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## Associations between therapy skills and patient experiences of change processes in cognitive behavioral therapy for psychosis



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### ABSTRACT

Despite the promising findings in relation to the efficacy of cognitive behavioral therapy for psychosis (CBTp), little attention has been paid to the therapy skills necessary to deliver CBTp and to the influence of such skills on processes underlying therapeutic change. Our study investigated the associations between general and technical therapy skills and patient experiences of change processes in CBTp. The study sample consisted of 79 patients with psychotic disorders who had undergone CBTp. We randomly selected one tape-recorded therapy session from each of the cases. General and technical therapy skills were assessed by the Cognitive Therapy Scale for Psychosis. The Bern Post Session Report for Patients was applied to measure patient experiences of general change processes in the sense of Grawe's psychological therapy. General skills, such as feedback and understanding, explained 23% of the variance of patients' self-esteem experience, but up to 10% of the variance of mastery, clarification, and contentment experiences. The technical skill of guided discovery consistently showed negative associations with patients' alliance, contentment, and control experiences. The study points to the importance of general therapy skills for patient experiences of change processes in CBTp. Some technical skills, however, could detrimentally affect the therapeutic relationship.

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### 1. Introduction

In the last two decades cognitive behavioral therapy (CBT) approaches for psychoses have been developed which are specifically designed to reduce severity of positive symptoms. Positive symptoms such as persecutory delusions and hallucinations, which interfere with the patient's ability to maintain social relationships, cause serious distress and life disruption in patients. The most recent meta-analyses (Zimmermann et al., 2005; Wykes et al., 2008) demonstrated that cognitive behavioral treatment for psychosis (CBTp) has a moderate effect on symptom reduction and on general well being of patients suffering from psychosis. Based

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on the earlier meta-analysis of Pilling et al. (2002) the British National Institute for Health and Clinical Excellence (2009), for example, recommended CBTp for routine care. In the meantime, also the United States' psychosocial treatment recommendations (Dixon et al., 2009) suggest that schizophrenia patients with persistent psychotic symptoms should be offered CBTp to reduce the severity of symptoms. A limitation of CBTp, however, is that dropout rates are often high, especially among acutely ill patients (Startup et al., 2004). Dickerson and Lehman (2011) assume that this difficulty with engagement occurs because frequent one-on-one contacts amount to therapeutic overload for many patients. Nevertheless, CBTp seems to be of most benefit to patients when delivered fully, including specific cognitive and behavioral techniques (Dunn et al., 2012).

Despite the promising findings in relation to the efficacy of CBTp, little attention has been paid to the therapy skills necessary to deliver CBTp and to the influence of such skills on therapeutic

processes and therapy outcome. Haddock et al. (2001) underline that CBTp trainings should provide trainees with both more general therapy skills such as understanding and interpersonal effectiveness as well as with expert CBT skills such as guided discovery and dealing with homework. Although CBTp clearly has many principles and actions in common with CBT for depression or anxiety disorders it has a number of relevant departures, mainly due to the nature of psychotic disorders (Haddock and Tarrier, 1998). For example, the skill of evaluating evidence to support and refute unusual beliefs about hallucinations in conjunction with subsequent cognitive restructuring and behavioral experiments can be viewed as specific for CBTp (Fowler et al., 1995). As a result, any instrument measuring therapist competencies in CBTp has to take into account the non-standard nature of some CBT work with patients suffering from psychoses (Haddock et al., 2001).

To this day, there is virtually no psychotherapy process research linking therapeutic skills in CBTp with processes underlying therapeutic change. However, to improve patient compliance with CBTp and, thus, therapy outcome we need to understand what general and specific therapist competencies account for patient experiences of core therapeutic process. In the past few years psychotherapy research has shown that therapeutic change is induced less by specific techniques than by more pantheoretical factors (Hubble et al., 1999). Gibbons et al. (2009), for example, found that improvements in self-understanding and views of the self in a sample of patients with depression and anxiety disorders were associated with symptom change across diverse psychotherapies. Other research showed that although changes in cognition were found among patients treated with cognitive therapy, they did not predict changes in depressive symptoms (Jarrett et al., 2007). Further, with regard to schizophrenia, there are relatively consistent findings that anomalies in probabilistic reasoning or a personalizing attributional bias, for example, are associated with delusions (Langdon et al., 2010). However, the literature provides no convincing support for the hypothesis that the reduction of such cognitive biases would mediate improvement in delusion or other psychotic symptoms (Freeman, 2007; Menon et al., 2008). Therefore, the beneficial effects of CBTp most likely arise, at least partly, from the realization of general principles of change represented by different therapy schools.

