Do psychotherapeutic models have a role in rehabilitation and recovery?

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Introduction

Psychotherapeutic models have a role in rehabilitation and recovery, but it is a role that has been increasingly questioned. A variety of models are currently used as first-line treatments in schizophrenia, the most researched being Cognitive Behavioural Therapy for Psychosis (CBTp). However, a number of recent reviews have questioned its evidence base, and suggested that it is ‘oversold’ when compared to more practical and skills-based approaches focused on psycho-education and social network development (Jones 2018; McKenna & Kingdon 2014; Morin & Franck 2017). Some scepticism is needed, however, in interpreting meta-analyses of psychotherapeutic interventions, which don’t lend themselves well to this kind of study. In particular, there is a problem with seeing psychotherapies as ‘quasi-neuroleptics’ (Birchwood et al. 2014), or treatments in a rigid sense, aimed at reducing symptom severity. Psychotherapeutic techniques are rather aimed at altering the cognitive and affective responses to symptoms, in part by challenging maladaptive beliefs about them. They also work to challenge broader cognitive schemata that may interfere in developing a healthy self-understanding (or reflexivity). It is these strategies that make them key to psychiatric rehabilitation: In developing personal insight into one’s illness and its origins, they enable the person to grapple with it in relation to themselves, and thus become more active participants in managing it. In this essay I develop the idea of psychological reserve to further elucidate this process.

In the interests of space, this essay largely focuses on the management of schizophrenia, which represents the major case-load of rehabilitation services (Wolfson 2009). In section one, I aim to review the current provision of psychotherapies in psychosis and the evidence base that supports it. In the second section, I describe some of the methodological and organisational issues that affect certain kinds of quantitative evaluation, which come in part from a misconception of how these therapies work. I go on to consider how psychotherapies could be considered integrated tools in rehabilitation, rather than siloed treatments. Finally I describe two novel therapeutic models which look to augment current theories using adjuncts to enhance their efficacy.

I. The efficacy of psychotherapy

There is some controversy about the utility of psychotherapy in the service-user groups rehabilitation psychiatry supports. These are complex patients with long histories of interpersonal difficulty and disorganised daily life. They find it hard to engage with services, especially those that demand the regularity and commitment therapy often does (Roberts 2006). Given this, it is unsurprising that rehabilitation services tend to prioritise a more practical and skills-based approach aimed at reducing social disability directly (Resnick & Goldberg 2019; Wolfson 2009).
Nevertheless, NICE recommends the use of psychotherapeutic models both as primary treatments and as a broader guiding philosophy in the recovery process. For psychosis, both Cognitive Behavioural Therapy for Psychosis (CBTp) and Family Therapy (FT) are recommended as first-line psychological interventions, and it suggests considering ‘psychodynamic principles’ in helping service-users understand their experiences (NICE 2014).

Since its characterisation in the 1990s, CBTp has become a mainstay of rehabilitation and recovery services. It aims to improve understanding and help challenge maladaptive and catastrophising cognitions by normalising illness experience. It also addresses symptoms directly by helping to challenge the veracity of delusions, and adjusting the affective response to persecutory auditory hallucinations (AH) (Roberts 2006). In this way, cognitive therapeutic models are used to modulate and alleviate symptom experience and understanding, thus developing the kinds of adaptive cognitions which enable greater personal and interpersonal functioning.

Conversely, formal psychoanalytic psychotherapy is thought to be poorly tolerated in this service-user group due to its intensive nature. However, more relaxed and informal programmes are utilised, such as reflective writing and inpatient therapeutic communities. Psychodynamic models are employed in nursing care, where staff can incorporates the principles of therapeutic holding, transference and empathetic validation, in order to encourage self-reflection and further enablement (NICE 2014; Roberts 2006: 187). In particular, an awareness of users’ past traumas and attachment styles may help to understand and mitigate projective identification and splitting directed at care-providers, and avoid ‘damaging reenactments’ which would otherwise hinder the rehabilitative process.

The efficacy of these interventions has been examined in an extensive literature, but definitive conclusions remain stubbornly elusive. CBTp, for example, has been validated as an effective treatment for alleviating symptoms in a number of meta-analyses (Burns et al. 2014; Pilling et al. 2002; Roberts 2006: 170). However the evidence has been reexamined in other analyses which have concluded effect sizes appear at best modest or insignificant (Thomas 2015), leading some to argue that CBTp has been ‘oversold’ (McKenna & 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), despite the inclusion of sixty controlled trials in its quantitative analysis. For psychodynamic approaches, the evidence is similarly equivocal, and even less investigated (eg. Cullberg et al. 2002).

