Cognitive–behavioural therapy for psychosis

I am writing to comment on this debate (Turkington & McKenna, 2003) from the point of view of a practising clinician who regularly works with people who are experiencing or recovering from psychotic symptoms. I find both cognitive–behavioural and psychodynamic models useful in my work.

Many research practitioners have reservations about using randomised controlled trials as the main test of the effectiveness of psychotherapeutic interventions (see McPherson et al, 2003). Problems raised relate to the method developed for trials of medication on the assumption that psychotherapy works in the same way. For example, blindness to modality in patients and therapists is not possible, randomisation is ethically questionable and is unlikely to bring about the best clinical outcomes, and use of control groups is problematic as it is impossible to control the variables sufficiently to be sure of revealing specific effects. Given these reservations, the apparently small effects of cognitive–behavioural therapy (CBT) with psychosis obtained in randomised controlled trials might be seen as very encouraging. Many studies have included medication-resistant patients, which adds to their significance.

It is interesting that some of the controls employed, such as supportive counselling and befriending, also obtained short-term improvements over treatment as usual. Much more work needs to be done to tease out the different active ingredients in different kinds of work with individuals. This was the conclusion reached by a detailed meta-analysis of CBT (and other interventions) for schizophrenia (Pilling et al, 2002). There is recent evidence for effectiveness of psychodynamic psychotherapy with psychosis under certain conditions (Jackson, 2001). Cognitive and psychodynamic psychotherapists have begun to explore areas of common ground, possibilities for recognising the different contributions from different approaches to therapeutic work and the issue of suitability of individuals to different paradigms of intervention (Milton, 2001). Furthermore, there is currently much interest in the contribution of the social environment to ongoing disability in psychosis, which may link with the success of befriending. The Department of Health’s (2001) Mental Health Policy Implementation Guide on early intervention in psychosis encourages services to address issues around stigmatisation and social marginalisation. These areas of intervention can combine in a flexible and holistic approach that is both sophisticated and acceptable to individuals with psychosis, and that (along with the undoubted contribution of medication) offers them worthwhile options for treatment and support into recovery.

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Turkington & McKenna (2003) debate the disingenuous title of whether CBT is worthwhile for psychosis. It is clear that conflict of interest has led to a publication bias with an absence of negative clinical reviews of CBT in the literature. Even so, the current evidence base relies on studies that are based in experimental settings, address a broad spectrum of different diagnoses, and have problems with fidelity to a specific CBT treatment. The most recent meta-analysis (Cormac et al, 2003) finds no convincing change on rating scales at long-term follow up of CBT treatment for schizophrenia, and Pilling et al (2002) suggest that further research is needed to elucidate the therapeutic factors that mediate mental state changes in psychosis. In addition, the most recent published randomised controlled trial of CBT reported no significant differences in clinically significant outcome or even on a unique patient-rated scale (Durham et al, 2003).

The efficacy of these trials with reference to relapse rates or hospital usage is not proven when compared with standard treatment or generic supportive counselling, and the case for the effectiveness and cost-effectiveness of specific psychological treatment teams working with people with psychosis has not been made.

The aim of CBT for psychosis is to develop a collaborative explanation of symptoms and experiences, with a theoretical mechanism of effectiveness to increase control and decrease distress. This aim cannot be accomplished without an aetiological understanding based on hard evidence. The problem of diagnosis of psychosis needs to be addressed since the trials included subjects with a mixture of chronic and acute psychoses, and there was no attempt to assess the duration of untreated illness prior to intervention (independent of whether the index episode was a first or subsequent episode). Worse outcome has been associated with longer duration of untreated psychosis (Johnstone et al, 1992). Rather than abandon CBT for psychosis because of its unproven clinical effectiveness, the way ahead may be to focus on symptom profiles linked to an axis of duration. A theoretical stage-specific CBT model would not exclude the clear biological neurotoxic aetiology of non-affective psychoses, and allows this debate to move on.


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NICE guidelines and maintenance ECT
The recently released National Institute for Clinical Excellence (NICE) guidelines on the use of electroconvulsive therapy (ECT) discourage the use of maintenance ECT in depressive illness, the reasons being that: ‘. . . the longer-term benefits and risks of ECT have not been clearly established . . .’ (NICE, 2003).