In the field of psychotherapy process research several significant variables inducing or moderating therapeutic change have been identified (Orlinsky et al., 1994). On the basis of broad empirical data, Grawe et al. (1994) extracted five general change processes which are (1) the therapeutic bond, (2) problem actuation, (3) resource activation, (4) mastery, and (5) motivational clarification. Gassmann and Grawe (2006), for example, found that problem actuation alone did not reliably lead to therapeutic progress in a sample of patients with anxiety and affective disorders; only when combined with resource activation could the integrative psychotherapy (Grawe, 2004) unfold its therapeutic potential. Thus, problem actuation and resource activation obviously complement one other. While the actuation of the problem helps the patient to clarify what to change, resource activation focuses on how this is possible. Motivational clarification and mastery are complementary as well. Without motivational clarification patients take action that can be potentially detrimental to their future (Grawe, 2004). Among patients with schizophrenia disorders, a better therapeutic alliance was associated with improved global and social functioning, lesser amount of symptoms, better quality of life, and greater medication compliance (Frank and Gunderson, 1990; Gehrs and Goering, 1994; Neale and Rosenheck, 1995; Solomon et al., 1995; Svensson and Hansson, 1999; Hansson et al., 2008). Therefore, these findings suggest that therapists, who utilize their competencies to induce a positive experience of such change processes in their patients, will achieve better treatment outcome.

The main research question of the present exploratory study was: To what extent are patient experiences of general change processes in CBTp associated with general and CBTp specific therapy skills? We hypothesized that both better general and specific therapy skills would be predictive of more positive patient appraisals regarding the therapeutic bond as well as mastery, clarification, problem actuation, or resource activation experiences. We further expected that general therapy skills would explain a larger proportion of patient experiences than CBTp specific skills.

## 2. Methods

### 2.1. Participants

#### 2.1.1. Framework of the study

Participants were part of a multicenter, randomized clinical trial comparing a cognitive behavioral intervention (CBTp) to supportive therapy (ST) for patients with persistent positive symptoms (ISRCTN 29242879; The POSITIVE-Study). The study protocol has been previously published (Klingberg et al., 2010b). We had obtained written informed consent to take part in the study from all participants. The study was approved positively by the local ethics committees and was carried out in accordance with the latest version of the Declaration of Helsinki.

#### 2.1.2. Eligibility criteria

To be eligible for the POSITIVE study, participants had to meet the following criteria: (1) fulfilling diagnostic criteria of schizophrenia (DSM-IV 295.1, 295.2, 295.3, 295.6, 295.9), schizophreniform disorder (DSM-IV, 295.4), schizoaffective disorder (DSM-IV 295.7) or delusional disorder (DSM-IV 297.1), confirmed by a structured clinical interview (SCID-I; Wittchen et al., 1997); (2) aged 18–59; (3) presence of delusions or hallucinations of at least moderate intensity according to the Positive and Negative Syndrome Scale (PANSS items P1 or P3  $\geq 4$ ); (4) persistence of positive symptoms for at least 3 months with or without compliance regarding antipsychotic medication; (5) no diagnosis of substance abuse or substance dependence according to DSM-IV/SCID-I as primary clinical problem implying the intention of the institution responsible for treatment to initiate a specialized treatment of substance abuse/dependence; (6) IQ  $> 80$  according to the Mehrfachwahl-Wortschatz-Intelligenztest (MWT-B; Lehl, 1992), a German multiple-choice vocabulary test measuring the premorbid intellectual level; (7) no organic brain disease (other than schizophrenia) according to standard patient examination procedures; (8) fluency regarding the German language; and (9) travel time to the study center of less than 1 h.

#### 2.1.3. Sample

Between April 2007 and November 2010 a total of 330 eligible patients underwent one of the two study treatments at the outpatient Departments of Psychiatry and Psychotherapy of the Universities of Tuebingen, Frankfurt, Duesseldorf, Bonn, Cologne, and Essen (Germany). The present analyses included 79 (47.6%) out of 166 systematically recruited patients of the CBTp condition, who had given written informed consent to tape recording of their therapy sessions. Details of the recruitment strategy have been published elsewhere (Klingberg et al., 2010b). The patients of the ST condition have not been considered in the present analyses as cognitive behavioral interventions were not intended in the control group.

The sample description is shown in Table 1. Symptoms were assessed with the Positive and Negative Syndrome Scale (PANSS; Kay et al., 1987). The PANSS scores indicate that the present sample shows relatively more positive than negative symptoms. More than two-thirds of the patients showed a persistence of positive symptoms of more than 6 months. Ninety-four percent of the patients were multi-episode cases. All patients received antipsychotic medication according to their individual needs without restriction by the study protocol. Medication was prescribed by psychiatrists independent of the study team. Ninety percent of the patients showed favorable medication compliance according to the Compliance Rating Scale (Kemp et al., 1996). The Global Assessment of Functioning (GAF, according to DSM-IV) score indicates serious symptoms or serious impairment in social or occupational functioning.

The 87 CBTp patients who had not given their consent to tape recording had a significantly ( $p < 0.01$ ) lower GAF-score ( $M = 43.6$ ,  $S.D. = 8.2$ ) and, at a trend level ( $p < 0.10$ ), a higher score on the PANSS negative syndrome scale ( $M = 2.2$ ,  $S.D. = 0.7$ ) than the 79 patients of the present study. With regard to the other characteristics listed in Table 1 no significant differences resulted between the two sub-samples of the CBTp condition. The group comparisons were conducted by means of two-tailed *t*-tests for independent samples and chi-square statistics (with schizophrenia, paranoid type versus other diagnoses).

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