Correspondence

EDITED BY STANLEY ZAMMIT

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.

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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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