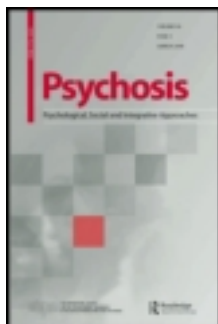


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Incorporating psychotherapeutic methods in routine community treatment for patients with psychotic disorders

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PURPOSE: This study sought to establish which psychotherapeutic methods can be used effectively in routine clinical encounters (in contrast to formal therapy) with people with psychotic disorders. **METHODS:** To identify psychotherapeutic methods for use in routine community care, a range of experts were consulted. A literature search was then undertaken to establish the evidence base for the identified techniques in this setting. **RESULTS:** Five methods were identified as suitable for this application. More literature was identified for adapting solution-focused therapy, client-centred therapy and cognitive behavioural therapy (CBT) for routine psychiatric care than for adapting problem solving therapy and interpersonal therapy. Also more studies have investigated the use of CBT in psychosis than the other methods. However there is a dearth of evidence addressing this application of the methods. At this stage, there is no compelling evidence base to consider any of the five methods superior to the others for use in this setting. **CONCLUSIONS:** More empirical research addressing the effectiveness and optimising the models of psychotherapeutic methods for routine community treatment of people with psychotic disorders is required. Such research might guide training of clinicians and influence practice of community care.

Keywords: psychotic disorders; psychotherapeutic techniques; outpatient effectiveness

Introduction

For people suffering from psychotic disorders, using psychotherapeutic methods in the course of routine clinical encounters (as opposed to formal therapy sessions) provides potential for considerable benefits and improved outcomes. There is already growing evidence on formal applications of different types of psychotherapy for this patient group and calls for their wider application. However, this does not translate into understanding the impact achievable in the usual course of routine appointments. A significant proportion of mental health care occurs in out-patient settings where formal, structured psychotherapy is often not undertaken.

The application of psychotherapeutic methods has been identified as one of the principles that may guide effective communication in psychiatry (Priebe et al., 2011). Psychotherapeutic methods have common elements that are shared across different methods and specific ones that are based on the theory for the given

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methods. Common elements of psychotherapeutic methods potentially enable therapeutic benefit in both formal and routine out-patient settings, such as effects of inter-personal processes like clinician-patient relationships (McCabe & Priebe, 2004). However, this raises the issue of whether psychotherapeutic methods including the specific elements can be utilised in routine clinical encounters in out-patient mental health services and effectively benefit patients (Priebe & McCabe, 2008).

We set out to review the evidence base for how psychotherapeutic methods can be used in routine clinical encounters with psychotic people. Three criteria had to be met for a method to be considered widely applicable in this setting. These are that the technique should:

- Have a conceptual model referring to an established body of literature.
- Be a model and technique robust enough to be broadly applicable in different community settings (e.g. community centres, patient's homes) and across different time frames (e.g. length of individual appointments and over follow-up appointments over the course of years).
- Not be limited by specific aims.

We aimed to identify, through a consultation with experts, what psychotherapeutic methods are appropriate for wide application in routine clinical encounters with people suffering from psychotic disorders. In a second step, we conducted a review of the evidence for the applicability and effectiveness of each of the psychotherapeutic methods in routine community care of people with psychotic disorders.

Method

The specified criteria for including a method and a provisional list were shared with independent experts. The experts were purposively selected academics conducting applied research in community mental health care, including psychosocial treatments. They reflected a geographical distribution in areas of practice (United Kingdom, United States, Sweden and Switzerland) and a range of professional backgrounds. They were invited to comment on the suitability of the techniques identified and suggest others they considered relevant. Nine experts were contacted by email and responded (see Acknowledgements).

The lists of techniques considered by each of the experts overlapped, although they were not identical. Client-centred therapy (CCT) was the only method that all experts agreed on. For an exhaustive approach, we included all methods highlighted by at least two experts. These were solution-focused therapy (SFT), CCT, problem solving therapy (PST), interpersonal therapy (IPT) and cognitive behavioural therapy (CBT).