The only result of this will be to limit the patients’ right to choose their treatment. The few patients who are considered for maintenance ECT live in the community and, therefore, are not subject to the Mental Health Act 1983. They will receive ECT because they want to and will have at any time the right to withdraw from it. These patients will have already tried, unfortunately without success, any other possible maintenance treatment and tend to respond only to ECT during their frequent acute episodes. Because of these experiences they know very well the pros and cons of ECT in their individual cases.

These are patients who, knowing their illness and the effects of ECT, have reached the conclusion that they prefer to receive ECT on a monthly basis rather than having to accept a life sentence of constant and frequent relapses of their depressive illness. If the maintenance ECT works and keeps them functioning in the community, it is my experience that they will be happy to continue with it for a long time. If it does not work, after a few attempts they will stop, encouraged by their psychiatrist.

Every patient is different and we still know very little about depression. The only result of the application of the NICE guidelines on maintenance ECT will be to deprive informed and intelligent patients of the freedom to choose a treatment that, if used appropriately, can make the difference between a life of misery and a relatively normal existence (Andrade & Kurinji, 2002).

Consistent with the report of Jones et al, we found a striking difference in the prevalence of flashback symptom severity across generational cohorts. However, with specific questioning about this symptom using the standard diagnostic instrument for PTSD, the Second World War cohort who suffered extreme stress and currently meet criteria for PTSD did report flashbacks. The six former POW subjects who reported a current clinically significant level of flashbacks have informed us that this phenomenon was present in the 1940s. Of course, we cannot know whether these subjects would have reported flashbacks in the 1940s without having been exposed to the interim cultural changes.

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Counselling and psychotherapy: media distortion
As the authors of the Cochrane Collaboration review on ‘psychological debriefing’ (Rose et al, 2002) following exposure to a traumatic experience, we were concerned to see our research taken out of context during the recent media debate on counselling and psychotherapy. Our research related to the lack of evidence supporting a ‘one-off’ intervention following trauma. Even its proponents would not regard this intervention as counselling or psychotherapy. Yet journalists have cited this research as new and generalised its findings to the extent of proclaiming that all counselling and psychotherapy is not useless but dangerous. This is unjustified.

The research is not new. We first published this as a systematic review in 1998 (Rose & Bissin, 1998) and it continues to be updated in the normal way. The generalisation of our findings is scientifically unacceptable and, more importantly, potentially harmful. It is clear that counselling and psychotherapy are not beneficial to everyone. However, there is good evidence that many psychological treatment approaches are effective, including multiple-session early
intervention following traumatic events for those with acute stress disorder (Bryant et al., 1999).

Mental health problems are stigmatised, yet we now have powerful evidence-based psychological treatments for many common but serious disorders such as depression, phobias, panic disorder and obsessive–compulsive disorder. It would be regrettable if the legitimate debate on the role of counselling for everyday problems and difficulties were to inadvertently prevent people with treatable disorders from accessing helpful psychological therapies.


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One hundred years ago

A hospital for the insane in Syria

The treatment of lunatics in the East has not yet fully emerged from the clouds of ignorance and barbarism which have surrounded it for ages. One of the first reformers who attempted to introduce the methods of humanity and science in this field in the near East was Mr. Theophilus Waldmeier, a gentleman resident in Syria, who commenced in the spring of 1896 the work of helping and providing for the numerous sufferers from mental disease in Syria and Palestine. His efforts were crowned with success and within two years a hospital for the insane was built near Beyrouth on the slopes of the Lebanon Mountains. This institution has been in full working order and has been doing good work for two years. In the fourth annual report recently issued there is an account of the institution and of its work for the year ended March 31st, 1902. The building, which includes wards for male and female patients, is of stone; the grounds, which were hitherto barren, have been cultivated; and at the time of the report (1902) there were about 35 patients in the hospital. Patients come and go without much difficulty being experienced, as relatives are sometimes prone to take them away before recovery is complete. “One poor Jewish woman was brought to the hospital suffering from acute mania. . . . She was left by her relatives apparently under the idea that she would be miraculously healed in a day or two by the doctor. After a few days they returned and found her about the same, and being disappointed at this they immediately took her away, probably to put her in some dungeon or cave noted for casting out evil spirits, there possibly to die in chains.” Fortunately, adds the report, such cases are becoming rarer as the results of the work of the hospital are becoming more known amongst the people. 14 patients were discharged as recovered during the year. New wards are nearly completed for increased accommodation, so that the hospital will shortly be able to house 100 patients. 52 patients were admitted during the year.

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