Pathways to psychological treatments for psychosis

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Abstract

The distressing symptoms of psychosis, delusions, and hallucinations used to be thought of as unsuitable for psychological therapies. Recent research on the continuities between normal experiences and those found in psychosis has led to the development of a wider range of psychological therapies, adapted from approaches for anxiety and depression, to the more complex presentations found in psychosis. These can include overlaps with anxiety disorders, depression, obsessive–compulsive disorders, trauma, and personality disorders. Many people also have comorbid substance misuse. In addition, there are issues relating to stigma, social exclusion, and barriers to recovery. Thinking about these overlaps has led to more creative therapeutic approaches with a developing evidence base. Of these, family interventions for psychosis and cognitive behavioural therapy for psychosis have some evidence for efficacy, and are recommended by National Institute for Health and Clinical Excellence guidelines for schizophrenia in combination with antipsychotic medication (being updated in 2008–2009). Problems remain regarding improving effectiveness, implementation, and increasing access across the National Health Service to psychological therapies for those with these more severe conditions.

Keywords anxiety; cognitive behavioural therapy; community management; delusions; distressing positive symptoms; family intervention; hallucinations; psychosis; schizophrenia

The positive symptoms of psychosis used to be defined as unamenable to rational argument and thus not likely to be responsive to psychological treatments. Indeed, the case against psychodynamic approaches in psychosis was made forcefully by Mueser and Berenbaum.[1] However, particularly in the last 18 years, evidence for both family interventions and individual cognitive behavioural therapy (CBT) for psychosis has accumulated; meta-analyses and reviews of both areas now suggest that these specific psychological interventions can be efficacious.[2–5] This has been confirmed by the National Institute for Health and Clinical Excellence (NICE) guidelines for schizophrenia,[6] due to be updated 2008–2009.

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What's new?

- NICE guidelines for schizophrenia confirm that cognitive behavioural therapy and family intervention are efficacious psychological treatments in psychosis, in combination with optimal medication. They are being updated for 2008–2009
- Cognitive remediation, which involved retraining attention and memory skills, has a developing evidence base
- For the psychological management of psychosis in the community, the recovery model is seen as helpful, with its emphasis on optimism and reducing social exclusion

Continuum of experiences in psychosis

From a psychological perspective it is no longer thought that psychotic experience is qualitatively different from normal experience. There is now good evidence for this idea of a continuum, with considerable overlap between 'normal' populations and those with identified psychosis. This suggests strongly that those who comprise clinical populations are more likely to show distress, and that high levels of conviction and preoccupation do not distinguish normal and delusional ideas.

Since the 1980s it has been argued that single-symptom research (i.e. into delusions or hallucinations) is more productive than diagnostic systems which are not stable and do not predict treatment or outcome.[7] Subsequently, Garety and Hemsley showed that people with delusional beliefs have reasoning biases and then 'jump to conclusions'.[8] People with psychosis may also have poor source monitoring and a disruption to the 'sense of self'; they may show attributional biases and attentional preference for a 'negative' world view. More recent models of psychosis suggest that basic psychosocial or biological vulnerabilities interact with cognitive and emotional factors to bias appraisals, so that anomalous experiences become psychotic symptoms, and that these processes, plus isolation and stress, help both to develop and then to maintain such symptomatology.[9–13]

Consideration of the overlap, rather than the divide, between psychosis and other conditions has allowed more creative use of psychological therapies. CBT, which has been found to be useful in conditions such as anxiety and depression, has been adapted in order to encompass the attentional, reasoning, and attributional biases, cognitive deficits, and social sensitivity found in psychosis. Turkington and Kingdon[14,15] have proposed that different sub types – 'sensitivity to stress', 'drug related', 'anxiety' and 'trauma' psychosis – are more meaningful to service users and also less stigmatizing than the term 'schizophrenia', although further work is needed to establish reliability or validity for them. It can also be helpful to think about the emotional and cognitive pathways both into and out of psychosis, in order to consider the range of treatment strategies available. Thus, dismantling the categorical nature of psychosis has encouraged more flexible thinking about therapy.

Pathways to psychosis

Anxiety: psychotic experiences are particularly likely to be triggered by panic or high levels of anxiety to a wide range of 'threat'. The overlap between schizophrenia and anxiety states is around 40%. Recently we have shown that, after a relapse, patients' high anxiety could be predicted by high expressed emotion levels (criticism) in carers.[13] This suggests that the affective route might be particularly important in family intervention work.

Depression: the pattern here is around low self-esteem, low mood-induced psychotic experiences such as hallucinations, and the depressive content of delusional ideas. The evidence for the overlap between psychosis and depression is quite marked, with 40% of those with psychosis having low self-esteem. Extreme negative evaluation of self and others is linked to negative schemas, which are in turn linked to symptom distress. In one study up to 50% of patients with recent-onset psychosis had clinical depression.[16] About 30% of those with schizophrenia will attempt suicide, and between 5% and 15% will commit suicide.

Post-traumatic stress disorder (PTSD): around 30% of individuals with diagnosed psychosis also satisfy criteria for previous trauma. Frame and Morrison[17] have suggested that there is a range (46–98%) of overlap between acute psychosis and PTSD. Bebbington et al.[18] showed that people with psychosis have raised rates of previous trauma, particularly bullying at school and abuse. We also have evidence that trauma can lead to higher levels of intrusions in schizotypal groups, and these may indeed be misinterpreted, leading to psychotic symptoms.

