Evidence-Based Psychotherapies

Reasoning with Psychosis Patients: Why Should a General Psychiatrist Care about Cognitive-Behavioural Therapy for Schizophrenia?

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Evidence of Treatment Efficacy and Effectiveness

It is now generally accepted that optimal management of schizophrenia requires a comprehensive approach combining pharmacologic management with psychosocial interventions (1). One of the most exciting developments in the last decade is the body of work indicating that cognitive-behavioural therapy (CBT) adds to treatment efficacy in schizophrenia. Much of the controlled research has been done on treatment-resistant patients with chronic schizophrenia, with CBT interventions modified for psychosis added to usual pharmacologic and case management. In this research, patients receiving CBT experienced greater improvement of positive symptoms, negative symptoms and distress than did patients in treatment-as-usual or comparison conditions (2–10). Rector and Beck (11) found effect sizes on positive symptoms of 1.3 for CBT, compared with 0.63 for controlled conditions; they found effect sizes of 1.08 on negative symptoms for CBT, compared with 0.47 for controlled conditions. CBT conditions continued to demonstrate benefit over controlled conditions three to 18 months later (2,7,8,10,12–14).

CBT interventions in the acute phase of psychosis have had mixed results. Drury and others found that intensive CBT for inpatients with acute psychosis reduced time to recovery by 25 per cent to 50 per cent, shortened admission time by 50 per cent, and reduced relapse rates over the ensuing nine months, compared with control interventions (15). However, gains had largely disappeared after five years (16). Two studies targeting inpatients in the early years of psychosis were disappointing (17,18).

While CBT’s efficacy in treating chronic schizophrenia has been established, the question of effectiveness is vital. What would results be in actual clinical practice, with practitioners less expert in CBT for psychotic disorders and without the extensive training, supervision and treatment integrity checks characterized by controlled clinical trials? Turkington and Kingdon (8) tested a brief, focused “cognitive techniques” approach comprising six sessions of 20 to 40 minutes each over a period of two months. Both the time commitment and the nature of the cognitive techniques involved were considered feasible for general psychiatrists and did not require extensive specialized training. Schizophrenia patients in various inpatient and outpatient settings received either the cognitive techniques intervention or a time-matched “befriending” intervention delivered by a consultant psychiatrist, in addition to the usual management by their treating team. Patients receiving cognitive techniques interventions significantly improved on symptom measures over the two months of treatment, while those receiving befriending interventions did not. In addition, the cognitive techniques group spent less than one-half the time in hospital during the six months following the commencement of therapy. The authors conclude that outcomes could improve if psychiatrists moved from a medication-monitoring stance to a more hands-on approach with psychosis patients.

A second study evaluated brief CBT delivered by non-expert therapists in a secondary care setting (9). Community nurses received 10 days of training in CBT and ongoing weekly supervision. They administered up to six hour-long sessions of CBT to schizophrenia patients over a period of two or three months. Compared with a treatment-as-usual group, the CBT group experienced significant improvement in overall symptomatology, insight and depression, together with fewer drop-outs. The authors comment that symptom changes are comparable to those delivered by expert therapists and better than those observed with psychoeducation or family therapy alone.

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Cognitive-Behavioural Therapy for Schizophrenia

CBT approaches are to be distinguished from cognitive remediation, which targets the cognitive deficits in attention, memory, social perception and executive function found in schizophrenia (1). Rather, CBT for schizophrenia has as its central focus the psychotic experience and a person’s attempt to understand it (19). Delusions and hallucinations are seen as existing on a continuum with normal beliefs and perceptions, with varying levels of conviction, pervasiveness and flexibility. The content of psychotic symptoms mirrors everyday concerns, such as the fear of being excluded, demeaned or attacked. These aberrant beliefs and perceptions develop and are maintained by information-processing biases such as the tendency to overestimate coincidences, jump to conclusions, attribute internal events to external sources and blame others when things are not going well. These and other biases have been found experimentally to distinguish subjects vulnerable to psychotic illness from control subjects (20).

Several comprehensive CBT approaches to psychosis have been elaborated (21–24). While there are differences among them, all draw on the cognitive therapy principles established by A.T. Beck and colleagues (25). Therapist and patient work collaboratively, setting session agendas and therapy goals. Thoughts in problematic situations are identified, their impact on mood and behaviour elucidated and thinking biases identified. Thoughts are considered to be hypotheses that, through gentle questioning and guided discovery, can be examined, tested and modified.

Standard CBT techniques have been modified in several ways to address problems specific to psychosis. These modifications are described below.

1. Most important is the creation of a strong therapeutic alliance—which may be difficult with patients struggling with mistrust, suspicion and denial. By working initially from the patients’ perspective and accepting their thoughts and feelings without judgement, the necessary atmosphere of trust can develop. Sessions should be tolerable and emotional upset modulated by changing the topic or shortening the session.

2. Therapist and patient arrive at a joint understanding of the psychotic experience that involves normalizing it and reducing stigma. The focus is not on psychoeducation about the diagnosis of schizophrenia, (which may never be part of the patient’s understanding) but rather on elaborating an individualized account that links the patient’s life history and personality with the stressors and factors shaping the development of fearful beliefs or experience of voices.