Each method was then subject to a literature search. We undertook database searches in the following electronic libraries: PsychINFO (1806–2008), MEDLINE (1950–2008), EMBASE (1974–2008), Cumulative Index to Nursing and Allied Health Literature (CINAHL) (1982–2008). The search terms were the method's name (or variations of it) and any of the relevant database descriptors that cover papers dealing with people suffering from psychotic disorders (including mental disorders, psychiatry, psychiatric symptoms, psychiatric patients, community mental health services, community mental health centres, mental health, mental disease, etc.). The results were limited to human studies, relevant adult age groups and

English language publications. The search strategy is available on request from the authors.

The abstracts of papers identified were examined to determine potentially relevant papers which were then retrieved and reviewed. The reference lists of retrieved papers were also searched for potentially relevant papers.

Furthermore, a (necessarily) limited publication search was undertaken. The publisher databases of Gaskell and Cambridge University Press were searched, covering the past 20 years. A Google Books Advanced Search was undertaken using each technique's name (or variations of it) in October 2009, and relevant books in publication dealing with the technique in psychosis accessed. Another source was inviting the experts we approached to specify relevant studies.

Results

Problem solving therapy (PST)

PST is a brief, structured method helping patients understand links between their symptoms and problems, define current problems, learn structured problem solving techniques and have positive experiences solving problems (Mynors-Wallis, 2001). The evidence base for the efficacy of applying formal PST to a range of mental and physical health problems is established in reviews and meta-analyses (Malouff, Thorsteinsson, & Schutte, 2007; Nezu, 2004).

A Cochrane systematic review of the formal application of PST in schizophrenia (Xia & Li, 2008) found three small trials meeting inclusion criteria, two related to out-patient services (Bradshaw, 1993). There was no evidence to determine efficacy of this application because of inconclusive data.

Nonetheless, a review details the rationale for training people with schizophrenia in problem solving (Falloon, Barbieri, Boggian, & Lamonaca, 2007). The authors outline a problem solving training group course for people with schizophrenia, citing evidence of its application in Italy (Barbieri, Boggian, Falloon, & Lamonaca, 2006).

Two small pilot studies with mostly people with psychosis are reported with details of another PST program. No definitive impact on the group's problem solving cognition was established (Siegel & Spivack, 1976). Another module teaching groups with psychotic disorders interpersonal problem-solving skills found significant benefit in the structured problem-solving group compared to an open-ended discussion group (Lieberman, Eckman, & Marder, 2001).

Incorporating problem-solving treatment in routine general psychiatric out-patient clinics has been advocated by describing the method and how readily it fits the setting (Mynors-Wallis, 2001). However, evidence cited refers to non-psychotic disorders.

Solution-focused (oriented) therapy (SFT)

SFT is a future-focused, goal-directed method examining previous solutions and exceptions to a problem and through a series of techniques encouraging more of those behaviours (Trepper, Dolan, McCollum, & Nelson, 2006).

It has been advocated for various situations (Bannink, 2007; Trepper et al., 2006) and has evidence supporting its efficacy and effectiveness (Gingerich & Eisengart, 2000; Macdonald, 2003), albeit established outside treating severe mental

illness. An uncontrolled naturalistic study of formal SFT reported “good outcome” (i.e. attendee reported achieving their goals) in 76% of patients traced a year after therapy (Macdonald, 2005), and in 70% when pooled with the two earlier studies. However, only few patients had major psychotic illness.

Approaches using SFT for psychosis suggest the principles apply to formal therapy and day-to-day work for community psychiatric nurses. Modifications, which are advised to the SFT for people with psychosis relate to safety issues and boundaries; how to deal with strange answers; maintaining focus, taking a position of “puzzlement” but reinforcing any “normal” explanations so long as they are proposed by the patient; avoiding tasks which suggest another party has responsibility for reported phenomena; and ensuring any task is one which the therapist feels comfortable co-operating with. No specific treatment (including medication) is advocated; rather a principle is maintained of accepting that treatments are only helpful if the patient advocates this, and patients are supported in their own preferred method of hallucination control (Hawkes, 2003). An important principle for working with “psychosis” is that a patient’s world view is only accepted to the point that it becomes unhelpful, unethical or dangerous to continue doing so (Hawkes, Marsh, & Wilgosh, 1998). Examples given from authors’ experience illustrate the approach (O’Hanlon & Rowan, 2003). They emphasise a hopeful approach, focus on fluctuations in mental state, use of externalisation as a technique to develop an identity separate from the illness, and have techniques to value and validate experiences.

