The role of **psychotherapeutic models** in **rehabilitation** and **recovery**

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Abstract

AIM: To examine the role of psychotherapies in recovery from severe mental illness (SMI), and highlight novel advances in their use and deployment.

BACKGROUND: Despite an extensive evidence base, there is some controversy about the use of psychotherapies in rehabilitation psychiatry. Specifically, there is uncertainty surrounding the purpose of psychotherapies: Whether they aim to reduce symptoms directly (as "quasi-neuroleptics") or indirectly, by addressing the affective and cognitive responses to symptoms. This paper aims to identify the factors which psychotherapies utilised in order to effect change and facilitate recovery.

METHODS: Narrative literature review. Literature was sourced using online search tools (Medline) and the review of article references.

RESULTS: Evidence of psychotherapies, including Cognitive Behavioural Therapy for Psychosis (CBTp), Family Therapy (FT), and psychodynamic psychotherapies were reviewed. Studies were equivocal when assessing the efficacy of both CBTp and psychodynamic approaches, with more consistent evidence for FT. Outcome measures used to assess psychotherapies were imprecise, however, including many measures that psychotherapies didn't attempt to target.

DISCUSSION: Psychotherapies focus on affective responses to symptoms, developing in patients emotional and perceptive abilities which are poorly assessed in current study designs. This review proposes the concept of "psychological reserve" as a term for the reflexive analytical capacities that are developed through psychotherapeutic work. It is used to orientate and contextualise complex and difficult experiences, thus enabling patients to become more active participants in their own recovery. The review highlights the need for new robust outcome measures that assess these capacities in order to further examine the role of psychotherapies in the treatment of SMI. It also considers novel modes of psychotherapeutic delivery, including Avatar-Based Therapy, and drug-assisted psychotherapies.

The efficacy of psychotherapy

There is some controversy about the utility of psychotherapy in the rehabilitation of patients with severe mental illnesses, with rehabilitation services tend to prioritise a more practical and skills-based approach aimed at reducing social disability directly (Roberts 2006). For psychosis, both Cognitive Behavioural Therapy for Psychosis (CBTp) and Family Therapy (FT) are recommended as first-line psychological interventions (NICE 2014).

CBTp aims to improve understanding and help challenge maladaptive cognitions by normalising illness experience (Roberts 2006). It also addresses symptoms directly by helping to challenge the veracity of delusions, and adjusting the affective response to persecutory auditory hallucinations (AH). Cognitive models are used to modulate and alleviate symptom experience and understanding, thereby developing the kinds of adaptive cognitions which enable greater personal and interpersonal functioning.

The efficacy of CBTp remains elusive. It has been validated as an effective treatment for alleviating symptoms in a number of meta-analyses (Burns, Erickson et al. 2014) whereas other analyses have concluded that effect sizes appear at best modest or insignificant (Thomas 2015), leading some authors to argue that CBTp has been 'oversold' (McKenna and Kingdon 2014). A recent Cochrane review of CBTp versus standard care concluded that it didn't reduce long-term relapse rate, and that the data was too weak to assess improvement in overall mental state (Jones 2018).

FT has better evidence: A Cochrane review of Family Therapy (FT) concluded that there was good evidence for its efficacy in reducing relapses and improving symptom management (Pharoah, Mari et al. 2010). FT works to construct a supportive family network, focusing on collaboration and communication, and helping family members to understand the diagnosis and early signs of relapse (Roberts 2006). Whilst loosely informed by various approaches, the very practical focus here is on challenging stigma and reversing social isolation.

The evidence afforded by RCTs and meta-analyses of psychotherapies should be read with caution. It is often difficult to measure their intended effects with these types of studies. A number of authors have noted the ways psychotherapies are structured–for example the way patients are assigned to therapists, and the long dyadic therapeutic relationship–can contribute to potential bias and reasons for exclusion (McKenna and Kingdon 2014, Thomas 2015, Jones 2018).

Outcome measures are also highly heterogeneous, which may make replication and application challenging. The Cochrane review for example reports 73 different outcome categories, more than the number of papers it analyses (Jones 2018). To combat this, 'omnibus' global assessments like PANNS and BPRS are often used as primary outcome measures, but they are so broad that they also measure many things these therapies don't seek to target (Thomas 2015): Psychotherapy addresses cognitive and affective responses to symptoms, rather than symptoms themselves. Symptom changes are recorded as primary outcomes in these studies, whilst other measures which are targeted by psychotherapy (such as self-insight, interpersonal relations, and hostility) are considered secondary outcomes.