There is probably better evidence for a more skills and support focused approach whose emphasis lies on network building and psycho-education (Baronet & Gerber 1998; Morin & Franck 2017; Resnick & Goldberg 2019). For example a similar Cochrane review of FT concluded there was some evidence for its efficacy in reducing relapses and improving symptom management (Pharoah et al. 2010). FT works to construct a supportive family network, emphasising collaboration and communication, and helping family members to understand the diagnosis and the signs of relapse (Roberts 2006: 163). Whilst loosely informed by various approaches, FT has a very practical focus on challenging stigma and reversing social isolation. In this way it resonates perhaps more closely with many of the core principles of rehabilitation psychiatry (Wolfson 2009); and the broader history of the movement (Anthony & Liberman 1986).

It is tempting to conclude from this that psychotherapeutic models, formally or rigidly understood, lack the justification for extensive use in psychiatric rehabilitation. Instead a more flexible and practical approach is more appropriate, and certainly easier to deploy in this service-user group. Indeed, this might explain the predominance of this approach in rehabilitation services, and the relative under-provision of psychotherapies in rehabilitation services, despite being government mandated (Colling et al. 2017; Nordentoft & Austin 2014). This is no doubt exacerbated by the overwhelming expense of training enough psychotherapists (Thomas 2015).
We should show caution, however, in interpreting the evidence afforded by RCTs and meta-analyses of psychotherapies. It is difficult to measure their effects with these types of studies, which is something different from saying they have little or no effect. 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—are often interpreted as evidence of potential bias and reason for exclusion (Jones 2018; McKenna & Kingdon 2014; Thomas 2015).

Outcome measures are also highly heterogeneous, which makes searching for replication 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\(^1\) and BPRS\(^2\) 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. Yet paradoxically, symptom changes are recorded as primary outcomes in these studies. Whilst measures such as self-insight, interpersonal relations and hostility (to name a few)—in other words, the “stuff” that psychotherapies target—are considered secondary outcomes; outcomes which anyway tend to show more consistent effects (Jones 2018).

This seems to have the causality the wrong way round: Rather than thinking of CBTp or other psychotherapies as ‘quasi-neuroleptics’ (Birchwood et al. 2014), or treatments in a rigid sense, we need to see them instead as therapeutic processes that aim to develop in service-users the kinds of qualities that enable them to recover. In other words, to build out capacities such as reflexivity and emotional literacy, producing a kind of psychological “reserve” that may well be relied on to alleviate symptoms. The variability and individual specificity of this process is inevitably lost to a large degree in quantitative analysis, but is a striking feature of the published case-reports (eg. Kukla et al. 2016; McGlashan & Nayfack 1988). These often show an integrative approach, drawing on a variety of models—cognitive, meta-cognitive and psychodynamic—contingently and adaptively. Where it is absent, emphasis is placed on the development of personal narrative, increasing one’s capacity to actively engage in the world as agentive participant, as well as reflecting on more organisational and schematic issues (Kukla et al. 2016).

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 (Leng et al. 2014). In rehabilitative psychiatry, we too can talk about reserves: Social reserves, perhaps, are the communities and family networks which we rely on in times of distress, and are shown to be protective against mental illness (Resnick & Goldberg 2019). This is something rehabilitation psychiatry has long understood and utilised in recovery, as emphasised by FT. We can also talk about psychological reserves, those sets of reflexive analytical capacities which help to orientate and contextualise complex and difficult experiences, and which are often under-developed and under-utilised in patient populations across psychiatry (Kukla et al. 2016).

The benefit of this is that as recovery proceeds, so does a patient’s understanding of their own illness, and their sense of ownership of it. 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-participant in the management of their illness (Greene & Hibbard 2012). This is often an especially difficult task in psychiatric populations, where insight may well be impaired, and disabling stigma precludes a productive sense of identifying ownership with one’s illness. 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 (Anthony & Liberman 1986).

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\(^1\) Positive and Negative Syndrome Scale

\(^2\) Brief Psychiatric Rating Scale
It is also precisely the substance that psychotherapies can take up. And whilst this essay has only space to argue for psychotherapy’s role in this in the context of rehabilitation from persistent psychosis, it 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 can be considered and integral and dynamic part of the recovery process (Morin & Franck 2017).

III. New enhanced models

Having considered the utility of psychotherapeutic models as a component of recovery, I will move on to describe some novel therapeutic techniques which show promise in targeting these systems—specifically that of developing insight and reflexivity. There is a vast panoply of psychotherapeutic models, many of them predicated on widely diverging meta-cognitive theories (e.g. Beck 1991; Freud & Strachey 1964). In practice, a plurality of approaches are utilised in recovery in a contingent and adaptive manner (McGlashan & Nayfack 1988). What increasingly marks out innovation in the field is not new theories but rather new methods of deployment. This is demonstrated by two new “adjunct-enhanced” models of delivering psychotherapy: Avatar-based therapy (ABT) and drug-assisted psychotherapy.

