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Cognitive-behavioral group therapy for schizophrenia

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Author

Boyd (formerly Ritscher), Jennifer E

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Cognitive-Behavioral Group Therapy for Schizophrenia

Bechdolf, A., Knost, B., Kuntermann, C., Schiller, S., Klosterkötter, J., Hambrecht, M., & Pukrop, R. (2004). A randomized comparison of group cognitive-behavioural therapy and group psychoeducation in patients with schizophrenia. *Acta Psychiatrica Scandinavica*, 110, 21-28.

Pinkham, A. E., Gloege, A. T., Flanagan, S., & Penn, D. L. (2004). Group cognitive-behavioral therapy for auditory hallucinations: A pilot study. *Cognitive & Behavioral Practice*, 11, 93-98.

Group therapy is an attractive treatment modality for schizophrenia because, for the individual with this often isolating and demoralizing condition, it offers an opportunity to engage constructively with peers and, for the therapist or clinic, it provides a service in an efficient and cost-effective manner. Group therapy can focus both on the positive symptoms of this illness, such as hallucinations, and the negative symptoms, such as social withdrawal. While the evidence base is still relatively scant, there are some data indicating that group therapy can be helpful for both inpatients and outpatients with schizophrenia (Kanas, 1996). Until now, however, there has been essentially no empirical work specifically focusing on the use of cognitive-behavior therapy (CBT) in a group format for inpatients with schizophrenia.

In contrast, there is mounting evidence supporting the use of CBT in an individual therapy format for treating schizophrenia and related disorders. Turkington, Dudley, Warman, and Beck (2004), for example, have shown its effectiveness for coping with hallucinated voices which cause distress and impairment directly and also indirectly because they can evoke discrimination and stigmatization if disclosed to others (Ritsher, Lucksted, Otilingam, & Grajales, 2004). Therefore, learning how to reduce the distressing impact of the voices and learning to control one's responses to voices in public places will likely go far to instill hope, improve mo-

role, and facilitate community integration. Although individual CBT may well help train patients to be less influenced by their voices and to gain mastery over this symptom, group CBT has the added benefit of providing a forum in which participants can learn coping skills in collaboration with peers who are going through similar experiences.

The promise of group CBT for schizophrenia was recently put to the test in the two empirical studies of hospitalized patients that are reviewed here. The first of these, by Pinkham, Gloege, Flanagan, & Penn (2004), targeted the specific symptom of auditory hallucinations. The research team used a CBT treatment manual that was developed in the United Kingdom for outpatients (Wykes, Parr, & Landau, 1999). Replicating and extending this work, Pinkham and colleagues conducted both a short-term group and a long-term group, thus allowing for preliminary analysis of dose-response data. Outcomes were assessed with highly targeted, well-validated, and relevant measures: the Auditory Hallucinations Rating Scale (PSYRATS), the Beliefs About Voices Questionnaire-Revised (BAVQ-R), the Positive and Negative Syndrome Scale (PANSS), and the Wide Range Achievement Test-III (WRAT-III), each described in detail in the study.

The intervention included standard CBT techniques, such as training in self-monitoring and coping strategies, as well as guidance in actually using the self-monitoring to evaluate the effectiveness of the coping strategies, and adjusting those strategies accordingly as part of homework assignments. These time-limited groups were structured such that each session had a specific agenda. The first group met weekly in 7 one-hour sessions. In order to provide more time on difficult topics and to assign more homework, the second group covered the same topics in 20 one-hour sessions spread over 10 weeks. Data were collected and analyzed from the five different patients in each group.

Analyses showed improvements in important patient outcomes, with substantial effect sizes (BAVQ-R effect size = .51, $p < .05$; PSYRATS effect size = .72, $p < .10$; PANSS effect size = 1.1, $p < .10$). While not all of these clinically meaningful changes were statisti-

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cally significant due to the extremely small sample sizes, the findings suggested changes in beliefs about voices, the impact of auditory hallucinations, and the severity of symptoms. Results did not show a clear advantage for the 20-session group over the 7-session group. The authors cautioned that with such small samples it is not wise to draw firm conclusions. Still, this pilot study displays the feasibility and promise of this method for use with inpatients and others with positive symptoms. It will be of great interest to see the results of the larger-scale study that the authors intend to carry out.

