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COMMENTARY

Psychological treatments for psychosis

INVITED COMMENTARY ON… PSYCHOLOGICAL TREATMENTS FOR SCHIZOPHRENIA SPECTRUM DISORDER†

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Kathryn Greenwood is principal investigator on a study funded by the National Institute for Health Research that aims to understand and address knowledge and attitudinal barriers to the implementation and uptake of cognitive–behavioural therapy for psychosis.

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†See pp. 16–23, this issue.

SUMMARY

Most of the novel psychological therapies reviewed by Turkington & Lebert have their roots in at least one traditional approach of cognitive, behavioural and meditation practice. These therapies offer exciting prospects, but none as yet has a strong enough evidence base to warrant routine implementation in the National Health Service. In a climate of scarce resources, implementation of novel therapies is likely to come at the cost of traditional therapies with a stronger evidence base. Clinical practice must not run ahead of the evidence, but we must enable new, targeted treatments to be implemented in a timely manner once their evidence base becomes secure.

DECLARATION OF INTEREST

None

Turkington & Lebert (2017, this issue) outline the history and key theories in the development of cognitive–behavioural therapy (CBT) for psychosis, commencing with the revelation that it is safe, acceptable and indeed helpful to talk with people about their experiences of psychosis. Key components of CBT are described. These include working with appraisals of psychotic experiences and reducing unhelpful 'safety' behaviours that help people to feel 'safe' in the short term, but maintain and exacerbate difficulties in the longer term. The concept of 'normalising' a person's experiences to aid understanding and reduce stigma is introduced. CBT should also establish an engaging therapeutic relationship, should understand and validate emotions, should collaboratively explore but not directly challenge thinking, and should include cognitive and practical approaches. Family intervention is reviewed briefly.

New treatments build on traditional cognitive and behavioural models

The authors then outline new treatment approaches for psychosis, the presentations that these may be most suited to and their current evidence base. Eye movement desensitisation and reprocessing (EMDR) is suited to people with trauma and psychosis; cognitive adaptation training and cognitive remediation to people with cognitive impairments; and acceptance and commitment therapy, open dialogue, positive psychology and cognitive adaptation training address negative symptoms, social and functional impairments and depression. These therapies focus on acceptance, values and open social communication. They involve rebuilding interests and positive experiences, and restructuring the environment to accommodate cognitive impairments. Mindfulness for voices affects beliefs about power and control, but its greatest and most durable effect is on mood (Chadwick 2016). Several novel therapies, including compassion-focused therapy, metacognitive therapy and EMDR, which includes the installation of positive cognitions to promote inner strength, address distressing psychotic experiences.

However, the large majority of these interventions draw on traditional models. This is important to grasp in order that clinicians do not feel overwhelmed by the proliferation of new models. Those addressing psychotic experiences either complement or extend the cognitive model. Freeman's worry-based intervention, described as a metacognitive therapy by Turkington & Lebert, is described by Freeman and colleagues (2015) as CBT targeted at a process (worry) that maintains paranoia. It can be combined in a modular CBT package with other targeted interventions. Similarly, mindfulness-based intervention for voice hearers combines mindfulness with cognitive therapy (Chadwick 2016). The reliance largely on cognitive models to target distressing psychotic experiences is consistent with the evidence base, where a recent meta-analysis has shown that CBT is more effective than other therapies for positive symptoms (Turner 2014). Compassion-focused therapy, acceptance and commitment therapy

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and mindfulness all include meditation practice, while positive psychology and cognitive adaptation training have behavioural origins. Hence, many of these new and emerging therapies build on a set of core therapeutic models.

Clinical practice should not go beyond the evidence base

Some of these models overlap closely with core models and evidence bases, whereas others are more distinct. Many of these novel therapies have a limited evidence base for psychosis, and services should be wary of their routine implementation before we know that they work. One exception is cognitive remediation therapy (as opposed to cognitive adaptation therapy), for which there is growing evidence, a number of trials and meta-analyses, and some promising outcomes for more strategic approaches, combined with vocational rehabilitation (McGurk 2007; Wykes 2011). In other novel therapies, care should be taken as clinical practice is currently outpacing the evidence.

This is important because the delivery of any new intervention requires funding for staff, training and supervision. Ongoing work in which I am involved[a] suggests that interest in novel interventions interrupts the delivery of evidence-based practice. Indeed, National Institute for Health and Care Excellence (NICE) and other guidelines recommend that psychological therapies, including family intervention and CBT, be offered to all people with psychosis (Schizophrenia Commission 2012; NICE 2014). Yet in the context of scarce resources, clinicians are forced to decide which of their caseload to refer for a psychological intervention. Fewer than 10% of people with psychosis are offered such interventions (Haddock 2014), and clinicians' decision-making is hampered by a lack of clarity concerning who might benefit from which interventions (Prytys 2011). In this respect, Turkington & Lebert's article is valuable in providing clinicians with guidelines to enable them to understand and distinguish between interventions and their potential match with a patient. However, more work is needed to ensure, especially for more novel therapies, that the evidence base supports delivery, before these newer interventions are widely implemented.

Who benefits from traditional approaches?

Clinicians also need to understand who might benefit from current evidence-based approaches. There is early evidence to suggest that patients may be more open to CBT if they believe their difficulties are long term and psychological, and their outcomes may be better if they believe in the intervention and in their own ability to change (Freeman 2013). The above-mentioned ongoing work by our group also suggests that what may hamper progress for one person may be a facilitator to therapeutic change for another. It is not always easy to predict what will work for whom. Such knowledge may come through the therapeutic process itself, and need not be a prerequisite to referral. We would advocate that the decision to offer or engage in CBT, for example, should be reached mutually with the patient, taking into account their willingness to talk about their experiences and their ability to identify problems or goals.

Solutions to support implementation and delivery

Our work also suggests that psychological interventions are more likely to be offered in the context of a cohesive, supportive team and service structure which holds a holistic, biopsychosocial model of psychosis, and which views the well-being of the patient as paramount. The specific psychological therapies that are offered are influenced by the training, interests and preferences of team clinicians, the service and the trust. Thus, clinical leads should carefully consider the expertise and ethos of their teams to deliver evidence-based interventions.

In addition to the new interventions outlined, future directions in psychological therapies might include a focus on ease of implementation, through psychologically informed interventions such as guided self-help and coping strategy enhancement (Naeem 2015), brief interventions targeted at specific mechanisms and processes (Freeman 2015) and digitally supported interventions to promote therapeutic engagement outside the therapy session (Hardy 2016).

Conclusions

Many novel interventions are not entirely new, but build on existing core models. It is important to understand this, to avoid feeling overwhelmed or confused by the proliferation of new therapies and the expectations for new learning. New therapies compete for delivery with established therapies. Although many new therapies are extensions of the same core principles, the more novel they are, the more we need to ensure that they work before we offer them routinely.

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