun to refuse to attend school. When he was attending school, he frequently lacked language to describe his thoughts, intentions, experiences and emotions. His self-narrative seems to certainly be impoverished, as he is unable to capture his experience in words. Rather, his inaction seems to speak louder than anything he has said.

We cannot know what James' subjective self-experience is, as we have limited material from the case and his capacity for language seems to be disrupted. What little we do know, however, points to a diminished sense of self. He feels uncomfortable around others, unsure of himself and how to act. He gets the sense that people are looking at him menacingly, he is not sure if he should make eye contact with others. He also has the sense that he is having déjà vu with relative frequency. All of these experiences could signal either a diminishment of available self-positions, as in barren sense of self, or the dominance of one or two fixed self-positions, as in monological self-experience. For example, James states that he finds New York dirtier and noisier after returning from South Carolina. This may signal a difficulty in James' ability to shift to and from the self-position of self-as New Yorker to self-as visiting other places, for instance. He becomes fixed that something is no longer the same in New York and has difficulty re-entering his self-position in this context.

One of the characteristic images of the prodrome is captured in the case of James; James sitting by himself, silent and unable to describe what is happening to him when he is discovered by the janitor at his school. This occurs after James has isolated himself

from his friends and family and lost interest in many of the activities he once enjoyed. Even more striking, James is literally at a loss for words when asked to write an essay in class. Upon hearing this passage, one is at once stuck by the silence and inability to act that James is struggling with. Within this very imagery, we can find core components of dialogic theory; the lack of language, interpersonal and intrapersonal dialogue, loss of agency and diminished sense of himself.

From cognitive theory, we can see that James has perhaps an underlying externalizing bias, as evidenced by his increased thoughts about politics, blaming George Bush for 9/11 and fantasizing about violence, and feeling that society was controlled by TV and mass media, all coinciding with his diminished self-experience and experience of himself as different, uncomfortable and unable to act in appropriate ways. Many of his thoughts are common and contextually quite typical as a black, teenage male living in New York City. However, he appears to have a proclivity to locate his difficulties outside of himself, which can lead to automatic thoughts that are externalized, negative and indicate underlying schemata and core beliefs based on vulnerability towards psychotic-like thinking.

Based on the research suggesting three prodromal syndromes, as stated in other chapters in this thesis, James could meet the criteria for the prodrome. Based on the Genetic Risk and Deterioration syndrome (GRD), (assuming that James' mother's psychotic-like experience does indeed qualify for genetic risk), James does in fact show significant signs of social and role functioning decline. It is also possible to argue that he is experiencing attenuated psychotic symptoms (hearing his name whispered, seeing the dark shadow, feelings of paranoia, etcetera), which are captured by the Attenuated

Positive Symptoms syndrome (APS). One of the challenges to using an objectified instrument to account for prodromal risk is that, as in the case of James, the symptoms are frequently difficult to categorized and objectify. There are several examples of this within the case material: the questions of James' mother's "psychotic break" accounting for genetic risk, cultural and race factors including James' experience of paranoia as a young black male in his neighborhood, and other vague but unusual perceptual and sensory abnormalities.

Coupled with these underlying vulnerabilities and his limited sense of himself, James is already exhibiting signs of negative or diminished self-experience. Given the above criteria signaling a vague risk, evidence of a negative symptom picture and from our new understanding of the prodrome based on both cognitive and dialogic theory, it is certain that James is at high risk for psychotic experience. We know from this new understanding that negative symptoms often indicate an active attempt to cope with an altered sense of self. We can also extrapolate that James' extreme withdrawal and lack of language signals limited options for self-positions and a lack of language for describing his experience. We know from his mental status exam that he was able to describe a limited self-experience in the last few months. His initial reaction to why he was evaluated, however, is indicative of severely limited language-based communications of what is troubling him.

Limitations

There are certainly limitations to these theoretical conceptualizations. One question that may arise is related to the notion that psychosis may arise as a result of chemical imbalances in the brain or structural brain abnormalities. Both theories do allow

for the possibility that brain dysfunction or abnormality could be the cause of psychosis and its prodrome. Cognitive theory, for instance, would respond that the conflation of biological, neurological, psychological and social factors combine to contribute to vulnerability and onset of psychotic illness. This thesis has explored psychotic illness that is not related to medical illness, substance abuse, or severe affective or mood disorders. In the absence of these conditions, there are still aspects of psychotic illness that appear to be left unexplained by cognitive theory. The theory rests on the principle that human suffering related to psychopathology has psychological underpinnings related to information processing. Many human experiences are outside the cognitive realm and involve physiological and special sensations, affect, emotion and meaning making, among many other things. Cognitive theory heavily rests on reflection on thinking, cognition and intellectualization of human experience, which does preclude many other ways of experiencing and understanding the world.