A review assessing the evidence for incorporating SFT principles into mental health nursing notes that an enthusiasm to incorporate SFT into day-to-day practice lacks rigorous evidence (Ferraz & Wellman, 2008). Nursing literature identifies that SFT fits mental health nursing philosophy (Webster, 1990) and outlines practical applications, for example, goal-setting and care planning (Brimblecombe, 1995; Hawkes & Marsh, 1993).

SFT principles also fit psychiatric rehabilitation and recovery values, and arguments to incorporate its techniques into individual case management to enhance engagement and collaboration are made (Schott & Conyers, 2003).

A framework for incorporating SFT perspectives and techniques in community care aligns it with facilitating strengths-based case management to support recovery in individual interactions (Greene et al., 2006).

A series of single case experiments found conviction in chronic delusions can decrease in some patients during formal SFT (Jakes & Rhodes, 2003). Another case study using SFT for a person with acute psychosis suggested it enabled belief modification (Rhodes & Jakes, 2002). Another author explaining SFT application for auditory hallucinations reported it was effective in 10 cases, although lacking details (Blymyer, 1991).

Client-centred therapy (CCT)

CCT suggests that three “therapist conditions”, that is, unconditional positive regard, an empathic understanding and congruence in the relationship with the patient, are essential to facilitate therapeutic change (Rogers, 1957). These principles are also claimed to underlie any helping relationship, which suggests that incorporating them in routine community treatment would not require much specifying or adjustment.

A changed emphasis in what constituted CCT enabled its application for people with psychosis (Gendlin, 1962). This use in the Wisconsin study found significant associations between both accurate empathy and congruence/genuineness in therapeutic relationships and improved outcomes for people with schizophrenia (Rogers, Gendlin, Kiesler, & Truax, 1967). The study's limitations have been reviewed (Marshall, 1977). A subsequent report on the nine years before and after therapy found no overall differences in hospitalisation between therapy and control groups but a trend favoured those who received high levels of therapeutic conditions (Truax, 1970).

A CCT development called pre-therapy (Prouty, 1994; Prouty, 2003) focuses on developing psychological contact with people who struggle to form helpful relationships – that is, adjusted to concrete styles of people with psychosis. A review of pre-therapy outcome studies only identified small studies, lacking statistical power and unrelated to outpatients (Dekeyser, Prouty, & Elliott, 2008).

The person-centred approach is considered compatible with developmental psychology and psychopathological research on psychosis (Binder, 1998).

The concept of psychosis has been re-formulated to fit person-centred frameworks (Lambers, 2003). Potential incompatibilities, and solutions, to routinely incorporating CCT approaches with psychiatric approaches in England's health service have been discussed (Freeth, 2007). Freeth sets out how aspects of this approach constitute a powerful set of attitudes and values which can be included within individual patient interactions despite the system not necessarily providing an enabling environment. In the context of severe psychopathology and psychosis, she offers practical examples of the application of pre-therapy through contact reflections, that is, literal reflections of the person's verbal and non-verbal behaviour (e.g. concrete situational reflections of the immediate surroundings, and facial reflections stating what is seen on the person's face or the feelings that seem expressed). A small qualitative study from adult community mental health services suggests patients value the approach (Blank, 2004).

Interpersonal therapy (IPT)

IPT is a time-limited technique for developing new strategies dealing with major interpersonal problem areas (grief, interpersonal role disputes, role transitions, interpersonal deficits) related to a patient's mental state (Weissman, Markowitz, & Klerman, 2000). It was adapted from its original structure treating non-psychotic depression to treating several other disorders. No specific modification for psychosis was identified.

The application for Bipolar I disorder, "interpersonal and social rhythm therapy", was established as efficacious in a two-year follow-up trial (Frank et al., 2005). A pilot evaluation of an intensive IPT training programme for health professionals, which focused on non-psychotic acute depression in a community mental health service relevantly identified challenges adopting the technique to the setting (Reay, Stuart, & Owen, 2003).

Cognitive behavioural therapy (CBT)

CBT focuses on how maladaptive aspects of functioning (behaviours, emotions and cognitions) are maintained by an individual's environment and aspects of their

belief systems (Morrison, 2009). Goal-oriented, systematic techniques are used to solve the problems (Roth & Fonagy, 2005).

The original CBT search strategy returned an unmanageable >24,000 results from the PsycINFO database alone, considerably more than other techniques. Consequently an alternate approach was used to assess the evidence base for CBT efficacy in psychosis; additionally we relied on the limited literature known to us regarding its adaptation to the setting, recognising that missing studies was possible.