ABT is specifically designed for patients with persistent persecutory AH (Leff et al. 2013). It utilises audio-visual equipment to create an “avatar”—a digitalised representation of the patient’s AH—which is controlled by the therapist. In a series of structured encounters, patients come to confront these representations. Patients shift from a position of subservience to one of control, as the power and aggression of the represented AH is deliberately attenuated by the therapist. The efficacy of this treatment has been established in comparison to current treatment (CBTp) in a number of controlled trials (Craig et al. 2018). Although, again, the quality of the evidence has been questioned in a Cochrane review (Aali et al. 2020). Whilst it may seem like the aim of this model is to target and modulate symptoms, it emerges from a growing understanding of hallucinations not (just) as the biological consequences of aberrant cortical activity, but also reflective of embedded life experiences, often representing ‘a personal response to painful unresolved emotions whose meaning or purpose can be deciphered’ (Longden et al. 2012: 231). Through encountering AH in this way, psychosis can be re-experienced as part of oneself, made sense of in the context of one’s life, building the kind of self-insight that enables a degree of self-management in future events. As some authors have noted, effect sizes in this adjunct-enhanced therapy are larger with less time-intensive work, offering a plausibly scalable intervention (Craig et al. 2018).

Drug-assisted therapy has recently emerged as an exciting new current in psychotherapeutic research. This has largely been driven by a renewed interest in psychedelic compounds, and their therapeutic promise in a wide range of contexts, after many decades of neglect. The utilisation of psychedelics to enhance therapy has strong neuroscientific and pharmacological underpinning: 5-HT_{2A} receptor activation stimulates a dramatic increase in cross-cortical integration, which is theorised to relax limiting beliefs, promote insight and emotional release, allowing for the revision of firmly-held prior beliefs (Roseman et al. 2018). This enhancement seems to dramatically increase the personal significance of the therapeutic process for the user. In this way it is a profoundly novel strategy: Rather than a pharmacological target being used to induce the remission of symptoms, it targets and augments the patient’s cognitive capacities to develop personal reflexivity. This is then used to address the maladaptive schemas that exacerbate the psychopathological condition. In other words, causality the right way round. This radical realignment of approach perhaps explains its breadth of utility; including in treatment-resistant depression and addiction (Nutt et al. 2020). It may also explain its larger and more durable effects, deliverable within a shorter therapeutic time-frame.

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3This can be thought of as a move away from the dramatic “shifts” in theory of the twentieth century, to a more adaptive “drift” in technique that has been seen more recently.
Currently, having a history of psychosis or severe personality disorder are considered exclusion criteria for participant enrolment in this research. This “safely slowly” approach is sensible given the history of mainstream concern around these treatments. However it is unestablished that they cause harm in these populations, especially when administered in a clinical context. There is also evidence that some classes of psychedelics avoid activating striatal dopaminergic pathways, and may even inhibit their activity, avoiding a major component of psychotic neuropathology (González-Maeso & Sealfon 2009). So whilst this modality of drug-assisted therapy will have a near-term role primarily in populations with neurotic disorders, there is still potential for its utility, perhaps with a different adjunct, in the rehabilitation of those with schizophrenia.

Adjunct-enhanced therapies offer novel strategies to enhance the effectiveness of psychotherapies as treatments in psychiatric conditions. These increased effects seem to relate to the novel ways in which they are able to develop reflexive capacities in their users, building out the psychological reserve that produces a self-enabled recovery.

Conclusion

This essay has argued for the role of psychotherapeutic models in recovery and rehabilitation, which have been questioned by some as lacking evidence. Highlighting the need for caution in interpreting meta-analyses, it has urged a re-thinking of therapies not as ‘quasi-neuroleptics’ treating symptoms, but rather practical contingent processes aimed at developing a set of cognitive capacities that can aid recovery. It has highlighted two novel therapeutic models that employ adjuncts to enhance this process, potentially increasing their efficacy in the rehabilitation context.

The essay has made use of a largely artificial dichotomy; that between skills-based and psychotherapeutic approaches in rehabilitative psychiatry. These inform each other, and often draw on similar methodologies (Morin & Franck 2017). However, it is used heuristically to emphasise the distinction between the two foci in recovery, described as social and psychological reserve, which are both important in promoting recovery and protecting against relapse. What distinguishes psychological reserve, however, is that the capacities it is characterised by are 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 by social psychiatry.

Looking to the future, it is important that further research is conducted to establish the efficacy of the psychotherapeutic techniques discussed here; both those currently deployed, and novel practices such as adjunct-enhanced therapies. It is also important that research looking at establishing effect is sensitive to the particularities and contingencies of these practices, which are in so many ways distinct from a conventional pharmacological intervention. In particular, research needs to be conducted 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.

It is also vital that if these services do enable service-users to be more active participants in their health (or even if not), this capacity is 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 (Vennik et al. 2016).

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Bibliography


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