Dalla CBT alla meta cognizione:
trattamenti cognitivo-comportamentali nelle psicosi

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Schizophrenia Bulletin vol. 34 no. 3 pp. 523–537, 2008
doi:10.1093/schbul/sbm114
Advance Access publication on October 25, 2007

Cognitive Behavior Therapy for Schizophrenia: Effect Sizes, Clinical Models, and Methodological Rigor

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Background: **Guidance in the United States and United Kingdom has included cognitive behavior therapy for psychosis (CBTp) as a preferred therapy. But recent advances have widened the CBTp targets to other symptoms and have different methods of provision, eg, in groups.** ***Aim:*** **To explore the effect sizes of current CBTp trials including targeted and nontargeted symptoms, modes of action, and effect of methodological rigor.** ***Method:*** **Thirty-four CBTp trials with data in the public domain were used as source data for a meta-analysis and investigation of the effects of trial methodology using the Clinical Trial Assessment Measure (CTAM).** ***Results:*** **There were overall beneficial effects for the target symptom (33 studies; effect size = 0.400 [95% confidence interval {CI} = 0.252, 0.548]) as well as significant effects for positive symptoms (32 studies), negative symptoms (23 studies), functioning (15 studies), mood (13 studies), and social anxiety (2 studies) with effects ranging from 0.35 to 0.44. However, there**

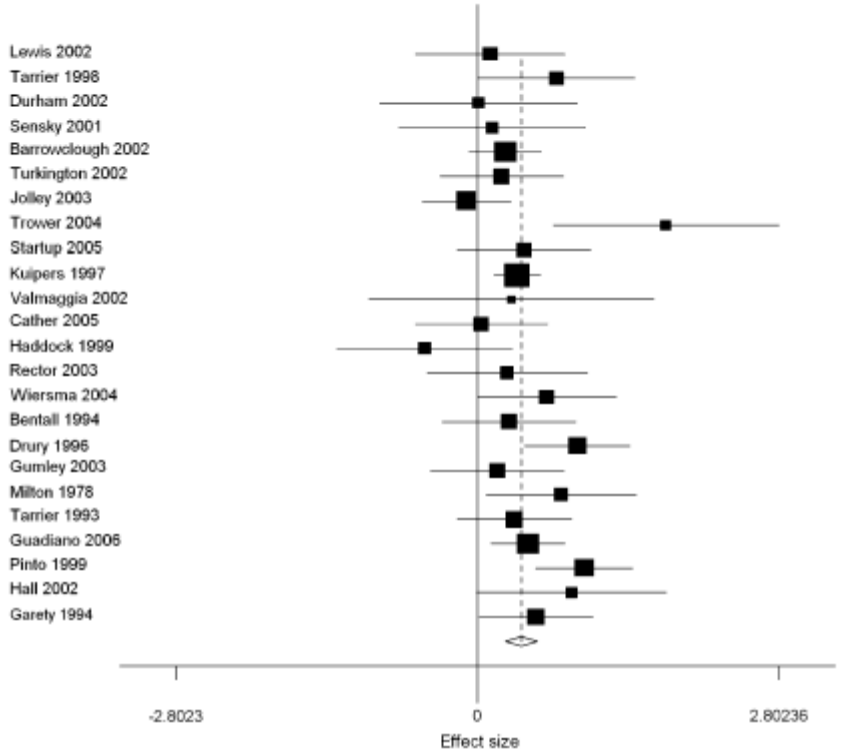

Table 3. Results of Meta-analyses

	Mean Weighted Effect Size	95% Confidence Interval	Heterogeneity Test (*df*), Significance Level	No. of Studies	Sample Size
Target symptom	0.400	0.252, 0.548	74.1 (32), significant at the 5% level	33	1964
Positive symptoms	0.372	0.228, 0.516	61.7 (31), significant at the 5% level	32	1918
Negative symptoms	0.437	0.171, 0.704	118.1 (22), significant at the 5% level	23	1268
Functioning	0.378	0.154, 0.602	36.7 (14), significant at the 5% level	15	867
Mood	0.363	0.079, 0.647	52.7 (12) significant at the 5% level	15	953
Hopelessness	−0.190	−0.547, 0.166	10.0 (3), not significant	4	431
Social anxiety	0.353	n/a	n/a	2	61

Trial	Year	United Kingdom	Individual/ Group	Primary Aim	Positive Symptom Effect Size
Milton et al[54]	1978	Y	I	P	0.78
Tarrier et al[55]	1993	Y	I	P	0.35
Garety et al[56]	1994	Y	I	P	0.55
Bentall et al[57]	1994	Y	I	P	0.29
Drury et al[58]	1996	Y	I	P	0.93
Kuipers et al[59]	1997	Y	I	P	0.37
Tarrier et al[60]	1998	Y	I	P	0.73
Daniels[61]	1998	N	G	N	0.64
Levine et al[62]	1998	N	G	P	2.36
Pinto et al[63]	1999	N	I	P	0.99
Haddock et al[64]	1999	Y	I	P	−0.49
Halperin et al[65]	2000	N	G	SA	n/a
Sensky et al[66]	2001	Y	I	P	0.14
Bailer et al[67]	2001	N	I	N	0.34
Barrowclough et al[26]	2001	Y	I	P	0.26
Lewis et al[68]	2002	Y	I	P	0.12
Turkington et al[69]	2002	Y	I	P	0.23
Durham et al[70]	2002	Y	I	P	−0.32
Hall and Tarrier[71]	2002	Y	I	P	0.88
Valmaggia et al[72]	2002	N	I	P	0.32
Granholm et al[73]	2002	N	I	F	0.62
Gumley et al[74]	2003	Y	I	P	0.19
Rector et al[75]	2003	N	I	P	0.28
Jolley et al[76]	2003	Y	I	P	−0.10
Kingsep et al[77]	2003	N	G	SA	n/a
Trower et al[53]	2004	Y	I	CH	1.75
Wiersma et al[78]	2004	N	I	P	0.65
Bechdolf et al[79]	2004	N	G	P	0.02
Startup et al[80]	2005	Y	I	P	0.44
Cather et al[81]	2005	N	I	P	0.04
Granholm et al[82]	2005	N	I	F	−0.07
Wykes et al[83]	2005	Y	G	P	0.02
Gaudiano and Herbert[84]	2006	N	I	P	0.47
Barrowclough et al[40]	2006	Y	G	P	0.04

In una metanalisi di Wikes, Everitt e Tarrier (2008), 34 studi randomizzati controllati verificano l'efficacia della CBT verso campioni di controllo, attraverso uno strumento di assessment, il CTAM (Clinical Trial Assessment Measures). I trattamenti riguardano protocolli sia individualizzati sia di gruppo.
I risultati evidenziano un beneficio complessivo (effect size 0,400) e un significativo effetto nei confronti di:

- ❑ sintomi positivi (32 studi);
- ❑ sintomi negativi (23 studi);
- ❑ funzionamento (15 studi); umore (13 studi);
- ❑ ansia sociale (2 studi)

Note: CTAM, Clinical Trial Assessment Measure; primary aim: P, positive; N, negative; SA, social anxiety; CH, command hallucinations; F, functioning; n/a, not applicable; y, yes; N, no.

The effect of cognitive behavioral treatment on the positive symptoms of schizophrenia spectrum disorders: A meta-analysis

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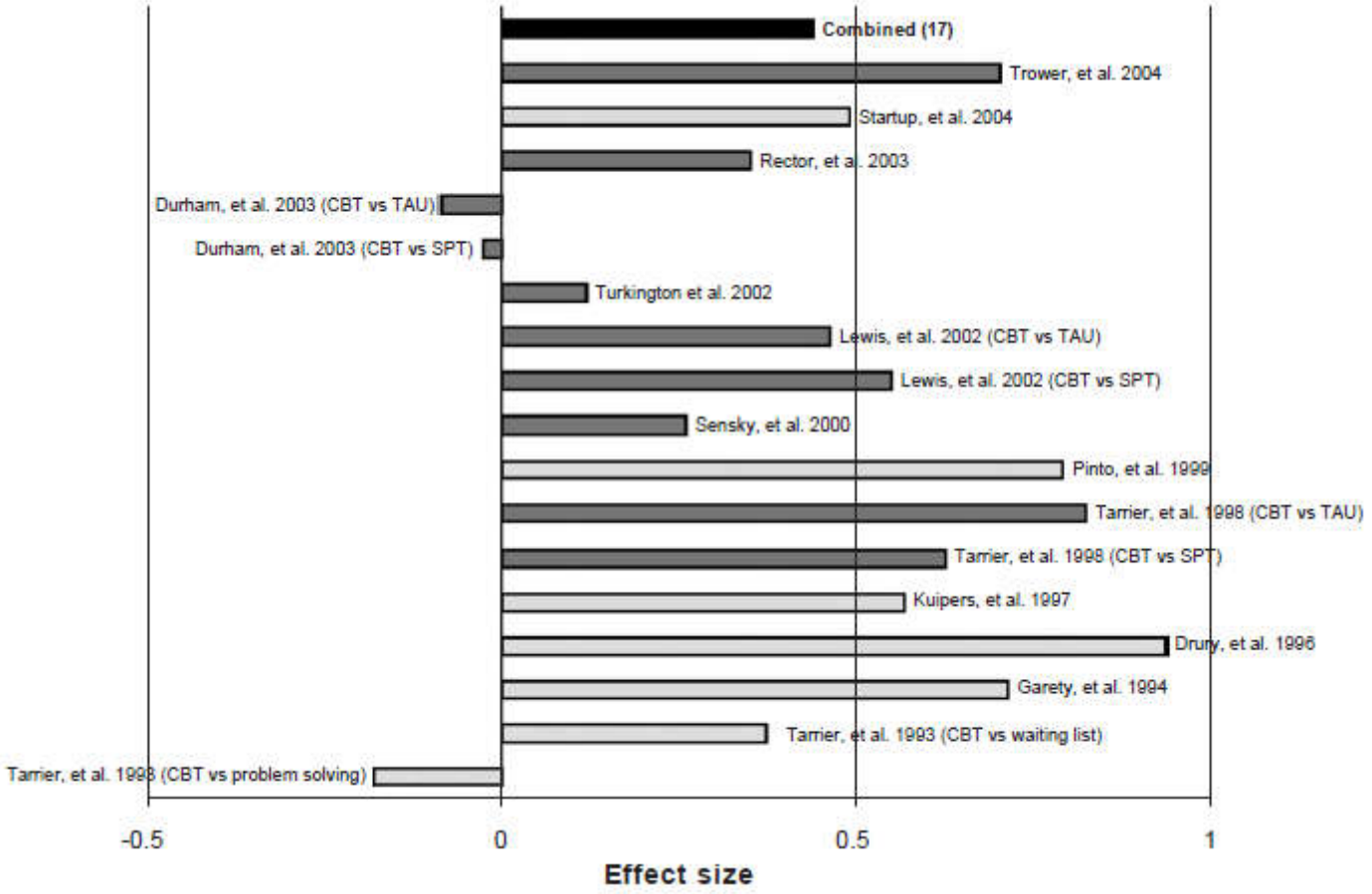
Schizophrenia Research 77 (2005)



Method: Fourteen studies including 1484 patients, published between 1990 and 2004 were identified and a meta-analysis of their results performed.

