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INDIVIDUAL COGNITIVE-BEHAVIOR THERAPY IN THE TREATMENT OF HALLUCINATIONS AND DELUSIONS: A REVIEW

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ABSTRACT. *The limitations of biochemical treatments in reducing the severity of hallucinations and delusions has led to an increased interest in the investigation of psychological treatments for these symptoms. These investigations have spanned the last 4 decades and have covered a range of psychological approaches from psychoanalytically oriented psychotherapy to behavioral approaches. More recently, findings that some psychotherapies are not effective treatments for psychosis and that cognitive-behavior therapy can be an effective treatment for neurotic disorders have led to increasing interest in the investigation of the effectiveness of cognitive-behavior therapy for psychosis. This review describes and evaluates the research on the cognitive-behavioral treatment of hallucinations and delusions and describes the cognitive models from which the treatments have developed. The conclusion is that, on the whole, the literature provides fairly strong evidence for the efficacy of cognitive-behavioral approaches in the management of chronic*

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psychotic disorders and associated symptoms, although there are a number of areas where further development is necessary. *© 1998 Elsevier Science Ltd*

THE USUAL FIRST-LINE TREATMENT for patients with psychotic symptoms such as hallucinations and delusions is neuroleptic medication. The finding that this type of medication was effective in the treatment of psychosis during the 1950s (Delay, Deniker, & Harl, 1952) brought about important developments in the care and management of people with schizophrenia (e.g., by reducing positive symptoms during acute crises and preventing subsequent relapse rates). Despite this, neuroleptic medication has some limitations with regard to its efficacy on psychotic symptoms. For example, a substantial number of patients will continue to experience persistent and distressing hallucinations and delusions or will be subject to periodic relapse of these symptoms despite appropriate doses of neuroleptic medication. Although the introduction of atypical neuroleptics has gone some way to improve outcome for neuroleptic nonresponders, medication still does not provide full remission for large numbers of patients. The discovery of drug therapies that will completely eradicate the occurrence or relapse of psychotic symptoms has remained elusive since the 1950s when chlorpromazine (a drug still in use in the United Kingdom today) was first introduced as a possible treatment for psychosis.

PSYCHOTHERAPY AND SCHIZOPHRENIA

As a result of the limitations in drug treatments, many clinicians and researchers have seen the need for development of complementary treatment approaches that can enhance the effectiveness of medication and improve patient outcome. The main areas investigated are those that have involved some form of psychotherapy, although, by the mid-1980s most researchers and clinicians interested in schizophrenia were familiar with large-scale studies showing little or no efficacy of supportive or psychodynamic psychotherapy in the treatment of the disorder and its symptoms (Gunderson et al., 1984; May, 1968; Mosher & Keith, 1980; Stanton et al., 1984).

In contrast, the research on cognitive-behavioral therapy for the positive symptoms of schizophrenia, which spanned the same historical period and continues today, is less universally familiar. However, studies of cognitively oriented behavioral approaches to treating schizophrenia go back at least to Meichenbaum's work (Meichenbaum & Cameron, 1973), and less cognitively oriented behavioral approaches were being widely studied at least a decade before that (see Curran, Monti, & Corriveau, 1982; Paul & Lentz, 1977). Historically, cognitive-behavior therapy was developed for the treatment of neurotic disorders, such as anxiety or depression. Its efficacy in the treatment of these disorders is now well established. The assumption behind cognitive-behavior therapy, as applied to any disorder, is that the occurrence and maintenance of a symptom or problem are mediated by cognitive and environmental processes that may be modified by teaching more adaptive cognitive and behavioral skills. The cognitive-behavioral models driving the application of treatment are more developed in some disorders than others. For example, Clark (1988) described a comprehensive cognitive model of panic that explains its development and maintenance and that provides a formulation for guiding specific interventions that are intended to modify the processes that are contributing to symptom occurrence.

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