



A systematic review examining factors predicting favourable outcome in cognitive behavioural interventions for psychosis

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ABSTRACT

Psychosis is a debilitating mental health condition affecting approximately 4 persons per 1000. Cognitive behavioural therapy for psychosis (CBTp) has been shown to be an effective treatment for psychosis and is recommended by several national guidelines. CBTp does not work equally well with everyone, however, with some 50% of clients receiving little benefit. This review sets out to systematically assess the literature and methodological quality of a number of studies, which examine factors predicting successful outcome in CBTp. The databases CINAHL, Cochrane, EBSCO, EMBASE, ISI Web of Science, MEDLINE (Ovid), PsycARTICLES, PsycINFO, PubMed, and Scopus were electronically searched. English language articles in peer reviewed journals were reviewed. Search terms “psychosis”, “psychotic disorder”, “cognitive behavioural therapy”, “cognitive therapy”, “randomised controlled trial”, “predictor”, and “treatment outcome” in various combinations were used as needed. Only randomised controlled trials (RCTs) were included. Results suggest that female gender, older age, and higher clinical insight at baseline, each predicted better outcome in CBT interventions with psychotic patients, as did a shorter duration of the illness, and higher educational attainment. Several other factors, such as higher symptom severity at baseline, were suggestive of predictive capacity but further research to clarify was indicated. Providers of mental healthcare should consider these findings when offering CBTp. The onus is also on healthcare providers to better equip non-responders to CBTp. Further investigation into a limited number of predictive factors, with an agreed set of outcome measures, would allow future researchers more direct comparisons between studies.

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1. Introduction

Psychotic disorders are a group of illnesses characterized by the experience of a range of unusual, often distressing, mental and emotional events such as delusions and hallucinations. Psychosis can be experienced by individuals having diagnoses of schizophrenia, bipolar disorder, and psychotic depression, or the psychosis may be drug-induced. Traditionally, clinicians and researchers have categorised psychotic symptomology into positive symptoms and negative symptoms. Positive symptoms are characterized by prominent delusions, hallucinations, positive formal thought disorder, and persistently bizarre behaviour; negative symptoms, by affective flattening, avolition, and attentional impairment (Andreasen and Olsen, 1982). A recent systematic review conducted in the United Kingdom (Kirkbride et al., 2012) found the prevalence of psychosis in the population at 4 per 1000, with the annual incidence rate at 32 cases per 100,000.

Cognitive behavioural therapy (CBT) has been shown to be an effective, evidence-based, treatment for many debilitating

psychological difficulties such as depression and anxiety (Butler et al., 2006). In the past two decades growing evidence has demonstrated the effectiveness of using CBT with a population experiencing psychosis. A recent review of the efficacy of CBT for psychosis (CBTp) (Turkington et al., 2013) concluded that CBTp can show robust effect and strong patient acceptability (Morrison et al., 2012a). Several national guidelines e.g. Morrison et al. (2004) have recommended CBTp as a first-defence treatment, alongside antipsychotic medication, for both first-episode psychosis and drug-resistant psychosis. In Ireland, the Health Service Executive (HSE), in a National Clinical Care Programme, fully adopted the NICE (2009) guidelines and recommended all patients experiencing first-episode psychosis be offered CBT for psychosis, alongside medical treatment. A nationwide training programme was implemented in 2013 to equip frontline staff with CBTp skills (HSE, 2013).

Despite its demonstrated effectiveness, CBTp does not work equally well with everyone. In a recent review Lincoln et al. (2014a) report that, on average, 16% of patients discontinue CBTp, and of those who continue in therapy, approximately half do not show reliable symptom improvement (Wykes et al., 2008). Several studies have set out to examine which factors are predictive of positive outcome in CBTp with a view to optimising therapy provision.

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The process of setting out to identify variables which are predictive of therapy success is well established in the research literature. For example, [Ciao et al. \(2015\)](#) examined factors predicting and moderating outcome in Family Based Treatment for bulimia, and found that older adolescents made more rapid advances in self-esteem in therapy. [Button et al. \(2015\)](#), in a related finding, demonstrated that older age of adult clients favourably predicted response to CBT for depression. In contrast, [Torp et al. \(2015\)](#) reviewed predictive factors in CBT for paediatric OCD, and found that children and adolescents who were older, and had more severe OCD had significantly poorer outcomes after 14 weeks of treatment.

Studies of this kind seek to identify which demographic, personal, psychological or neuropsychological factors make it more likely for an individual to benefit from a particular therapy delivered under particular settings.

1.1. Predictors for successful CBT for psychosis

Many studies have attempted to identify which factors predict successful outcome in CBTp (see [Lincoln et al. \(2014b\)](#) for a review). However, the picture emerging from these studies is far from consistent. Researchers have not agreed on a set of outcome measures which can be consistently applied, or which baseline predictors to validate.