Results: Compared to other adjunctive measures, CBT showed significant reduction in positive symptoms and there was a higher benefit of CBT for patients suffering an acute psychotic episode versus the chronic condition (effect size of 0.57 vs. 0.27).

The Psychosis High-Risk State

A Comprehensive State-of-the-Art Review

JAMA Psychiatry. 2013;70(1):107-120.
Published online November 19, 2012.
doi:10.1001/jamapsychiatry.2013.269

Paolo Fusar-Poli, MD, PhD; Stefan Borgwardt, MD, PhD; Andreas Bechdolf, MD; Jean Addington, PhD; Anita Riecher-Rössler, MD, PhD; Frauke Schultze-Lutter, PhD; Matcheri Keshavan, MD; Stephen Wood, MD, PhD; Stephan Ruhrmann, MD, PhD; Larry J. Seidman, MD, PhD; Lucia Valmaggia, MSc, PhD; Tyrone Cannon, PhD; Eva Velthorst, MSc, PhD; Lieuwe De Haan, MD, PhD; Barbara Cornblatt, MBA, PhD; Ilaria Bonoldi, MD; Max Birchwood, DSc; Thomas McGlashan, MD; William Carpenter, MD; Patrick McGorry, MD; Joachim Klosterkötter, MD, PhD; Philip McGuire, MD, PhD; Alison Yung, MD

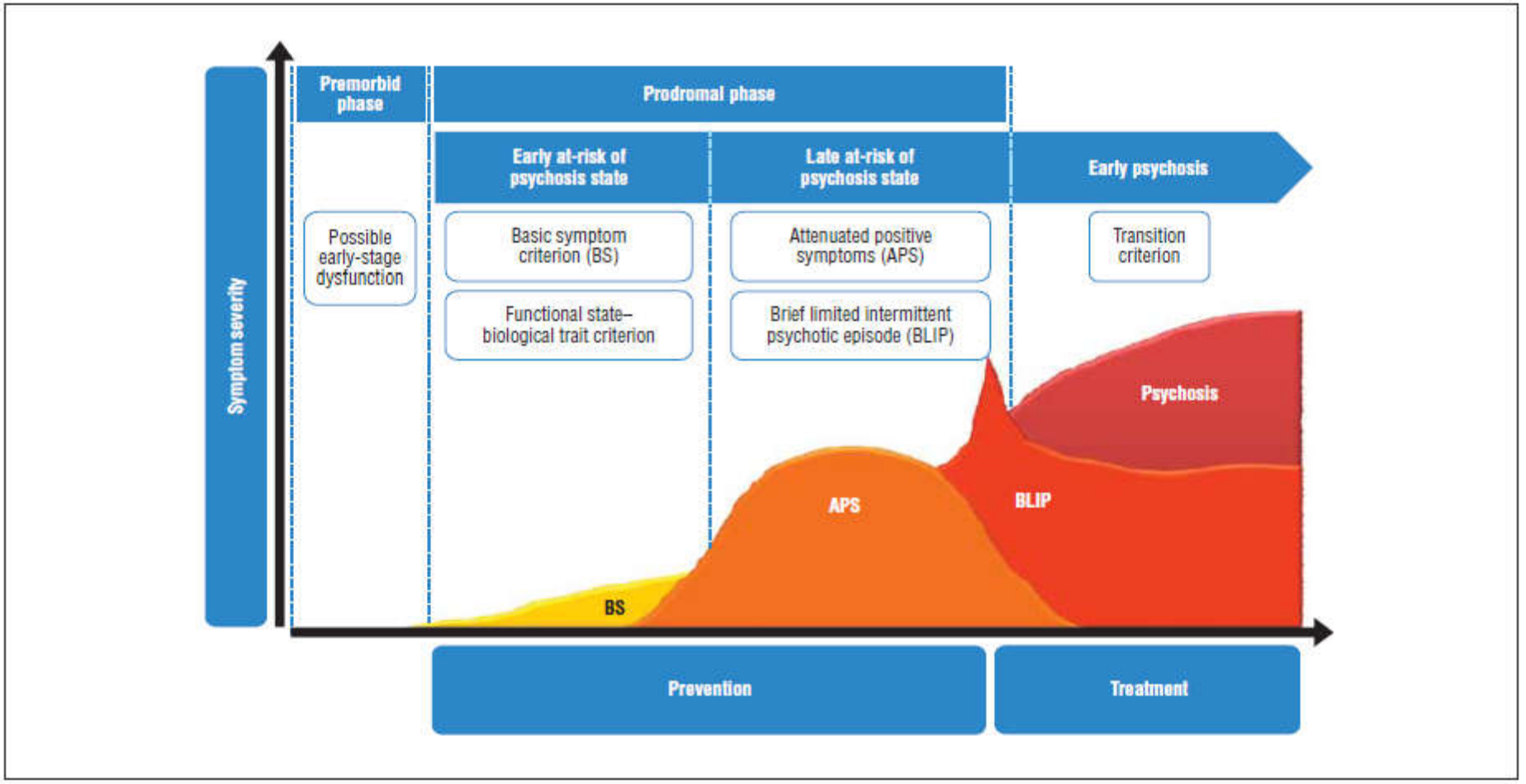


Figure 3. Model of psychosis onset from the clinical high-risk state. The higher the line on the y-axis, the higher the symptom severity.

Predicting Psychosis

Meta-analysis of Transition Outcomes in Individuals at High Clinical Risk

Paolo Fusar-Poli, MD, PhD; Ilaria Bonoldi, MD; Alison R. Yung, PhD; Stefan Borgwardt, PhD; Matthew J. Kempton, PhD; Lucia Valmaggia, PhD; Francesco Barale, PhD; Edgardo Caverzasi, PhD; Philip McGuire, PhD

Context: A substantial proportion of people at clinical high risk of psychosis will develop a psychotic disorder over time. However, the risk of transition to psychosis varies between centers, and some recent work suggests that the risk of transition may be declining.

Objective: To quantitatively examine the literature to date reporting the transition risk to psychosis in subjects at clinical high risk.

Data Sources: The electronic databases were searched until January 2011. All studies reporting transition risks in patients at clinical high risk were retrieved.

Study Selection: Twenty-seven studies met the inclusion criteria, comprising a total of 2502 patients.

Data Extraction: Transition risks, as well as demographic, clinical, and methodologic variables, were extracted from each publication or obtained directly from its authors.

Data Synthesis: There was a consistent transition risk, independent of the psychometric instruments used, of 18% after 6 months of follow-up, 22% after 1 year, 29% after 2 years, and 36% after 3 years. Significant moderators accounting for heterogeneity across studies and influencing the transition risks were the age of participants, publication year, treatments received, and diagnostic criteria used. There was no publication bias, and a sensitivity analysis confirmed the robustness of the core findings.

Conclusions: The state of clinical high risk is associated with a very high risk of developing psychosis within the first 3 years of clinical presentation, and the risk progressively increases across this period. The transition risk varies with the age of the patient, the nature of the treatment provided, and the way the syndrome and transition to psychosis are defined.

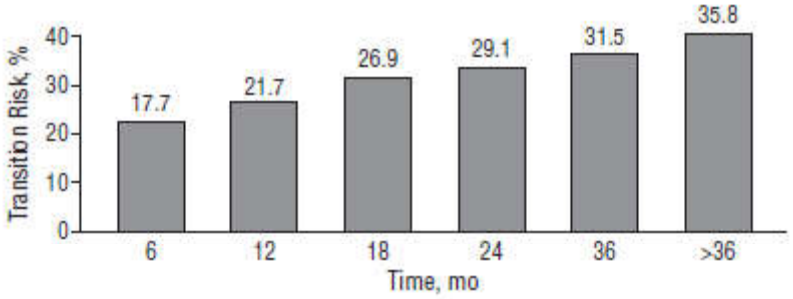
Arch Gen Psychiatry. 2012;69(3):220-229

Predicting Psychosis

Paolo Fusar-Poli, MD, PhD; Ilaria Bonoldi, MD; Alison R. Yung, PhD; Stefan Borgwardt, PhD; Matthew J. Kempton, PhD; Lucia Valmaggia, PhD; Francesco Barale, PhD; Edgardo Caverzasi, PhD; Philip McGuire, PhD

Arch Gen Psychiatry. 2012;69(3):220-229

tially prodromal symptoms.[3] This clinical syndrome has been termed an *at risk mental state*,[4] and operationalized criteria—the *ultra high risk* (UHR)[5] or *clinical high risk* (HR)[6] criteria—have been developed to identify the syndrome.[4] The criteria apply to young help-seeking patients and require 1 of 3 presentations: "attenuated" psychotic symptoms, full-blown psychotic symptoms that are brief and self-limiting, or a significant decrease in functioning in the context of a genetic risk for schizophrenia.[7] Additional prodromal criteria emerging from the basic symptoms (BS) literature[8] include subjective disturbances of cognitive processing and the perception of the self and the world.[9] Belonging to one of these prodromal groups, which we hereafter term the *clinical high risk* syndrome, is associated with impairments in neuropsychologic performance[10] and alterations in the structure[11-13] (for meta-analyses, see Fusar-Poli et al[14,15]), function[16-18] (for meta-analyses, see Smieskova et al[19] and Fusar-Poli et al[20]), connectivity,[21] and neurochemistry[22-24] of the brain.