Several published guides/manuals offer guidelines and procedures adapting and applying CBT for people with psychosis (Fowler, Garety, & Kuipers, 1995; Haddock & Slade, 1996; Kingdon & Turkington, 2005; Morrison, 2002; Nelson, 1997; Wright, Turkington, Kingdon, & Basco, 2009). Specific CBT adaptations for early phases of psychosis have also been detailed (Morrison, 2009), including cognitively orientated therapy for early psychosis (to address the impact of the disorder on the sense of self) and its application for delayed recovery from positive symptoms after the first episode (Gleeson & McGorry, 2004).

Several reviews and meta-analyses evaluate CBT use in schizophrenia. Some early ones reported promising effect sizes reducing psychotic symptoms (Rector & Beck, 2001), however, a Cochrane Review found inconclusive results (Jones, Cormac, Silveira da Mota Neto, & Campbell, 2004). Subsequent meta-analyses, reviews and discussions of the growing literature have been undertaken (Pfammatter, Junghan, & Brenner, 2006; Sensky, 2005; Tarrier, 2005; Zimmermann, Favrod, Trieu, & Pomini, 2005), including a large review supporting its use whilst cautioning against exaggerated claims of the magnitude of treatment benefit (Wykes, Steel, Everitt, & Tarrier, 2008). Contrasting with previous meta-analyses, the most recently published found CBT no better than non-specific control interventions in schizophrenia treatment, and no reduced relapse rates (Lynch, Laws, & McKenna, 2010).

Specific effectiveness trials have addressed CBT's impact when delivered by therapists in routine clinical settings. In one small trial, a third of patients responded to cognitive therapy to modify delusions (Jakes, Rhodes, & Turner, 1999). A trial by therapists within Community Mental Health Teams found improved positive symptoms, general mental health problems, depression and several dimensions of hallucination and delusion severity. There was no randomisation or blinding and the question of training and skills needed to effectively deliver CBT for psychosis arose (Morrison et al., 2004). A preliminary study using a techniques-oriented approach with a befriending control group demonstrated significant symptom improvement and tendency to shorter admissions (Turkington & Kingdon, 2000). In this paper, the case was made for using a techniques-oriented approach (rather than expecting that general adult psychiatrists have the time to get involved in extensive formal cognitive therapy of psychosis) which enables the psychiatrist to move from a monitoring to a "hands-on" approach. The approach was described as flexible, with the development and maintenance of rapport highlighted. They noted that direct confrontation was avoided and "tactical withdrawal" used to maintain rapport if needed. Inductive questioning was used to identify faulty cognitions related to the onset of the symptoms. This supported the development of a shared explanation which recognised individual stressors. Significance attached to events leading to delusions was explored collaboratively, and alternative explanations provided and discussed. "Inference chaining" was used for mood-syntonic delusions and systematised

delusions, thereby determining the underlying linked irrational belief and enabling work at the schema level that underlies the resistant psychotic symptoms. Further techniques addressing delusions and hallucinations (including teaching the person to not pay attention, distraction and focusing techniques and rational responding for hallucinations) are also detailed as having been incorporated.

Caution adopting CBT treatment for psychosis into routine settings has been sounded, notably based on the skill, training and supervision needed for modifying psychotic symptoms. Evidence of effectiveness in routine settings was not considered compelling (Roth & Fonagy, 2005). Concerns also include whether effects generalise beyond target symptoms, whether psychotic diagnostic group has relevance, limited numbers of effectiveness studies in typical clinical settings and no agreement on which CBT protocol to use (Gaudiano, 2005). Difficulties equipping the workforce with skills to provide cognitive-behavioural treatments for schizophrenia through various training projects have been acknowledged. Nonetheless, it has been suggested to equip community mental health practitioners with the capacity to apply CBT principles in routine interactions (Kinsella & Garland, 2008).

Discussion

Following experts' suggestions, five psychotherapeutic methods were identified for wide application in routine clinical encounters with patients with psychosis. The criteria for wide applicability were determined by our group as no clearly defined boundary (nor any well-defined field of research) establishes this. We purposefully set inclusive criteria, but focused on methods that can be used in routine meetings with individuals, thereby excluding family-based interventions and the open dialogue approach (Seikkula et al., 2006).

