Cognitive therapy may reduce psychotic symptom severity but not risk of transition to psychosis in young people at high risk

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QUESTION

Question: Is cognitive therapy effective in preventing transition to psychosis and reducing symptom severity in young people at high risk for schizophrenia and other psychoses?
Patients: 288 participants aged 14–35 years (mean 20.7 years), at high risk of psychosis and seeking help for symptoms. High psychosis risk was defined as experiencing brief limited intermittent psychotic symptoms, attenuated psychotic symptoms or state plus trait factors and assessed using the comprehensive assessment of the at risk mental state (CAARMS). Exclusion criteria included current or previous treatment with antipsychotic medication, moderate-to-severe learning disability, organic impairment or lack of fluency in English. Participants were referred from service organisations.
Setting: Manchester, Birmingham/Worcestershire, Glasgow, Cambridgeshire and Norfolk, UK; 2006–2010.
Intervention: Cognitive therapy in addition to mental state monitoring plus treatment as usual was compared with mental state monitoring plus treatment as usual (control). A maximum of 26 cognitive therapy sessions (1/week) were given over 6 months. Treatment as usual depended on local services and the referring organisation, and varied across study sites. Randomisation was stratified based on study site to address this variability.
Outcomes: *Primary outcome*: transition to psychosis, severity of psychotic symptoms and distress, assessed using the CAARMS, with higher scores indicating greater symptom severity and distress. *Secondary outcomes*: global function (global assessment of function), depressive symptoms (Beck depression inventory for primary care), social anxiety (social interactions anxiety scale) and quality of life (Manchester short assessment of quality of life, MANSA).
Patient follow-up: 65.3% at 12 months, 22.6% at 24 months.

METHODS

Design: Randomised controlled trial.
Allocation: Concealed.
Blinding: Single blinded (assessors).
Follow-up period: 12–24 months.

MAIN RESULTS

Overall, 23 (8%) of the 288 participants transitioned to psychosis, 10 (6.9%) from the cognitive therapy group and 13 (9%) from the control group. There was no significant difference in transition to psychosis between the two groups (OR 0.73, 95% CI 0.32 to 1.68, p=0.45). Participants in the cognitive therapy group demonstrated a greater reduction in the severity of psychotic symptoms compared to the control group at 12 months (estimated difference on CAARMS severity scale: −3.67 points on the, 95% CI −6.71 to −0.64, p=0.018). The treatment effect became borderline significant when applying the Bonferroni correction to take into account the three primary outcomes. At 12 months, there was no significant difference between the cognitive therapy and monitoring only in distress from psychotic symptoms (estimated difference on CAARMS distress scale: −3.03, 95% CI −6.95 to +0.94, p=0.14). At 12 months cognitive therapy also did not differ from monitoring only on global assessment of functioning (estimated difference: +1.85, 95% CI −1.34 to +5.05, p=0.26), depression (−0.37, 95% CI −1.34 to +0.60, p=0.45), social anxiety (−2.77, 95% CI −5.98 to +0.45, p=0.09) and quality of life (+2.24, 95% CI −0.60 to +5.08, p=0.12).

CONCLUSIONS

Cognitive therapy may reduce the severity of psychotic symptoms in young people at high risk compared with monitoring alone. It does not have a significant effect on transition to psychosis, distress due to psychotic experiences, depressive symptoms, social anxiety or quality of life.

ABSTRACTED FROM

Morrison AP, French P, Stewart SL, *et al*. Early detection and intervention evaluation for people at risk of psychosis: multisite randomised controlled trial. *BMJ* 2012;**344**:e2233.

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COMMENTARY

The article by Morrison and colleagues presents the results of a well-designed study examining the effect of cognitive behavioural therapy (CBT) on emerging psychotic symptoms in those with a psychosis risk syndrome. The authors were unable to demonstrate that the CBT intervention reduces psychosis transition rate over 12–24 months; however, it did reduce severity of psychotic symptoms in the at risk group—important when considering stress reduction. Additionally, they found the transition rate from at risk mental state to psychosis (6.9–9%) was lower than in previous research (50%). This drop in transition rate has been mirrored in recent studies. It is important that the benefits outweigh the risks of whatever treatment offered in this group, as there are likely to be many 'false-positives'.

Leading up to the publication of DSM 5 there was much debate relating to the possible inclusion of the 'attenuated psychosis syndrome'. We now know it has been included in section 3 (needs more research) potentially providing an increased focus for this hitherto primarily research-based construct. This may lead to an increase in research funding and access to healthcare for those with this condition. Alternatively, we may see over-diagnosis of a subclinical syndrome leading to potentially harmful treatment or stigmatisation of those who may never develop full-blown psychotic illness. As it stands, attenuated psychosis syndrome has been included in section 3 of the new DSM-5, so it will not be recognised as a formal disorder, but one requiring more research, whicjh may be a good compromise.

Overall, if we are to offer interventions for help-seeking individuals with psychosis risk syndrome we should be offering the least harmful and best-tolerated (CBT or medication such as omega 3 fatty acids or selective serotonin reuptake inhibitors). The use of potentially harmful antipsychotic medication is less attractive as, although the transition rate to psychosis may initially be affected, the longer term side effects may be more problematic. Current directions in treatment, in keeping with this study, embrace a 'stress reduction' paradigm.[1]

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Competing interests None.

REFERENCE

1. **Early Psychosis Guidelines Writing Group.** *Australian guidelines for early psychosis*. 2nd edn. Melbourne: Orygen Youth Health, 2010.