No. of Studies	Follow-up, mo	Transition Risks, 95% CI
9	6	17.7 (12.3-24.9)
13	12	21.7 (16.6-27.8)
4	18	26.9 (19.5-35.9)
12	24	29.1 (23.2-35.7)
6	36	31.5 (23.8-35.0)
4	>36	35.8 (29.6-42.5)

P<.001 for all.

Figure 2. Meta-analyses of transition risks from clinical high risk to full psychosis at different time points of follow up.

Cognitive therapy for the prevention of psychosis in people at ultra-high risk

Randomised controlled trial

ANTHONY P. MORRISON, PAUL FRENCH, LARA WALFORD, SHÔN W. LEWIS, AOIFFE KILCOMMONS, JOANNE GREEN, SOPHIE PARKER and RICHARD P. BENTALL

Background Advances in the ability to identify people at high risk of developing psychosis have generated interest in the possibility of preventing psychosis.

Aims To evaluate the efficacy of cognitive therapy for the prevention of transition to psychosis.

Method A randomised controlled trial compared cognitive therapy with treatment as usual in 58 patients at ultra-high risk of developing a first episode of psychosis. Therapy was provided over 6 months, and all patients were monitored on a monthly basis for 12 months.

Results Logistic regression demonstrated that cognitive therapy significantly reduced the likelihood of making progression to psychosis as defined on the Positive and Negative Syndrome Scale over 12 months. In addition, it significantly reduced the likelihood of being prescribed antipsychotic medication and of meeting criteria for a DSM–IV diagnosis of a psychotic disorder. Analysis of covariance showed that the intervention also significantly improved positive symptoms of psychosis in this population over the 12-month period

Conclusions Cognitive therapy appears to be an acceptable and efficacious intervention for people at high risk of developing psychosis.

Cognitive Behavioral Therapy for Subjects at Ultrahigh Risk for Developing Psychosis: A Randomized Controlled Clinical Trial

Mark van der Gaag[*,1,2], Dorien H. Nieman[3], Judith Rietdijk[1], Sara Dragt[3], Helga K. Ising[2], Rianne M.C. Klaassen[4], Maarten Koeter[3], Pim Cuijpers[1], Lex Wunderink[5], and Don H. Linszen[3]

Van der Gaag et al. (2012) sperimenta un nuovo protocollo di trattamento CBT, rivolto a pazienti UHR specificamente finalizzato al trattamento dei bias cognitivi. Il campione è composto da 201 soggetti UHR, selezionati da un precedente screening (Prodrom Questionnaire) e randomizzati in un gruppo sperimentale (CBT) e di controllo (TAU).

Nel gruppo CBT transita verso la psicosi il 50% in meno dei pazienti rispetto al gruppo di controllo (10 rispetto a 22). Confrontata al TAU, la nuova CBT (che si basa su normalizzazione e consapevolezza dei bias cognitivi) mostra un effetto favorevole sia in relazione alla transizione nella psicosi, sia rispetto alla riduzione dei sintomi subclinici nei soggetti UHR.

Schizophrenia Bulletin vol. 38 no. 6 pp. 1180–1188, 2012

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Schizophrenia Bulletin vol. 38 no. 6 pp. 1180–1188, 2012

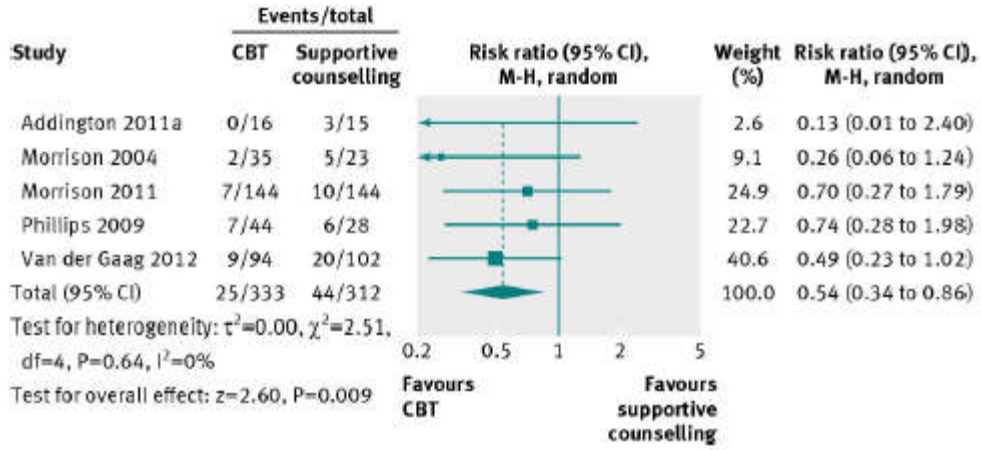
Table 2. Psychopathology Scores in the CBTuhr and TAU Groups

	Baseline, M (SD)		End of Treatment, M (SD)		12-mo F-U, M (SD)		18-mo F-U, M (SD)	
	CBTuhr (n = 95)	TAU (n = 101)	CBTuhr (n = 80)	TAU (n = 90)	CBTuhr (n = 75)	TAU (n = 76)	CBTuhr (n = 71)	TAU (n = 69)
CAARMS Intensity, 0–24	10.2 (3.0)	10.3 (2.5)	7.9 (4.3)	8.5 (3.9)	6.1 (4.7)	5.9 (4.2)	4.1 (4.2)	4.9 (3.5)
CAARMS Frequency, 0–24	12.3 (3.6)	12.7 (4.0)	9.2 (4.6)	10.5 (4.6)	7.7 (5.5)	7.7 (5.1)	5.2 (5.5)	6.9 (5.0)
CAARMS Distress, 0–400	173.1 (74.6)	171.0 (75.2)	105.7 (86.4)	135.8 (85.2)	87.2 (78.9)	91.0 (87.1)	71.9 (88.9)	73.9 (78.2)
BDI, 0–63	20.8 (11.8)	22.4 (12.9)	15.2 (10.5)	17.4 (14.4)	11.3 (9.5)	12.6 (11.4)	9.6 (9.4)	11.3 (11.1)
Clin. Depr., BDI ≥19	57.4%	58.0%	34.3%	39.5%	21.3%	30.5%	13.4%	20.6%
SIAS, 0–76	31.0 (16.5)	32.2 (17.3)	25.5 (13.9)	26.7 (16.6)	20.7 (12.5)	20.7 (15.6)	22.2 (13.8)	20.3 (15.2)
Clin. Soc. Ph., SIAS ≥36	41.5%	42.0%	27.5%	23.7%	15.5%	17.9%	20.0%	16.9%
MANSA, 12–84	51.9 (12.4)	51.6 (12.7)	50.0 (12.7)	50.0 (13.4)	61.1 (12.3)	60.6 (12.8)	57.0 (12.2)	55.5 (14.4)
SOFAS, 0–100	46.4 (4.8)	45.6 (5.1)	53.8 (9.7)	51.5 (10.6)	56.8 (11.8)	57.0 (13.3)	61.6 (12.8)	59.6 (13.7)
PBIQ-R								
Control, 5–30	13.7 (3.1)	13.6 (3.3)	11.6 (3.2)	12.6 (3.4)	10.8 (3.4)	11.4 (3.4)	10.1 (3.2)	10.8 (3.4)
Shame, 6–36	14.5 (3.8)	14.8 (3.9)	13.6 (3.7)	14.5 (4.1)	12.7 (3.9)	12.3 (4.1)	12.3 (3.6)	12.7 (4.1)
Entrapment, 6–36	15.8 (3.6)	16.2 (4.1)	**13.9 (3.9)**	**15.3 (4.0)**	12.9 (3.8)	13.3 (4.2)	12.4 (4.2)	12.9 (4.3)
Loss, 7–43	18.3 (4.2)	19.2 (4.9)	16.3 (4.4)	17.8 (4.7)	15.4 (4.3)	15.5 (4.9)	14.9 (4.0)	15.8 (4.8)
Participation, 5–30	10.7 (3.1)	11.3 (3.6)	9.7 (2.7)	10.5 (3.4)	9.1 (3.1)	8.9 (3.2)	8.9 (3.0)	9.3 (3.5)

Notes: F-U, follow-up; CAARMS Intensity, Intensity of subclinical psychotic symptoms on the CAARMS (unusual thought content, nonbizarre ideas, perceptual abnormalities, disorganised speech); CAARMS Frequency, Frequency of subclinical psychotic symptoms on the CAARMS; CAARMS Distress, distress due to subclinical psychotic symptoms on the CAARMS; Clin. Depr., Moderate to Severe Depression on the BDI; SIAS, Social Interaction Anxiety Scale; Clin. Soc. Ph., Clinical Social Phobia; MANSA, Manchester short assessment of Quality of Life; SOFAS, Social functioning assessment scale; PBIQ-R, Personal Beliefs on Illness Questionnaire-Revised; TAU, treatment as usual; CBTuhr, CBT for ultrahigh risk patients. Bold numbers indicate significant differences ($P < .05$) on univariate analyses with baseline score as a covariate.