Obsessive–compulsive disorder (OCD): Berman and colleagues[19] found that 25% of their sample with schizophrenia had identified obsessive or compulsive symptoms. Clinically there can be overlap between the thought–action fusion seen in OCD and the compulsion felt from command hallucinations. Repetitive voices and processes, such as worry, seem to differ in how they are experienced (as external rather than internal), more than in content or intrusiveness. Similarly some of the slowness and cognitive blocking found in OCD has overlap with the thought content accompanying negative symptoms, which is often unexplored or not well articulated, except as 'blankness' or more formally as thought block. We have recently found those with persecutory delusions have high levels of rumination.[20]

Personality disorder: for others with psychosis there seem to be issues of rigidity of thinking, a 'paranoid personality' including relationship problems, which predate the onset of frank psychosis, and a tendency to categorical rather than flexible thinking styles. We already know that reasoning biases relate to conviction in delusions, with a higher level of jumping to conclusions (using less evidence) and belief inflexibility.[21] Other evidence shows that those with psychosis may lack any alternative explanations for their ideas.[22] A survey of overlap between personality disorder and psychosis in a London community mental health team showed co-morbidity to be around 40% with much higher service use.[23]

Cognitive behavioural therapy for psychosis

CBT for psychosis developed initially from CBT for depression. Promising early case studies and uncontrolled trials have been endorsed to some extent by the results of larger randomized controlled trials (RCTs) of patients with medication-resistant psychosis. The NICE guidelines for schizophrenia reviewed evidence for 13 RCTs (n = 1297)[6]; other meta-analyses have been published since.[24–26] Evidence so far suggests that CBT is useful for persistent symptoms of psychosis and that longer treatments are more effective. Although supportive therapy can show gains during therapy, CBT can show improvements that continue during follow-up. Effect sizes remain small to moderate. NICE currently recommends that CBT should be made available to those with persistent symptoms. However, our understanding of the mechanisms involved needs to improve to increase effectiveness.[27]

Approaches used in CBT for psychosis vary somewhat, but include engaging patients in non-aversive individual sessions, help with improving coping repertoires, reviewing and reality-testing evidence that maintains delusional beliefs, re-evaluating beliefs about hallucinations, and improving self-esteem. Approaches focus on problem-solving and coping, on the meaning of symptoms and developing a joint model to inform intervention,[28] and on normalizing and dealing with beliefs.[29] Motivational interviewing to help patients consider the pros and cons of medication adherence may be part of these interventions. Interest in early intervention in psychosis is theoretically well argued. Evidence is just beginning to emerge that it can be helpful, does not make things worse, and may delay transition in prodromal cases.[30,31]

Family interventions

Family work for psychosis predates CBT, as it was developed in the 1980s. At that time it was felt that individual approaches could make things worse. It was also known from the literature on expressed emotion in families and from life events that 'toxic' environments were associated with poor outcomes in psychosis. These environmental effects were described in the stress vulnerability models of psychosis, current at that time.

The NICE guidelines included 18 RCTs of family intervention (n = 1458).[6] The most recent Cochrane update includes 43 studies in total (n = 4124).[5] The evidence shows that family intervention reduces relapse in schizophrenia. The guidelines recommend that family intervention be made available to those in contact with carers. Psycho-education on its own is recommended as a good practice point, but tends not to change outcomes. Interventions found to be helpful include involving whole families, psycho-education, improving communication, problem-solving, and cognitive reappraisal of difficulties. Several manuals are available.[32–34]

Other psychological interventions for psychosis

There are other psychological interventions, such as social skills training and cognitive remediation. However, the evidence for social skills training suggests that it does not generalize well or improve overall outcome in psychosis, and it is not currently recommended.[6] Cognitive remediation has an increasing evidence

base[35] and, particularly if combined with help in returning to work, does seem to be helpful in improving some functional outcomes.[36]

Management of psychosis in the community

The psychological treatments described have all been offered within the context of optimal medication and a wide range of community team support, such as help with education and work opportunities, accommodation, and benefits. This is essential in a complex disorder such as psychosis, where there may be residual difficulties and ongoing issues of loss and stigma. There is currently an emphasis on recovery models and on involving service users in treatment decisions.

NICE guidelines suggest optimal medication and the addition of individual CBT or family intervention (if there are carers) for those with persistent symptoms or frequent relapses. Offering such interventions within a community team setting relies on locally available psychological expertise, and this is as yet only partially available. Implementation of guidelines is still problematic. One model is both to train and to supervise individuals within either generic or specialist community teams, while providing managerial support for the time needed by staff to provide consistent longer-term therapy.

Family intervention has been particularly difficult to implement. These difficulties remain to be resolved. Psychological interventions are popular with service users, who say they would like to discuss their difficulties, and with carers who wish to be taken seriously and given support for their own needs.

Conclusion

Reconceptualizing psychosis to be within the orbit of psychological treatments, despite the severity of its phenomenology and its accompanying distress and disability, has opened up a range of treatments that were previously thought to be either inappropriate or likely to make things worse. Interventions that appear to have been more productive are those that recognize the reality and severity of some of the problems of psychosis, encourage carers and individuals to understand and compensate for the difficulties, and support small but consistent efforts at long-term change.

We are beginning to develop efficacious and effective psychological treatments for psychosis. Now that some progress has been made, it remains to be understood how and why such treatments work, how to improve them, and how to make them more available. ◆

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Practice points

- Placing the experiences of psychosis on a continuum with normality has allowed the development of psychological interventions previously found successful in anxiety and depression
- The evidence for CBT and for family intervention improving some outcomes in psychosis is reasonably well supported. They are both currently recommended for those with persistent symptoms and should be offered where possible, together with optimal medication[6]