Considering socio-demographic factors, some studies have found that younger patients benefit more in terms of positive symptoms ([Morrison et al., 2012a; Thomas et al., 2011](#)) and that higher educational attainment was shown to predict better outcome in negative symptoms ([Allott et al., 2011](#)).

The extent to which patients have insight into their symptoms, that they can attribute their symptoms to mental illness, and the influence of this insight on outcomes have also been examined. Higher insight at baseline predicted symptom improvement in two studies ([Garety et al., 1997; Naeem et al., 2008](#)) and [Brabban et al. \(2009\)](#) found that symptom reduction was associated with lower delusional conviction. Clinical factors have also shown to be predictive of therapy effectiveness. Lower baseline symptomology and, in particular, lower negative symptomology were shown to be related to more symptomatic improvement during CBTp ([Tarrier Beckett et al., 1993](#)).

Other potential predictor variables identified include; longer duration of untreated psychosis ([Drury et al., 1996](#)), greater self-reflectiveness ([Perivoliotis et al., 2010](#)), lower occupational functioning ([Allott et al., 2011](#)), and higher neuropsychological functioning ([Premkumar et al., 2011](#)).

The pattern of exploration of predictor variables of CBTp to date has largely been one of parallel, independent studies, each focusing on specific, often unique, predictors using similar but varying outcome measures. Study methodologies vary and contradictory findings are not uncommon. For example, [Tarrier Beckett et al. \(1993\)](#) found that lower baseline symptomology predicted greater outcome for CBTp, whereas [Morrison et al. \(2012b\)](#) found that more severe positive symptoms at baseline predicted better outcome.

To date there has not been an attempt to synthesise these findings using a systematic review. The timing of this current systematic review is important. International guidelines consistently recommend CBTp for patients with psychosis, yet CBTp is not as beneficial to some as to others. The more that is known about predictive factors, the better providers can target interventions towards patients more likely to benefit from treatment. Furthermore, by highlighting a population for whom CBTp is less effective, an informed re-evaluation of CBTp treatment modules would be possible, so that later versions of CBTp manuals would be more effective for a greater proportion of the population experiencing psychosis. Thus, the primary research question was: what baseline variables, if any, predict successful outcome in CBT for persons experiencing psychosis?

2. Method

2.1. Literature research

A literature search was electronically conducted using CINAHL, Cochrane, EBSCO, EMBASE, ISI Web of Science, MEDLINE (Ovid), PsycARTICLES, PsycINFO, PubMed, and Scopus. No initial restrictions were placed on the year, or language of the studies.

2.2. Keywords used

The main search terms included “psychosis”, “psychotic disorder”, “cognitive behavioural therapy”, “cognitive behavioural therapy”, “cognitive therapy”, “randomised controlled trial”, “randomized controlled trial”, “predictor”, and “treatment outcome” in various combinations as needed.

2.3. Inclusion and exclusion criteria

Randomised controlled trials (RCTs) comparing at least 2 levels of one clinical, demographic or personal predictive factor (e.g. High Baseline Insight vs. Low Baseline Insight), and examining the factor's effect on treatment outcome with a cognitive behavioural intervention for psychosis, were included in the review (see [Table 1](#)).

No limits were imposed on year of publication. Only articles published in full, with English text were included.

In refining the search of articles, any RCT in psychosis with an intervention naming cognitive behavioural therapy as an active component was included. This meant that not all studies included employed an exclusively manualised CBTp protocol. Of the 10 studies included in the final analysis, 5 studies used CBTp as an intervention ([Allott et al., 2011; Garety et al., 1997; Haddock et al., 2006; Lincoln et al., 2014a; Tarrier Yusupoff et al., 1998](#)). Two studies employed a brief CBT protocol ([Brabban et al., 2009; Naeem et al., 2008](#)). One study used a CBT Social Skills Training ([Emmerson et al., 2009](#)), one study focused on Work-based CBT ([Kukla et al., 2014](#)) and a further study utilised a CBT Coping Strategy Enhancement as the primary intervention ([Tarrier Beckett et al., 1993](#)).

To ensure methodological rigour, only studies examining predictive factors which were selected prior to the CBT intervention were included.

2.4. Data extraction

The following variables were extracted from each of the 10 finalised studies: author, year, sample size, intervention, predictors tested, statistical significance, outcome measures, quality score, and secondary analysis. The summary extraction table is listed in [Table 3](#).

2.5. Assessment of methodological quality

The CONSORT checklist of RCT quality ([Moher et al., 2012](#)) was applied to each of the 10 studies (see Appendix 4). Seven of the included

Table 1
Inclusion criteria.

- Randomised controlled trials (RCTs),
- Comparing at least 2 levels of one clinical, demographic or personal predictive factor,
- Examining the factor's effect on treatment outcome with a cognitive behavioural intervention for psychosis,
- No limits were imposed on year of publication,
- Only articles published in full, with English text were included,
- Any RCT in psychosis with an intervention naming cognitive behavioural therapy as an active component was included,
- Only studies examining predictive factors which were selected prior to the CBT intervention were included.

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