Early interventions to prevent psychosis: systematic review and meta-analysis

Megan R Stafford *systematic reviewer*[1], Hannah Jackson *research assistant*[1], Evan Mayo-Wilson *senior research associate*[2], Anthony P Morrison *professor of clinical psychology*[3], Tim Kendall *codirector National Collaborating Centre for Mental Health*[4]



Transition to psychosis for participants receiving CBT versus supportive counselling, (at 6-12 months; includes completers only). M-H=Mantel-Haenszel

BMJ 2013;346:f185 doi: 10.1136/bmj.f185 (Published 18 January 2013)

Abstract

Objective To determine whether any psychological, pharmacological, or nutritional interventions can prevent or delay transition to psychotic disorders for people at high risk.

Results 11 trials including 1246 participants and eight comparisons were included. Median sample size of included trials was 81 (range 51-288). Meta-analyses were performed for transition to psychosis, symptoms of psychosis, depression, and mania; quality of life; weight; and discontinuation of treatment. Evidence of moderate quality showed an effect for cognitive behavioural therapy on reducing transition to psychosis at 12 months (risk ratio 0.54 (95% confidence interval 0.34 to 0.86); risk difference –0.07 (–0.14 to –0.01). Very low quality evidence for omega-3 fatty acids and low to very low quality evidence for integrated psychotherapy also indicated that these interventions were associated with reductions in transition to psychosis at 12 months.

Conclusions Although evidence of benefits for any specific intervention is not conclusive, these findings suggest that it might be possible to delay or prevent transition to psychosis. Further research should be undertaken to establish conclusively the potential for benefit of psychological interventions in the treatment of people at high risk of psychosis.

Early interventions to prevent psychosis: systematic review and meta-analysis

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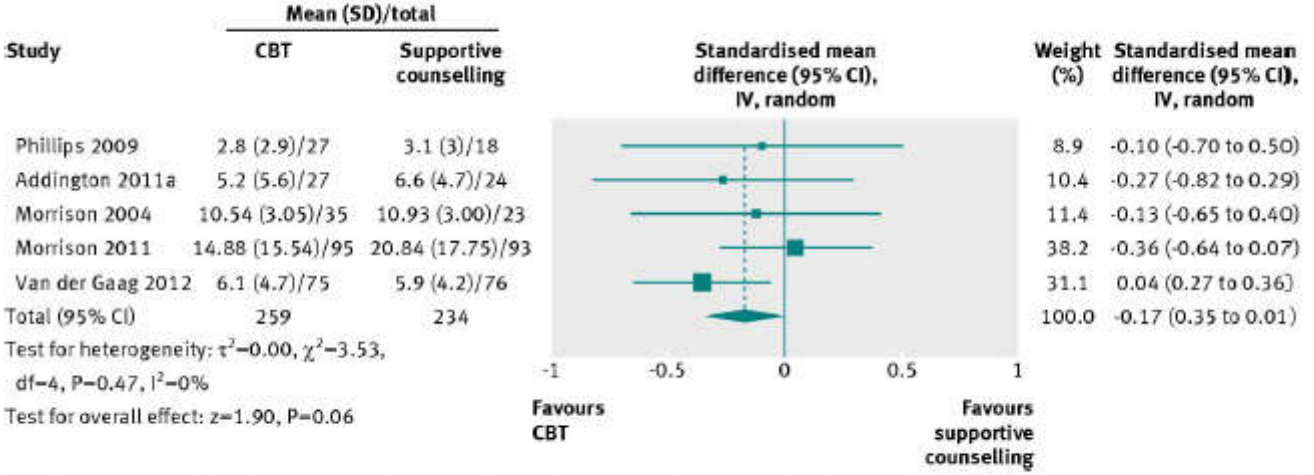


Fig 4 Positive symptoms of psychosis for participants receiving CBT versus supportive counselling (at 6-12 months). IV=inverse variance

What this study adds

This meta-analysis suggests that there are interventions that could prevent psychosis

Individual cognitive behavioural therapy, with or without family CBT, could be the most sensible first line treatment for people at a high risk

Further research is needed to establish the potential benefit of psychological interventions for people at high risk of psychosis

BMJ 2013;346:f185 doi: 10.1136/bmj.f185 (Published 18 January 2013)

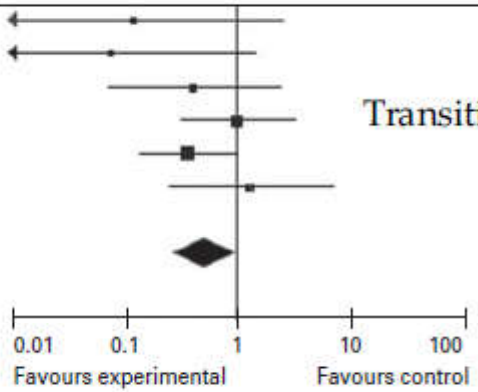
Cognitive behavioural therapy for psychosis prevention: a systematic review and meta-analysis

P. Hutton[1,2]* and P. J. Taylor[2]

Psychological Medicine (2014),

Study or subgroup	Experimental Events	Experimental Total	Control Events	Control Total	Weight	Risk ratio M-H, Random, 95% CI
Addington (2011)	0	27	3	24	5.0%	0.13 (0.01–2.35)
Bechdolf (2012)	0	63	6	65	5.2%	0.08 (0.00–1.38)
Morrison (2004)	2	37	3	23	13.5%	0.41 (0.07–2.30)
Morrison (2012)	6	144	6	144	28.0%	1.00 (0.33–3.03)
Van der Gaag (2012)	5	98	14	103	33.6%	0.38 (0.14–1.00)
McGorry (2012)	4	44	2	28	14.7%	1.27 (0.25–6.50)
Total (95% CI)		413		387	100.0%	0.52 (0.27–1.02)
Total events	17		34			

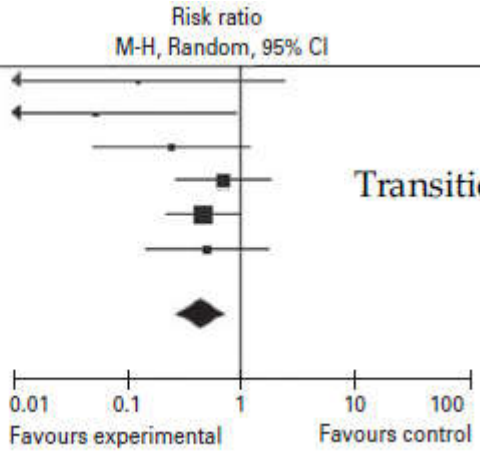
Heterogeneity: $\tau^2 = 0.09$; $\chi^2 = 5.72$, df = 5 ($p = 0.33$); $I^2 = 13\%$
Test for overall effect: $Z = 1.91$ ($p = 0.06$)



Transition at 6 months.

Study or subgroup	Experimental Events	Experimental Total	Control Events	Control Total	Weight	Risk ratio M-H, Random, 95% CI
Addington (2011)	0	27	3	24	2.7%	0.13 (0.01–2.35)
Bechdolf (2012)	0	63	9	65	2.9%	0.05 (0.00–0.91)
Morrison (2004)	2	37	5	23	9.6%	0.25 (0.05–1.18)
Morrison (2012)	7	144	10	144	26.4%	0.70 (0.27–1.79)
Van der Gaag (2012)	9	98	20	103	42.9%	0.47 (0.23–0.99)
McGorry (2012)	4	44	5	28	15.5%	0.51 (0.15–1.74)
Total (95% CI)		413		387	100.0%	0.45 (0.28–0.73)
Total events	22		52			

Heterogeneity: $\tau^2 = 0.00$; $\chi^2 = 4.60$, df = 5 ($p = 0.47$); $I^2 = 0\%$
Test for overall effect: $Z = 3.23$ ($p = 0.001$)



Transition at 12 months.

Conclusions. CBT-informed treatment is associated with a reduced risk of transition to psychosis at 6, 12 and 18–24 months, and reduced symptoms at 12 months. Methodological limitations and recommendations for trial reporting are discussed.

Cognitive–behavioural therapy for the symptoms of schizophrenia: systematic review and meta-analysis with examination of potential bias

S. Jauhar, P. J. McKenna, J. Radua, E. Fung, R. Salvador and K. R. Laws

Background

Cognitive–behavioural therapy (CBT) is considered to be effective for the symptoms of schizophrenia. However, this view is based mainly on meta-analysis, whose findings can be influenced by failure to consider sources of bias.

Aims

To conduct a systematic review and meta-analysis of the effectiveness of CBT for schizophrenic symptoms that includes an examination of potential sources of bias.

Method

Data were pooled from randomised trials providing end-of-study data on overall, positive and negative symptoms. The moderating effects of randomisation, masking of outcome assessments, incompleteness of outcome data and use of a control intervention were examined. Publication bias was also investigated.

Results

Pooled effect sizes were −0.33 (95% CI −0.47 to −0.19) in 34 studies of overall symptoms, −0.25 (95% CI −0.37 to −0.13) in 33 studies of positive symptoms and −0.13 (95% CI −0.25 to −0.01) in 34 studies of negative symptoms. Masking significantly moderated effect size in the meta-analyses of overall symptoms (effect sizes −0.62 (95% CI −0.88 to −0.35) *v.* −0.15 (95% CI −0.27 to −0.03), $P=0.001$) and positive symptoms (effect sizes −0.57 (95% CI −0.76 to −0.39) *v.* −0.08 (95% CI −0.18 to 0.03), $P<0.001$). Use of a control intervention did not moderate effect size in any of the analyses. There was no consistent evidence of publication bias across different analyses.

Conclusions

Cognitive–behavioural therapy has a therapeutic effect on schizophrenic symptoms in the 'small' range. This reduces further when sources of bias, particularly masking, are controlled for.

Declaration of interest

None.

