The usefulness for indicated prevention of severe mental disorders should play a central part in the further development of CBT

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Schizophrenic, severe major depressive and bipolar disorders often do not respond sufficiently to the usual pharmacotherapy and therefore constitute the world's greatest public health problem (1). Thus, we have every reason to be happy that we can offer cognitive behavior therapy (CBT) as an effective non-pharmacological adjunct to the millions of people who are treated for those conditions worldwide.

Obviously there are methodological problems as well as discrepant and negative results in numerous studies and meta-analyses on the effectiveness of complementary CBT in the above disease groups. Overall, however, the evidence speaks much more for than against the assumption that CBT or CBT-oriented strategies may improve the outcome of pharmacological treatment and prophylaxis, especially for treatment-resistant or chronic patients.

On the other hand, the "promise of CBT" should not be overestimated in this important area of therapeutics. Taken as a whole, the hitherto achieved effects are only moderate, and data concerning bipolar disorders are not sufficient. Also, the evidence of efficacy for CBT should not mean that other approaches are now excluded from the search for useful psychotherapies for severe mental disorders. The traditional vulnerability-stress-coping models and also the newer salience theory of psychoses (2) offer a good framework for the development and use of psychological treatment strategies. They show, in fact, that different environmental stressors as well as personal and environmental protective factors may be involved in each individual case. CBT programs can target various but obviously not all of these psychosocial factors.

Furthermore, important psychosocial influences such as trauma or migration interact with genetic-epigenetic and other biological factors (3). Therefore, even enthusiastic psychotherapists should not ignore that treatment and prophylaxis of severe mental disorders primarily deal with the current correction and future prevention of disorder-specific neuronal network pathologies in the human brain. The more we understand these pathologies, the more it will be possible to correct the network alterations by means of targeted neuromodulation. Research is currently testing new psychotropic drugs, neuroprotective substances and various brain stimulation methods to achieve this goal.

The debate on "promise and limitations of CBT" reflects the presently unsatisfactory state of development. To date there are still no really causally effective psychotropic drugs available for the treatment of severe mental disorders, due to the lack of knowledge about etiology. That is why we try to combine substances which only influence the final pathogenetic pathways, and therefore are only partially effective, with complementary psychological interventions. Here, CBT has proven particularly useful, as it has a favorable impact on some of the psychosocial factors which are important for the release of and coping with the clinical symptoms. Nevertheless, the therapeutic problems are far from being solved, and the search for causal treatment approaches must go on.

The directions for future research should include further testing of CBT in the initial high-risk states of psychosis or bipolar disorders (4). In persons who have already suffered from long courses of these diseases, with relapses or chronicity, CBT can only be an adjunct and at best produce the effects described in Thase et al's paper

(5). Often the primary therapeutic goal of recovery is not at all achievable and what can be obtained is only coping with symptoms or loss of functions in order to reduce the burden of the disease and improve the quality of life.

On the contrary, in the high-risk states, which can nowadays be characterized very well for psychoses (6) and increasingly better for severe mood disorders (7), we just observe initial changes of experience which, depending on the individual constellation of stressors and protective factors, can progress or not to the actual disease. The prevention of the outbreak of severe mental disorders is what is meant by the concept of indicated prevention (8).

Right from the beginning, CBT was involved in the studies of indicated prevention of schizophrenia and has repeatedly been shown to be effective as the sole therapy without concurrent use of medication (9). It seems to be able to even prevent the transition of early cognitive disorders into attenuated psychotic symptoms and their transition into full schizophrenic symptoms (10). If this approach of indicated prevention is successfully transferred also to severe mood disorders, it promises to be much more useful in the fight against the world's greatest public health problem than the late adjunctive strategy (11).

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CBT for psychotic disorders: beyond meta-analyses and guidelines – it is time to implement!

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The treatment of psychotic disorders has considerably improved since the introduction of antipsychotic medication more than half a century ago, and there is no doubt that this medication can reduce psychotic symptoms and the risk of relapse (1). However, even though pharmacological treatment is significantly better than placebo, there are a number of patients who experience side effects which in some cases can be harmful, and a proportion of people who still experience psychotic symptoms in spite of antipsychotic treatment (2). There are also patients who refuse antipsychotics because of the risk of side effects, the belief that they are able to handle their difficulties without medication, or a fundamental disagreement with the clinician about the nature of their symptoms. In other words: there is room for improvement, and the use of approaches other than medication alone should be explored.

There is clear evidence that cognitive behavior therapy (CBT) can reduce psy-

chotic symptoms in schizophrenia when added to pharmacotherapy (1). Several meta-analyses have supported this conclusion, although many studies did not meet optimal standards for randomized controlled trials with regard to blinded measurement of outcome. The effect size in the most rigorously conducted trials is small (3), and evidence is lacking about the effectiveness of short versus long duration CBT (4). Few trials have directly compared CBT with other talking therapies (5), and it is possible, but not yet proven, that other therapies may also be effective. However, based on current evidence, it has not been established that psychodynamic therapy is better than treatment as usual (1).

On this background, the American Schizophrenia Patient Outcomes Research Team (PORT) recommendations state that persons with schizophrenia who have persistent psychotic symptoms while receiving adequate pharmacotherapy should be offered adjunctive CBT to reduce the severity of symptoms (6), and the National Institute for Clinical Excellence (NICE) guidelines recommend to offer CBT to all people with psychosis or schizophrenia (7).

In a recent paper, Morrison et al (8) presented data indicating that CBT can be effective even among patients who do not want to take antipsychotic medication. Whilst the sample size was small, this result is promising and warrants replication.

Many CBT trials have focused on treatment resistant delusions, where the therapist and the patient will examine the basis and the likelihood of the delusional belief, exploring alternative explanations and identifying behavior that can reduce the stress related to the symptoms. Hallucinations can also be a target for CBT interventions. In a recently published multicenter trial, Birchwood et al (9) reported that CBT focusing on modifying conviction of beliefs linked to the construct of voice power, thereby challenging the omniscience and omnipotence of the voices, can successfully decrease compliance with command hallucinations. This finding is very important from a clinical point of view, as the patients were otherwise treatment resistant, and in many cases posed a significant danger to themselves or others.

Hallucinations and delusions, however, are not the only symptoms in schizophrenia. For many patients, negative symptoms, depression, anxiety and low self-esteem are experienced as much more debilitating. CBT has been shown to be a promising intervention in reducing these phenomena. A more holistic approach to treatment, focusing not only on primary symptoms but also on the functional and psychological consequences of having a severe mental illness, is congruent with the current emphasis on factors that can facilitate recovery.