In a larger study of 88 patients, Bechdolf and colleagues (2004) conducted a randomized controlled trial of 8 weeks of group CBT versus 8 weeks of group psychoeducation. In addition to having a control condition and pre- and post-tests, this methodologically superior study featured a 6-month follow-up assessment that included clinician ratings, rehospitalization rates, and medication compliance.

The therapy groups in this study used a CBT program developed by Tarrier and colleagues (1990), which included coping strategy enhancement, problem-solving techniques, and relapse prevention, with a particular focus on auditory hallucinations and delusions. The intervention protocol was designed for individual CBT, but Bechdolf and colleagues adapted it for use in groups.

The study found large and statistically significant improvements for both the CBT group and the psychoeducation group. Of note, patients in the CBT group experienced significantly fewer rehospitalizations. In addition, CBT seemed to affect relapse rates and medication compliance more than the psychoeducational control group, although not with statistical significance. There were hints that although the CBT group affected complex patterns of functioning involving relapse, rehospitalization, and medication compliance, it did so at the cost of short-term symptom improvement, since the CBT patients seemed to struggle more actively with their symptoms than did the patients in the psychoeducation group. In other words, the authors believe that the CBT intervention may have created stress for some of the pa-

tients, causing their acute symptoms to take longer to resolve than was the case for patients in the psychoeducation group. Thus, controlling for pretreatment psychopathology scores in an analysis of covariance, there was no clear advantage for the CBT group over the psychoeducation group in terms of psychopathology. Overall, then, the findings were somewhat mixed—both groups were effective, and CBT seemed somewhat more effective than psychoeducation on some outcome domains.

Taken together, these two articles represent a good beginning to a promising line of work that needs to be followed up with larger and more sophisticated studies. Large-scale studies would have the important advantage of allowing for the analysis of group-level effects. Future studies would also do well to focus more on the specific substantive aspects of group therapy that differentiate the effects of this modality from those of individual therapy. In particular, it would be useful to study whether group treatment is better suited to promote community integration, which is an essential aspect of recovery from severe disruptive disorders such as schizophrenia. And because CBT targets quality of life issues as well as symptom reduction, it has the potential to help patients combat the undermining effects of internalized stigma and alienation, that aspect of internalized stigma that most strongly predicts deteriorations in depressive symptoms and self-esteem (cf. Ritsher & Phelan, 2004). It will be exciting to watch this important new line of work develop further.

REFERENCES

- Kanas, N. (1996). *Group therapy for schizophrenic patients*. Washington, DC: American Psychiatric Press.
- Ritsher, J. B., Lucksted, A., Otilingam, P. G., & Grajales, M. (2004). Hearing voices: Explanations and implications. *Psychiatric Rehabilitation Journal*, 27, 219-227.
- Ritsher, J. B., & Phelan, J. (2004). Internalized stigma predicts erosion of morale among psychiatric outpatients. *Psychiatry Research*, 129, 257-265.
- Tarrier, N., Harwood, S., Yusopoff, L., Beckett, R., & Baker, A. (1990).

- Coping Strategy Enhancement (CSE): A method of treating residual schizophrenic symptoms. *Behavioral Psychotherapy*, 18, 283-293.
- Turkington, D., Dudley, R., Warman, D. M., & Beck, A. T. (2004). Cognitive-behavioral therapy for schizophrenia: A review. *Journal of Psychiatric Practice*, 10, 5-16.
- Wykes, T., Parr, A. M., & Landau, S. (1999). Group treatment of auditory hallucinations. Exploratory study of effectiveness. *British Journal of Psychiatry*, 175, 180-185.

Jennifer Boyd Ritsher, Ph.D.
University of California and
Department of Veterans Affairs
Medical Center
San Francisco, CA
E-mail: jennifer.ritsher@ucsf.edu