Table 2 Comparison between studies not using and using a control intervention

	CBT *v.* TAU		CBT *v.* control intervention			
	Effect size (95% CI)	Studies, *n*	Effect size (95% CI)	Studies, *n*	*Q*(*B*)	*P*
Overall symptoms	−0.33 (−0.45 to −0.21)	21	−0.32 (−0.74 to 0.09)	9	<0.001	0.99
Positive symptoms	−0.31 (−0.45 to −0.17)	19	−0.24 (−0.54 to 0.06)	10	0.17	0.68
Negative symptoms	−0.17 (−0.33 to −0.02)	20	−0.08 (−0.29 to 0.13)	12	0.49	0.48

CBT, cognitive–behavioural therapy; TAU, treatment as usual.

Cognitive–behavioural therapy for the symptoms of schizophrenia: systematic review and meta-analysis with examination of potential bias

S. Jauhar, P. J. McKenna, J. Radua, E. Fung, R. Salvador and K. R. Laws

The British Journal of Psychiatry

Study name	Statistics for each study: Hedges' *g*	Lower limit	Upper limit	Sample size: CBT	Control
Kuipers *et al* (1997)[1]	−0.342	−0.908	0.225	23	24
Levine *et al* (1998)[78]	−3.970	−5.871	−2.069	6	6
Haddock *et al* (1999)[79]	0.567	−0.338	1.472	8	10
Pinto *et al* (1999)[80]	−0.718	−1.370	−0.067	19	18
Bradshaw (2000)[53]	−1.453	−2.540	−0.366	8	7
Leclerc *et al* (2000)[63]	−0.087	−0.481	0.306	55	44
Sensky *et al* (2000)[8]	−0.082	−0.492	0.328	46	44
Turkington *et al* (2000)[81]	−1.136	−2.225	−0.047	10	5
Granholm *et al* (2002)[82]	−0.744	−1.735	0.247	8	7
Lewis *et al* (2002)[9]	−0.014	−0.293	0.265	78	131
Turkington *et al* (2002)[13]	−0.225	−0.420	−0.029	257	165
Durham *et al* (2003)[73]	0.190	−0.330	0.709	22	38
Gumley *et al* (2003)[83]	−0.417	−0.746	−0.089	72	72
Jolley *et al* (2003)[70]	−0.058	−0.896	1.013	7	8
Rector *et al* (2003)[84]	−0.698	−1.316	−0.081	24	18
Wang *et al* (2003)[85]	−0.524	−0.774	−0.273	126	125
Bechdolf *et al* (2004)[10]	0.290	−0.128	0.709	40	48
Startup *et al* (2004)[86]	−0.598	−1.086	−0.110	34	32
Granholm *et al* (2005)[54]	−0.047	−0.527	0.434	32	33
Valmaggia *et al* (2005)[89]	0.083	−0.436	0.604	35	23
Barrowclough *et al* (2006)[91]	−0.252	−0.646	0.142	54	45
Gaudiano & Herbert (2006)[62]	−0.482	−1.099	0.136	21	19
Penadés *et al* (2006)[92]	−0.554	−1.173	0.066	20	20
Deng *et al* (2008)[94]	−0.919	−1.281	−0.556	64	64
Garety *et al* (2008)[11] (no carer)	−0.124	−0.415	0.167	90	90
Garety *et al* (2008)[11] (carer)	−0.314	−0.899	0.271	21	23
Lecomte *et al* (2008)[69]	−0.150	−0.573	0.274	36	51
Wu *et al* (2008)[96]	−1.517	−1.960	−1.075	48	52
Farhall *et al* (2009)[34]	0.014	−0.391	0.420	45	47
Fowler *et al* (2009)[35]	−0.345	−0.938	0.248	20	23
Haddock *et al* (2009)[36]	−0.235	−0.749	0.279	28	29
van der Gaag *et al* (2011)[14]	−0.095	−0.368	0.178	109	97
Lincoln *et al* (2012)[38]	−0.288	−0.724	0.149	40	40
Rathod *et al* (2013)[97]	−0.176	−0.910	0.557	13	14
	−0.327	−0.467	−0.187		

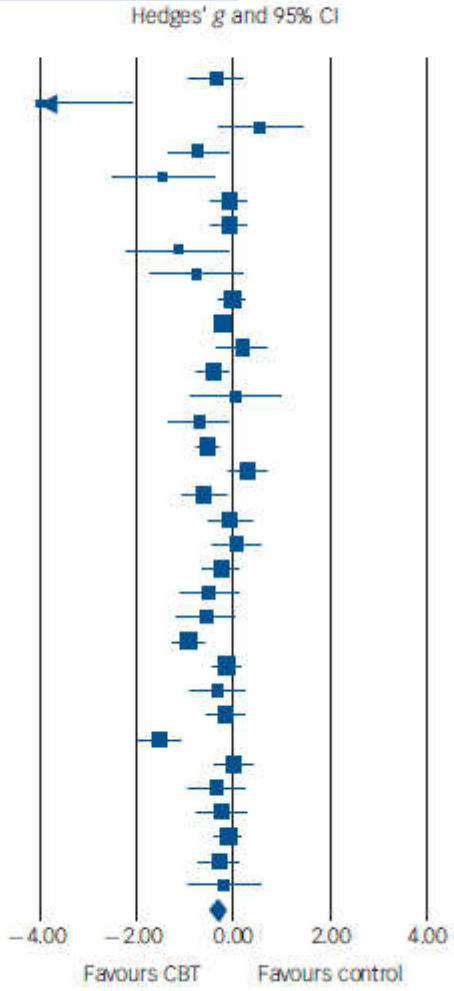
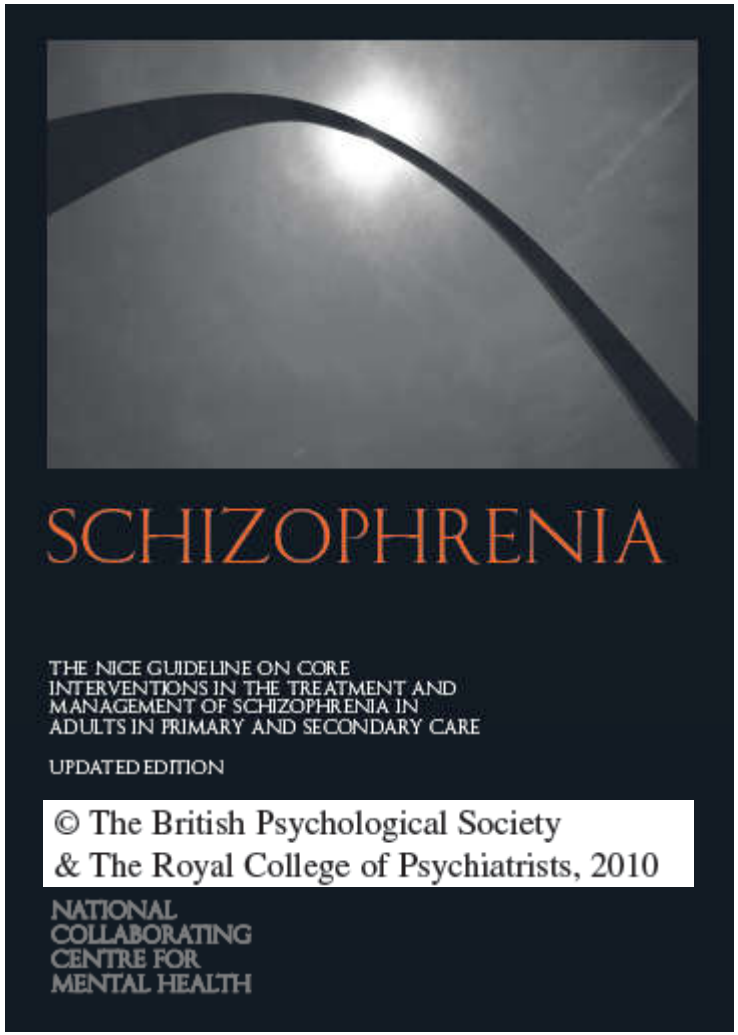
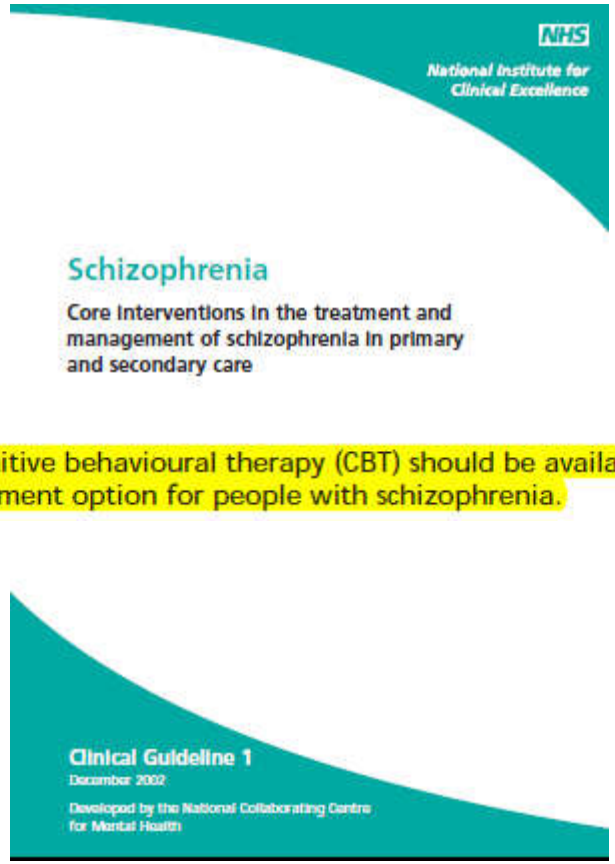


Fig. 2 Forest plot of studies in the meta-analysis of overall symptoms.

CBT, cognitive–behavioural therapy.





8.4.10.1 Offer cognitive behavioural therapy (CBT) to all people with schizophrenia. This can be started either during the acute phase[21] or later, including in inpatient settings.

8.4.10.3 Offer CBT to assist in promoting recovery in people with persisting positive and negative symptoms and for people in remission. Deliver CBT as described in recommendation 8.4.10.2.