Cognitive theory allows for any number of conditions to interact and explain the etiology of psychotic illness. This leaves us with innumerable factors combining in causation of psychosis. While the significance of cognitive theory's contribution is notable in understanding how psychotic thinking can be understood and addressed, it still leaves many unanswered questions about how to more narrowly conceptualize biological, genetic, neurological and developmental causes.

Dialogism, on the other hand, makes no claims at definitive etiological theory of prodromal syndromes. Postmodern theories, dialogism included, would state that psychotic symptoms are not actually symptoms of an underlying disease, but rather are a response to circumstances in which prodromal symptoms make sense. These "symptoms"

are an indication of the prodromal person's response to their altered sense of self. However, we do not receive clear information about where self-disturbance originates and how it comes about.

This thesis is limited to the two theoretical frameworks I have chosen to explore. The choice of these theories and my way of exploring and synthesizing them reveals my own theoretical and practical biases and is one way of conceptualizing the clinical phenomena of the prodrome.

Treatment and Practice Implications

The primary goal of treatment would be to assist James in moving from the collapse of internal and external dialogue towards improved capacity for such dialogue. Because James appears to be suffering with barren self-dialogue, it can also appear that in the diminishment of self-experience, self-positions have been lost of eliminated during the prodromal period. It could be assumed that the mechanisms of distorted cognitions and diminished dialogical processes means that cognitive ability and dialogical capacity have been lost, but this is actually not the case. As we know from research on self-disturbance and neurocognition, these vulnerabilities are often present in pre-morbid period and often onset more fully during the prodrome. Cognitive and dialogical capacity can be built during therapeutic interventions that include relational dialogue, promotion of internal dialogue, awareness of the role of automatic thoughts and cognitive thoughts in relapsing prodromal symptoms.

Psychotherapy is at its core a relational dialogue, involving an interpersonal dialogue between the therapist and the client. If self-experience is disrupted in its capacity for dialogue by the prodromal experiences, then providing access to increased

dialogue is a viable foundation for beginning treatment. Access to latent self-positions must also be addressed. There is evidence to suggest that initiating external interpersonal dialogue can assist in re-establishing intrapersonal internal dialogue (Lysacker & Lysacker, 2002). James' limited available self-positions could be rebuilt with the support of a therapist, with the therapist serving to assist in challenging automatic thoughts that can limit James' access. Tolerating uncertainty will be a crucial aspect of treatment, which can be somewhat hard to reconcile with cognitive behavioral work. It will be important for the therapist to *not* create a new self-narrative, new self-positions or initiate self-experience for James, but rather to use the therapeutic alliance to identify agreed upon cognitive distortions and automatic thoughts that are preventing the full range of self-experience.

It is also important to include the social network in James' treatment as a way of continued interpersonal external dialogue. This will also make it possible for the family to access language for what was previously difficult or impossible to describe. This can serve as a model for James' own internal dialogue. It can also serve to rebuild interpersonal connections that represent existent but silenced self-positions, such as self-as-son, self-as-brother, self-as-part of family, self-as Black or African American, etcetera. Returning to self-positions that have lain dormant can help to enrich the self-narrative and lessen feelings of paranoia, discomfort and limited sense of self that accompany negative externalized thoughts.

Conclusion

It is clear that the suffering and mental anguish experienced during the prodromal phase of psychosis warrants clinical attention. From this current study, we can conclude

that self-disturbance present during the prodromal phase and perhaps prior to the prodrome is quite likely to be one of the defining features of psychotic illness. Both cognitive theory and dialogic theory help us to see how underlying vulnerabilities conflate to create a diminished self-experience for individuals at high risk for schizophrenic illness. In turn, this disturbance of sense of self may be the crucial risk factor or indicator of psychotic experience. The two theories allow us to see the mechanism by which self-experience is altered in prodromal syndromes. This alteration lays the groundwork for the entrenchment of psychotic illness. Cognitive theory and dialogic theory, taken together, can offer many practical clinical interventions that address the key disruptions that occur during the prodrome.

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