

Correspondence

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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 use of a 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.

Department of Health (2001) *The Mental Health Policy Implementation Guide*. Ch. 5: Early intervention. London: Department of Health.

Jackson, M. (2001) *Weathering the Storms: Psychotherapy for Psychosis*. London: Karnac.

McPherson, S., Richardson, P. & Leroux, P. (2003) *Clinical Effectiveness in Psychotherapy and Mental Health*. London: Karnac.

Milton, J. (2001) Psychoanalysis and cognitive behaviour therapy – rival paradigms or common ground? *International Journal of Psychoanalysis*, **82**, 431–446.

Pilling, S., Bebbington, P., Kuipers, E., et al (2002) Psychological treatments in schizophrenia: I. Meta-analysis of family intervention and cognitive behaviour therapy. *Psychological Medicine*, **32**, 763–782.

Turkington, D. & McKenna, P. (2003) Is cognitive–behavioural therapy a worthwhile treatment for psychosis? *British Journal of Psychiatry*, **182**, 477–479.

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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.

Cormac, I., Jones, C., Campbell C., et al (2003) *Cognitive behaviour therapy for schizophrenia*. *Cochrane Library*, issue 1. Oxford: Update Software.

Durham, R. C., Guthrie, M., Morton, R. V., et al (2003) *Tayside–Fife clinical trial of cognitive–behavioural therapy for medication-resistant psychotic*

symptoms. Results to 3-month follow-up. *British Journal of Psychiatry*, **182**, 303–311.

Johnstone, E. C., Frith, C. D., Crow, T. J., et al (1992) The Northwick Park 'Functional' Psychosis Study: diagnosis and outcome. *Psychological Medicine*, **22**, 331–346.

Pilling, S., Bebbington, P., Kuipers, E., et al (2002) Psychological treatments in schizophrenia: I. Meta-analysis of family intervention and cognitive behaviour therapy. *Psychological Medicine*, **32**, 763–782.

Turkington, D. & McKenna, P. (2003) Is cognitive-behavioural therapy a worthwhile treatment for psychosis? *British Journal of Psychiatry*, **182**, 477–479.

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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).

Andrade, C. & Kurinji, S. (2002) Continuation and maintenance ECT: a review of recent research. *Journal of ECT*, **18**, 149–158.

National Institute for Clinical Excellence (2003) *Guidance in the Use of Electroconvulsive Therapy* (Technology Appraisal Guidance 59). London: NICE.

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Flashbacks and PTSD in US veterans

We read with interest the article by Jones *et al* (2003), who reported an absence of flashbacks in the symptom reports of ex-servicemen from the Second World War awarded pensions for post-combat disorders. As acknowledged by the authors, a limitation of the study is the retrospective review of historical descriptions of post-combat disorder symptoms in their sample population.

We administered the Clinician Administered Posttraumatic Stress Disorder Scale (CAPS) (see Weathers, 2001) to 82 American combat veterans of the Second World War who had also been held as prisoners of war (POWs). These veterans were seen as part of a compensation and pension examination conducted by the US Veterans Administration to examine the overall health status and presence of service-connected disabilities in these highly stressed veterans. CAPS interview question B-3 specifically asks the frequency (range: 0=none to 4=daily) and intensity (range: 0=none to 4=extreme) of flashback phenomena. Six of 41 ex-POWs (14.6%) who met criteria for post-traumatic stress disorder (PTSD) reported flashbacks in the month prior to the CAPS interview at a combined frequency and intensity score of 4 or greater. None of 41 ex-POWs who did not meet criteria for PTSD reported flashbacks at this level of frequency and intensity. In contrast, 75 of 124 Vietnam-era veterans (60%) who had been diagnosed with combat-related PTSD and were administered the CAPS while participating in a Veterans Administration PTSD treatment programme reported flashbacks at this level of severity.

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.

Jones, E., Vermaas, R. H., McCartney, H., et al (2003) Flashbacks and post-traumatic stress disorder: the genesis of a 20th-century diagnosis. *British Journal of Psychiatry*, **182**, 158–163.

Weathers, F., Keane, T. & Davidson, J. R. (2001) Clinician-administered PTSD scale: a review of the first 10 years of research. *Depression Anxiety*, **13**, 132–156.

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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 & Bisson, 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