NICE National Institute for Health and Care Excellence

Issued: February 2014 last modified: March 2014

Psychosis and schizophrenia in adults: treatment and management

Preventing psychosis

- If a person is considered to be at increased risk of developing psychosis (as described in recommendation 1.2.1.1):
  - offer individual cognitive behavioural therapy (CBT) with or without family intervention (delivered as described in section 1.3.7) **and**

First episode psychosis

- Early intervention in psychosis services should be accessible to all people with a first episode or first presentation of psychosis, irrespective of the person's age or the duration of untreated psychosis. **[new 2014]**

1.3.4.1 For people with first episode psychosis offer:

- psychological interventions (family intervention and individual CBT, delivered as described in section 1.3.7). **[new 2014]**

Subsequent acute episodes of psychosis or schizophrenia and referral in crisis

- Offer CBT to all people with psychosis or schizophrenia (delivered as described in recommendation 1.3.7.1). This can be started either during the acute phase or later, including in inpatient settings. **[2009]**

Issued: February 2014 last modified: March 2014

Psychosis and schizophrenia in adults: treatment and management

1.4.2.1 For people with an acute exacerbation or recurrence of psychosis or schizophrenia, offer:

- psychological interventions (family intervention and individual CBT, delivered as described in section 1.3.7). **[new 2014]**

1.4.4 Psychological and psychosocial interventions

1.4.4.1 Offer CBT to all people with psychosis or schizophrenia (delivered as described in recommendation 1.3.7.1). This can be started either during the acute phase or later, including in inpatient settings. **[2009]**

1.5.4.1 Offer CBT to assist in promoting recovery in people with persisting positive and negative symptoms and for people in remission. Deliver CBT as described in recommendation 1.3.7.1. **[2009]**

1.5.7.1 For people with schizophrenia whose illness has not responded adequately to pharmacological or psychological treatment:

- Review engagement with and use of psychological treatments and ensure that these have been offered according to this guideline. If family intervention has been undertaken suggest CBT; if CBT has been undertaken suggest family intervention for people in close contact with their families.

1.3.7 How to deliver psychological interventions

1.3.7.1 CBT should be delivered on a one-to-one basis over at least 16 planned sessions and:

- follow a treatment manual[a] so that:
  - people can establish links between their thoughts, feelings or actions and their current or past symptoms, and/or functioning
  - the re-evaluation of people's perceptions, beliefs or reasoning relates to the target symptoms
- also include at least one of the following components:
  - people monitoring their own thoughts, feelings or behaviours with respect to their symptoms or recurrence of symptoms
  - promoting alternative ways of coping with the target symptom
  - reducing distress
  - improving functioning. **[2009]**

The 2009 Schizophrenia PORT Psychosocial Treatment Recommendations and Summary Statements

Schizophrenia Bulletin vol. 36 no. 1 pp. 48–70, 2010

Lisa B. Dixon[1–3], Faith Dickerson[4], Alan S. Bellack[2,3], Melanie Bennett[2,3], Dwight Dickinson[2,3], Richard W. Goldberg[2,3], Anthony Lehman[2], Wendy N. Tenhula[2,3], Christine Calmes[3], Rebecca M. Pasillas[3], Jason Peer[3], and Julie Kreyenbuhl[2,3]

The Schizophrenia Patient Outcomes Research Team (PORT) psychosocial treatment recommendations provide a comprehensive summary of current evidence-based psychosocial treatment interventions for persons with schizophrenia. There have been 2 previous sets of psychosocial

Cognitive Behavioral Therapy

Recommendation. Persons with schizophrenia who have persistent psychotic symptoms while receiving adequate pharmacotherapy should be offered adjunctive cognitive behaviorally oriented psychotherapy to reduce the severity of symptoms. The therapy may be provided in either a group or an individual format and should be approximately 4–9 months in duration. The key elements of this intervention include the collaborative identification of target problems or symptoms and the development of specific cognitive and behavioral strategies to cope with these problems or symptoms.

The Nice Guideline for Recognition and Management (2013)

Opzioni di trattamento per sintomi non sufficienti per una diagnosi di psicosi.

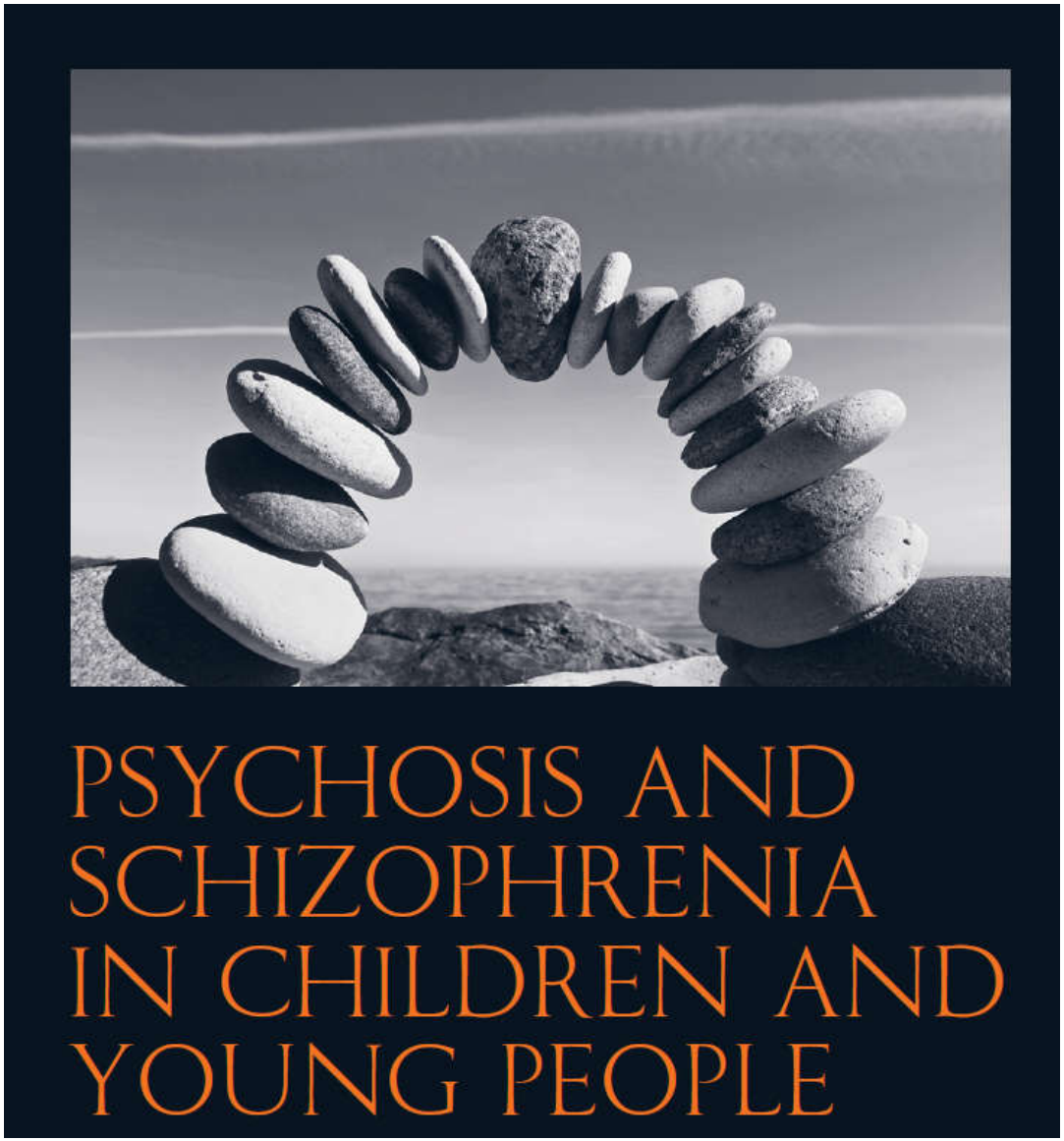
A fronte di sintomi psicotici transitori o attenuati, che non giustificano una diagnosi di psicosi o di schizofrenia va raccomandata la terapia cognitivo-comportamentale individuale (CBT), con o senza intervento familiare e offerti interventi congrui con le linee NICE, per giovani con disturbi d'ansia, depressione, disturbi di personalità emergenti o abuso di sostanze.

Opzioni di trattamento per il primo episodio psicotico

Farmaci antipsicotici orali, secondo raccomandazioni.

Interventi psicologici (intervento con le famiglie e CBT individuale somministrate secondo raccomandazioni).

Qualora i farmaci non siano accettati, informare, proseguire con CBT, verificare esiti dopo un mese.

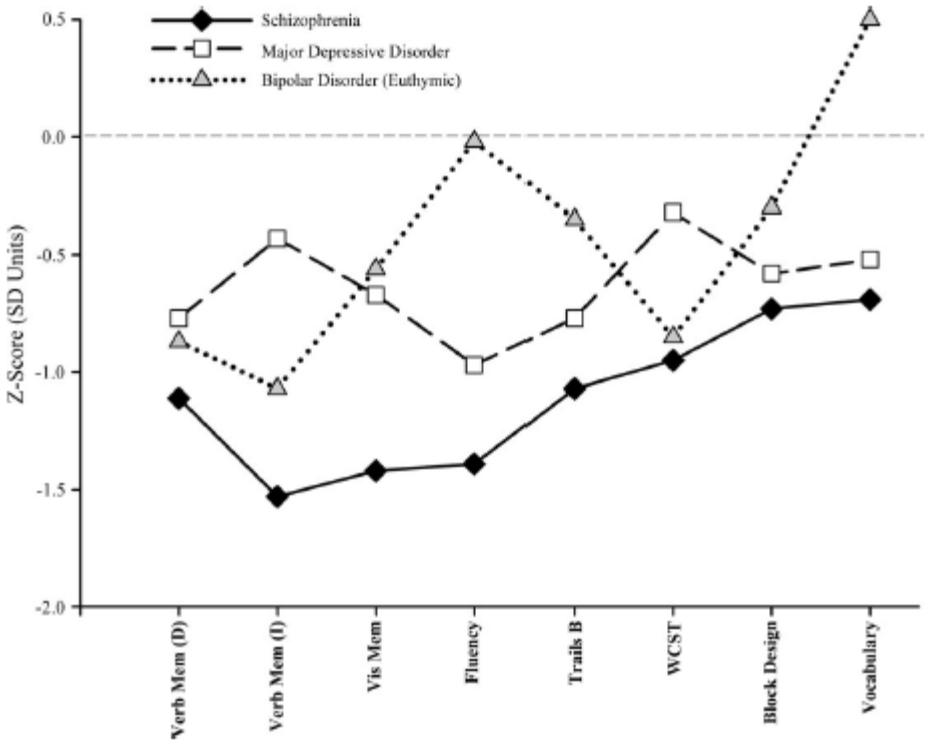


A Summary of the FDA-NIMH-MATRICS Workshop on Clinical Trial Design for Neurocognitive Drugs for Schizophrenia.