Although there is guidance specifying how the five methods can be formally used in psychosis, and evidence for this, its extent varies. CBT has a considerably larger literature and evidence base than any of the other techniques for application and efficacy in psychosis, but SFT, PST and CCT have some evidence supporting their use as therapies in psychosis. No guidelines for IPT in schizophrenia/psychosis were found, although it has been adapted for bipolar disorder.

However, a striking result of this study is the limited evidence base on applying the methods in routine settings in community care. They were all developed in specific psychotherapy settings, and most literature focuses on the theoretical school behind them. But setting specific factors are relevant to adapting any method for incorporation into routine clinical encounters, for example, accommodating less frequent/regular appointments which are briefer than those usually available for formal psychotherapy and that include other functions (e.g. reviewing medication prescriptions). Specific challenges adapting the methods to routine psychiatric settings have been documented (Reay et al., 2003; Rollinson et al., 2007), including many related to training clinicians, the other roles of clinicians, organisational issues and aspects of the actual methods.

The efforts to adapt the methods for routine community care in light of these challenges have been limited, but there are some such modifications in the literature. They include a framework to incorporate SFT into case management and advice on how to incorporate PST into routine psychiatric out-patient clinics. There have also been efforts to incorporate CBT into routine practice through a techniques-oriented approach and recommendations on how to incorporate a modified

client-centred approach into psychiatric practice. There is, however, hardly any evidence about the effectiveness of the adaptations, although a preliminary controlled study reported encouraging results for incorporating CBT into routine practice by clinicians (Turkington & Kingdon, 2000).

We can conclude that very little direct evidence answers our research question. Whilst a case has been made to use the various methods, it is unclear to what extent the approaches currently inform usual practice, and whether their use in this setting impacts on outcomes.

Our study has several weaknesses. Addressing the first research question is complex. Arguments can be made to consider other psychotherapeutic methods, or not to use these five. It is also possible to subsume PST under a broader umbrella of cognitive therapies. However, we took an inclusive approach considering all methods listed by at least two experts so that we are unlikely to have missed out on a widely relevant method. A comprehensive approach in the database searches limited the risk of omitting studies addressing the research question. Nonetheless, a risk remains that relevant evidence was missed, although it is unlikely major studies were omitted. This particularly relates to the CBT literature. For the CBT literature, however, several reviews were considered, thus limiting the risk of missing important studies. Books on the methods in routine setting may have been missed, since searching books is more challenging than journal papers in electronic databases. A further limitation is that the searches were limited to publications in English language.

Strengths of the study are that there was a relative consensus of experts on the suitable methods, that all methods listed by more than one expert were included, and that the literature was widely searched by using broad database descriptor search terms to be inclusive.

Clinical implications

Claims may be made for each of the methods to be used in routine care of people with psychotic disorders, and there is some literature on how to use them, but it is not underpinned by evidence, with the arguable exception of CBT. In routine settings, no method has established itself as clearly superior to the others. Some model or approach must in any event be used or applied to guide routine community-based encounters, and the judgement of which ought to be used is not yet determined by the evidence base available currently.

There is a need for further evaluating these approaches as formal therapies for psychosis. Equally or even more important however, as highlighted in this review, is the need for specific research to establish what could be effectively applied in routine practice by clinicians in community care. Given that some literature has already dealt with developing the included psychotherapeutic methods as complex interventions for this purpose, further efforts formalising adjustments for use of each of the methods in these settings are not starting from scratch. Thereafter, empirical research will be needed, developing understanding of the effectiveness of the methods and contributing to optimisation in these settings. This might require disentangling existing methods and combining some elements of different methods. To some extent, this is likely to happen in practice already as elements that are specific to one method such as CCT can be seen as common by the theory of other methods. The complexities inherent in further developing existing methods can be

approached using a framework such as that provided by the UK's Medical Research Council (Medical Research Council, 2008). Such research should inform training of clinicians and the profile of psychological expertise in teams providing community care for people with psychosis.

Conclusion

Different psychotherapeutic methods may be widely applicable to routine care for psychosis, but none has been thoroughly tested in this setting. Further developmental work adapting the methods for use in these settings, and testing their effectiveness, is required. Nonetheless, if following a psychological treatment model is beneficial regardless of the particular model, as has been suggested (Wampold, 2001), then even in the absence of more evidence efforts to incorporate psychotherapeutic methods into routine clinical settings might improve care.

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