This seems to have causality the wrong way round: Rather than thinking of CBTp or other psychotherapies as 'quasi-neuroleptics' (Birchwood, Shiers et al. 2014), or treatments in a rigid sense, these ought to be seen as therapeutic processes that aim to develop in service-users the kinds of qualities that enable them to recover.

Key points

- Psychotherapies play a key role in rehabilitation and recovery
- There is controversy surrounding their use and what they target
- Study designs struggle to assess many of the things psychotherapies aim to address
- This paper proposes **psychological reserve** as a rubric for analysing the capacities that psychotherapies aim to promote, and that enable recovery from SMI

Psychological reserve

Psychotherapeutic approaches contribute to recovery of the individual: They help to build capacities such as emotional literacy and self-insight, that can then be relied on in times of mental ill health. These capacities form part of what can be called "psychological reserve". In other areas of medicine we talk about the loss of physiological reserve as an important organising principle in explaining emerging illness and secondary prevention. In rehabilitation psychiatry, we too must look at reserves: Social reserves are the communities and family networks that can help alleviate distress and provide protection (Resnick and Goldberg 2019). This is something rehabilitation psychiatry has long understood and utilised in recovery. Psychological reserves are the sets of reflexive analytical capacities which help to orientate and contextualise complex and difficult experiences. They are important too in recovery but often under-developed and under-utilised in patient populations across psychiatry (Kukla, Whitesel et al. 2016).

The benefit of focusing on psychological reserve is that with progress in recovery a patient's understanding of their own illness also improves. Increasingly, in medicine, the idea of "patient activation" is being discussed as a way of enabling service-users to move from a position of passive receipt of care to active co-producer in the management of their illness (Greene and Hibbard 2012). This can be an especially difficult task in psychiatric populations, where insight may well be impaired along with disabling stigma. But as a goal it resonates strongly with the foundations of social psychiatry: "Activating the patient" is another way of saying "recovering the person", their sense of agency and self; the principle guiding recovery since the moral therapies of 19th century asylums.

It is also precisely the substance that psychotherapies can take up and, as an approach, also speaks to something generally true of recovery as a whole in psychiatry: That alongside the careful pharmacological management of symptoms, and work on building skills and social networks, psychotherapeutic practices need to be used. And rather than an end-line siloed therapy, it should be integrated as a dynamic part of the recovery process.

Novel modes of delivery

Avatar-based therapy utilises audio-visual equipment to create a digitalised representation of a patient's hallucination, which is then controlled by the therapist. Patients come to confront these representations, gaining control over it, as the power and aggression of the represented hallucination is attenuated by the therapist. Its efficacy has been established in a number of RCTs (Craig, Rus-Calafell et al. 2018).

Drug-assisted psychotherapies utilises psychedelics to enhance therapy by increasing in cross-cortical integration, relaxing limiting beliefs, and promoting insight (Roseman, Nutt et al. 2018). It augments the patient's cognitive capacities to promote personal reflexivity, overturning long-held maladaptive schemata.

Conclusions

There appears to be a largely artificial dichotomy; that between skills-based and psychotherapeutic approaches in rehabilitation psychiatry. There is little doubt that these inform each other, and often draw on similar methodologies. However, it is used heuristically to emphasise the distinction between the two foci in recovery, described as social and psychological reserves, which are crucial in promoting recovery and protecting against relapse. Psychological reserve is not only protective, but also self-enabling: Insight, reflexivity and self-narrative allow the service-user to become an active participant in their recovery. And whilst this reflects an emerging understanding of "patient activation" across medicine, it resonates just as strongly with the whole-person approach that has long been championed in social psychiatry.

Further research is needed to establish the efficacy of the psychotherapeutic techniques discussed here. In particular, research is needed to establish the hypothesis that the development of psychological reserves as a primary outcome is itself protective, with novel and more standardised measures needing to be developed. By enabling service-users to be more active participants in their health (or even if not), this capacity can be utilised to further development of services themselves: The principle of a mental health service co-produced by both healthcare staff and service-users only serves to emphasise the primary importance of insight and reflexivity as targets in the recovery process.

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