Robert W. Buchanan, Miriam Davis, Donald Goff, Michael F. Green, Richard S. E. Keefe, Andrew C. Leon, Keith H. Nuechterlein, Thomas Laughren, Robert Levin, Ellen Stover, Wayne Fenton, and Steve R. Marder

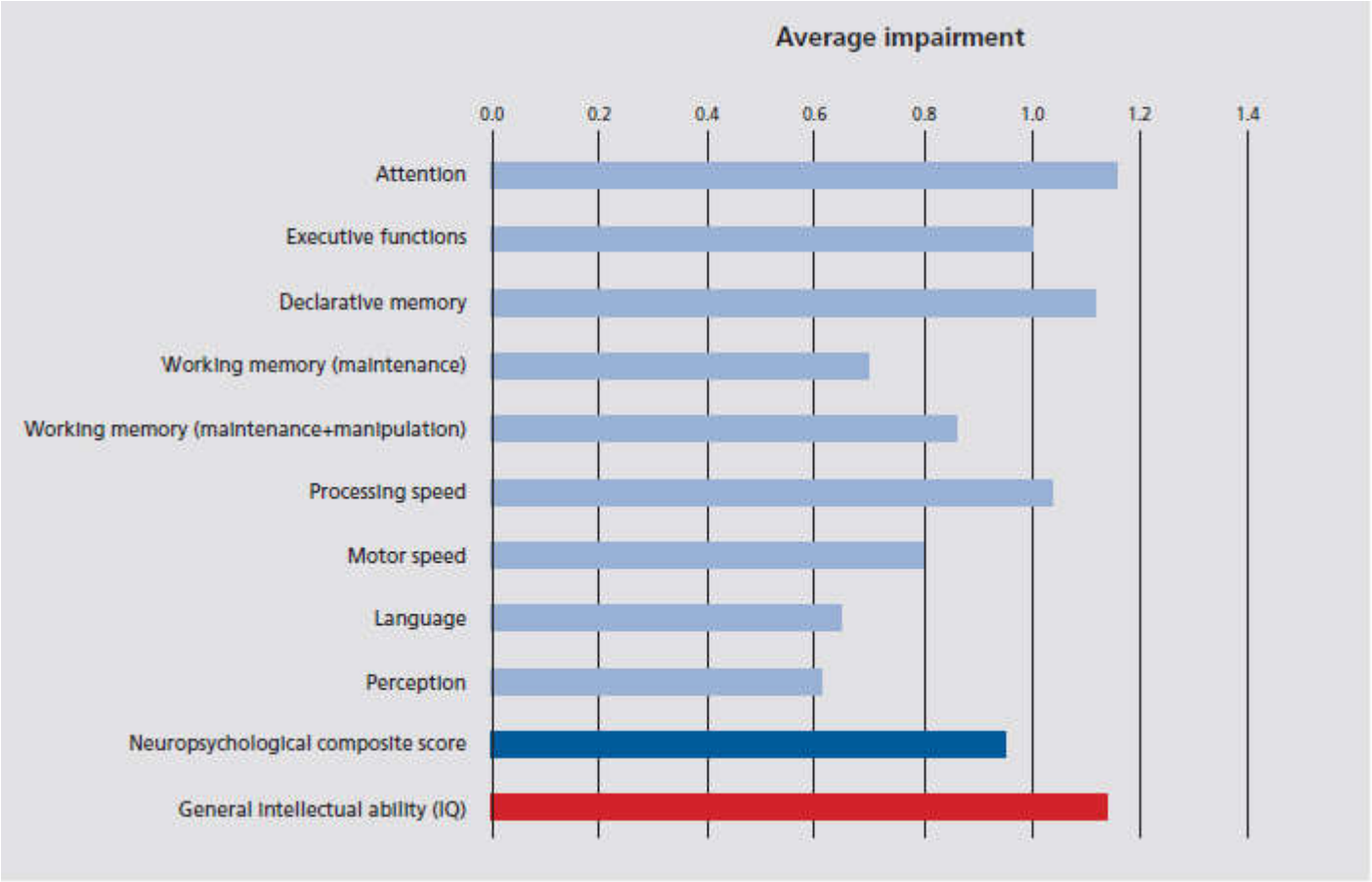
Schizophrenia Bulletin vol. 31 no. 1 pp. 5–19, 2005
doi:10.1093/schbul/sbi020
Advance Access publication on February 16, 2005

Neurocognitive deficits of schizophrenia are profound and clinically relevant. Patients with schizophrenia perform 1.5 to 2.0 standard deviation below healthy controls on a variety of neurocognitive tasks. The most prominent of these deficits are memory, attention, working memory, problem solving, processing speed, and social cognition.[1] These impairments exist prior to the initiation of antipsychotic treatment[2] and are not caused by psychotic symptoms in patients who are able to complete cognitive testing, which includes the overwhelming majority of patients.[3] The various cognitive deficits in schizophrenia have all been shown to be associated with functional outcomes such as difficulty with community functioning, difficulty with instrumental and problem-solving skills, reduced success in psychosocial rehabilitation programs,[4] and the inability to maintain successful employment.[5] In fact, cognitive deficits are better able to explain important functional outcomes, such as work performance and independent living,[6] than positive or negative symptoms.



The assessment of neuropsychological functioning in schizophrenia

Abraham (Avi) Reichenberg, PhD



The assessment of neuropsychological functioning in schizophrenia

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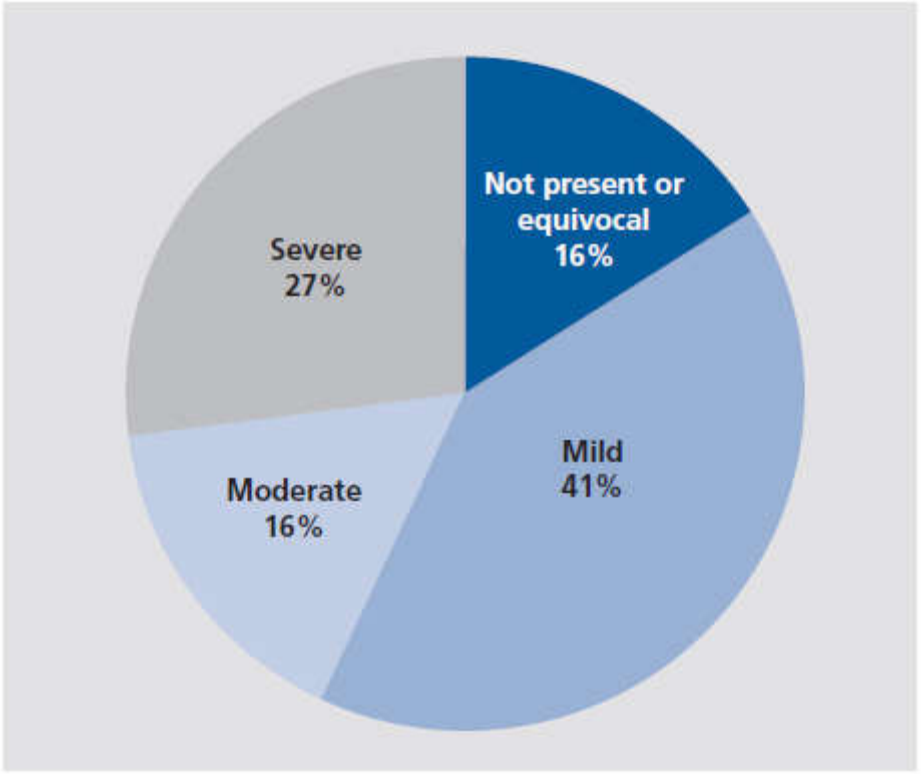


Figure 3. Rates and severity of cognitive impairment in schizophrenia patients. Data came from the Suffolk County Mental Health Project cohort[54,76,77] (N=94 cases). Definition of impairment: Mild: Performance between 1 and 2 standard deviations below norms on at least 2 cognitive ability areas. Moderate: Performance between 2 and 3 standard deviations below norms on at least 2 cognitive ability areas. Severe: Performance 3 or more standard deviations below norms on at least 2 cognitive ability areas.