3. Working with delusions involves gentle questioning rather than direct confrontation, as the latter has been shown to strengthen rather than weaken conviction in delusional beliefs (20). First, the context, meaning and emotional or behavioural consequences of the delusion are fully explored. Peripheral beliefs are addressed before more central ones. For example, a recent immigrant felt that the government was transmitting his thoughts worldwide. In his case, the initial focus was on questioning the technical feasibility of this idea. Later, the patient was prepared to explore the more central idea that he was not wanted in this country. A technique called inference chaining (8) is particularly helpful for resistant delusions: the patient was asked what it would mean to him if it were provisionally accepted that the government was in fact persecuting him. His responses revealed underlying beliefs about his own worthlessness and about being generally unwanted, for which he had tried to compensate by working hard and starting afresh in a new country. The delusion performed the function of protecting his self-esteem against depressing underlying beliefs—that were targeted more fruitfully than the persecutory delusion itself.

4. Working with auditory hallucinations focuses on the beliefs about the voices, rather than on the primary experience itself. Eighty-five per cent of voice hearers perceive their voices as powerful and omnipotent and themselves as weak and dependent—perceptions that have been linked with compliance to command hallucinations (26). Chadwick and Birchwood have elaborated an approach to voices involving beliefs about the identity of the voice, its purpose, its omnipotence and its controllability (24). Distress is significantly reduced when patients question these assumptions, learn techniques that modify the voice’s intrusiveness and discover through behavioural experiments that no dire consequences ensue when they disobey the voice (27).

5. Negative symptoms are approached in much the same way as is depression. Behavioural tasks include self-monitoring, activity scheduling, assertiveness training and graded task assignments. Cognitive targets include personal interactions and perceptions of others (perceived as “too demanding”) and the self (perceived as “a failure”) that may contribute to low self-efficacy and hopelessness. Secondary anxiety and depression are dealt with in a traditional CBT manner, with the understanding that psychosis is a major trauma threatening self-esteem.

6. Therapy terminates with an elaboration of the initial understanding of psychosis, a review of gains made and a review of the individual’s precursors to relapse. Likely obstacles to ongoing recovery are anticipated and planned for. The role of medications, social supports and services is discussed and the advantages and disadvantages of different strategies weighed. A didactic, directive approach is avoided: as in many other conditions, highlighting ambivalence, rather than adopting a firm position in favour of a given strategy, enhances motivation (28).

Relevance for the General Psychiatrist

The use of CBT approaches is an important development in the treatment of psychotic disorders. Not only does CBT improve outcomes in the lives of patients with psychosis, it also appears that it can be easily learned and
applied in community settings by psychiatrists and other community mental health workers. Despite the time commitment and expense that implementing CBT may initially require, reduced distress, symptoms and hospitalization rates may ultimately prove economically beneficial. While this possibility must be more fully explored, Kuipers and colleagues’ economic analysis of their study found the costs of CBT to be offset by reductions in service use and associated costs at 18-month follow-up (12).

Patient acceptance of CBT interventions is high, with study participants in trials at three separate centres reporting a satisfaction rate of 80 per cent or over (4,9,27). Turkington and others’ study used trained nurses in community setting and found that 57 per cent of participants rated their brief CBT program as helping them more than any previous treatment to understand their illness (9).

Do psychiatrists have time to talk to patients about their symptoms? Biologic psychiatry often frames schizophrenia in terms of abnormal neuronal transmission and brain dysfunction. In this model, the role of busy psychiatrists is to prescribe medication. Nevertheless, shared, credible explanations of psychosis that incorporate a vulnerability–stress model (29) and explain events with reference to the patient’s life have been found essential in improving treatment adherence and better coping with a devastating illness (8). Brief, focused CBT intervention such as that devised by Turkington and Kingdon (8) requires more time than medication monitoring, but it may be time well spent. These authors also argue that, when psychiatrists do not talk about psychotic symptoms, the rest of the treating team often follow suit, leaving patients with little opportunity to test out aberrant beliefs and develop coping strategies (8).

When participating in the development of treatment and training programs, psychiatrists should also consider how resources are best allocated. Mental health team members may spend much time in supportive encounters with patients; they could, with modest training, use cognitive principles cost-effectively to reduce distress and improve symptomatology and coping. Postgraduate programs should teach basic CBT skills to psychiatry residents, who could then use them in conjunction with medication to improve outcomes in many disorders.

Conclusion

Many questions remain concerning the use of CBT to treat psychosis. What are the effective ingredients of the approach? Are there subgroups of patients who respond better to CBT than others? Can CBT change the illness trajectory in schizophrenia? How does CBT interact with medication use and psychosocial interventions such as family work, cognitive remediation and social skills training? What is the optimal combination of these interventions?

Despite the work left to be done, it appears that CBT combined with standard treatments provides significant improvement in both positive and negative symptoms in schizophrenia. CBT for psychosis considers delusions and hallucinations on a continuum with normal beliefs and then gently explores them with special attention to the quality of the therapeutic alliance. Understanding the personal meaning and context of symptoms is integral to the approach and eases the burden of suffering in individuals with schizophrenia.

References


Continued on p 22


Myhr continued from p. 14