Social Cognition in Schizophrenia: Recommendations from the Measurement and Treatment Research to Improve Cognition in Schizophrenia New Approaches Conference

Michael F. Green[1–3], Berend Olivier[4], Jacqueline N. Crawley[5], David L. Penn[6], and Steven Silverstein[7]

Social cognition in schizophrenia is a central topic for the NIMH-MATRICS initiative because it is 1 of the 7 domains represented in the MATRICS Consensus Cognitive Battery for clinical trials in schizophrenia.[32] The domains for the cognitive battery were initially selected through careful examination of factor-analytic studies of cognition in schizophrenia,[33] and they include speed of processing, attention/vigilance, working memory, verbal learning, visual learning, and reasoning and problem solving. When these initial 6 factors were presented at the first MATRICS consensus meeting in April 2003, there was clearly expressed concern from the participants about the omission of social cognition. The MATRICS Neuro-

Schizophrenia Bulletin vol. 31 no. 4 pp. 882–887, 2005
doi:10.1093/schbul/sbi049
Advance Access publication on August 31, 2005

Domini cognitivi

- Velocità di elaborazione/processazione
- Attenzione/vigilanza
- Memoria di lavoro
- Apprendimento verbale
- Apprendimento visivo
- Ragionamento e problem solving

Cognizione sociale

- ToM, elaborazione emozioni, percezione sociale, stile attribuzionale

Cognizione sociale e suoi domini

Elaborazione delle emozioni

Implica la capacità di riconoscere le emozioni espresse da volti, immagini e componenti non verbali, come il tono della voce

Percezione sociale

Comprensione di ruoli e regole di contesti socio-relazionali

Teoria della mente

Capacità di inferire i propri stati mentali e quelli degli altri

Stile di attribuzione

Si riferisce al modo in cui l'individuo si spiega le cause del successo o insuccesso degli eventi sociali

(saltare alle conclusioni)

Theory of mind impairments in first-episode psychosis, individuals at ultra-high risk for psychosis and in first-degree relatives of schizophrenia: Systematic review and meta-analysis

Emre Bora *, Christos Pantelis

Theory of mind (ToM) deficit is a well-established feature of schizophrenia and has been suggested as a vulnerability marker of this disorder. However, as most of this evidence is based on studies in chronic patients, it is less clear whether ToM is impaired prior to or following the onset of a first-episode and whether it is evident in unaffected relatives of patients. In this meta-analysis, ToM performance of 3005 individuals with first-episode psychosis (FEP), individuals at ultra-high risk for psychosis (UHR) and unaffected relatives were compared with 1351 healthy controls. ToM was substantially impaired in first-episode psychosis (Cohen $d = 1.0$) and this deficit was comparable to findings in chronic patients. ToM was also impaired in unaffected relatives ($d = 0.37$) and UHR subjects ($d = 0.45$) and performances of these groups were intermediate between FES and healthy controls. Severity of ToM deficits in unaffected relatives and UHR subjects was similar to other cognitive deficits observed in these groups. Longitudinal studies of clinical and genetic high-risk subjects are necessary to investigate the trajectory of development of ToM deficits in schizophrenia.

Table 3
Mean weighted effect sizes for cognitive differences between relatives (Rels), UHR, FEP and healthy controls (HC).

Test	Samp	SchRel	HC	*d*	95% CI	*Z*	*p*	Q-test *p*	I^2
Rels-HC									
ToM	12	2388	929	0.37	0.19–0.54	4.18	<0.001	0.04	0.04
ToM verbal	8	2195	791	0.24	0.13–0.33	4.52	<0.001	0.42	0
ToM visual	9	294	261	0.36	0.10–0.63	2.70	<0.001	0.02	0.09
-Eyes	5	141	120	0.19	−0.10 to 0.48	1.31	0.19	0.13	0.05
UHR-HC									
ToM	7	332	249	0.45	0.23–0.67	4.1	<0.001	0.14	0.03
ToM verbal	4	192	133	0.49	0.26–0.72	4.2	<0.001	0.75	0
ToM visual-Eyes	6	282	215	0.40	0.14–0.70	2.94	0.003	0.05	0.07
FEP-HC									
ToM	8	285	228	1.0	0.81–1.18	10.54	<0.001	0.85	0
ToM verbal	4	188	132	0.99	0.76–1.23	8.21	<0.001	0.87	0
ToM visual	5	137	124	0.94	0.69–1.20	7.26	<0.001	0.42	0

concluding that ToM is a trait marker of schizophrenia

Schizophrenia Research 144 (2013) 31–36

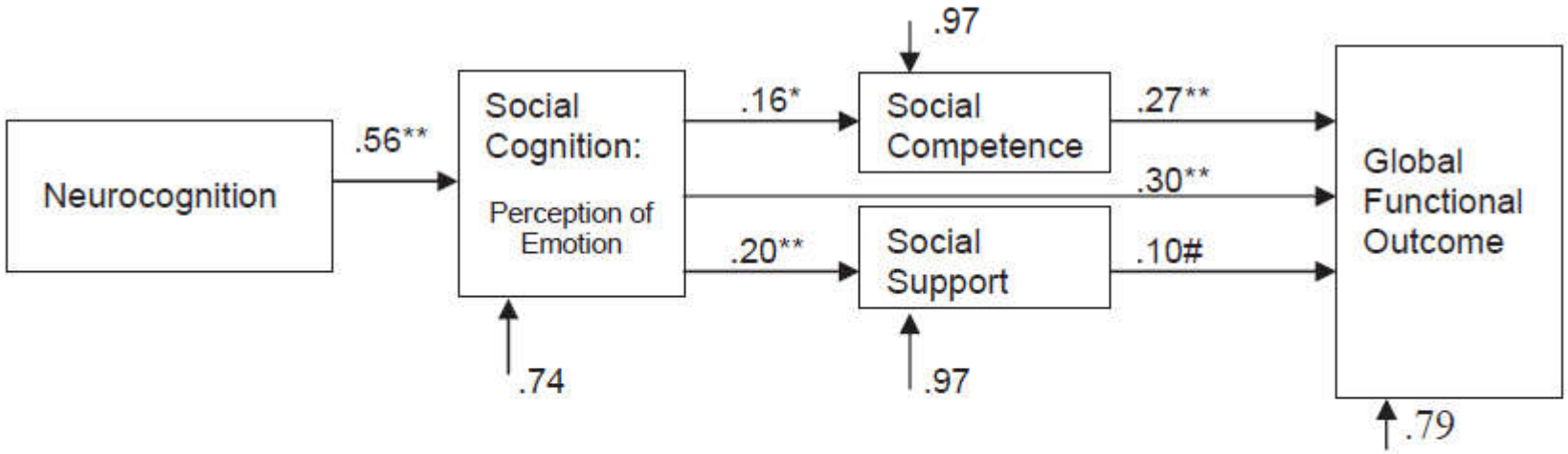
Biosocial pathways to functional outcome in schizophrenia

SCHIZOPHRENIA RESEARCH

John Brekke[a,*], Diane D. Kay[a], Kimmy S. Lee[b], Michael F. Green[c]

Objective: This study provided the first test of a biosocial causal model of functional outcome in schizophrenia, using neurocognition, social cognition, social competence and social support as predictors of both global and specific domains of functional outcome.

Results: Path analysis modeling showed that the proposed biosocial models had strong fit with the data, for both concurrent and 12-month global functional outcomes, with fit indices ranging from .95 to .98. The model explained 21% of the variance in concurrent global functional outcome, and 14% of the variance in 12-month prospective outcome.



** p < .01, * p < .05, # p <.10, one-tailed.

Fig. 3. Final model of concurrent global functional status.

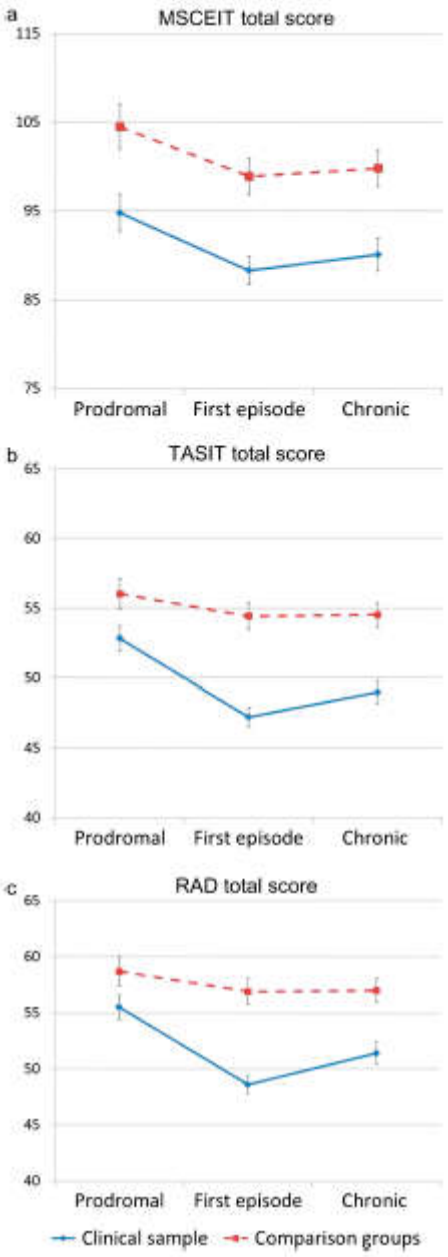


Fig. 1. Social cognitive performance across phase of illness. Panel a (top) shows the data for the MSCEIT total score, panel b (middle) for the TASIT total score, and panel c (bottom) for the RAD for the clinical samples (blue lines) and comparison groups (red lines).

Social Cognition in Schizophrenia, Part 1: Performance Across Phase of Illness

Michael F. Green*[,1,2], Carrie E. Bearden[1,3], Tyrone D. Cannon[1,3], Alan P. Fiske[4], Gerhard S. Hellemann[1], William P. Horan[1,2], Kimmy Kee[1,2,5], Robert S. Kern[1,2], Junghee Lee[1,2], Mark J. Sergi[1,2,6], Kenneth L. Subotnik[1], Catherine A. Sugar[1,7], Joseph Ventura[1], Cindy M. Yee[1,3], and Keith H. Nuechterlein[1,3]

Schizophrenia Bulletin vol. 38 no. 4 pp. 854–864, 2012

Social cognitive impairments are consistently reported in schizophrenia and are associated with functional outcome. We currently know very little about whether these impairments are stable over the course of illness. In the current study, 3 different aspects of social cognition were assessed (emotion processing, Theory of Mind [ToM], and social relationship perception) at 3 distinct developmental phases of illness: prodromal, first episode, and chronic. In this cross-sectional study, participants included 50 individuals with the prodromal risk syndrome for psychosis and 34 demographically comparable controls, 81 first-episode schizophrenia patients and 46 demographically comparable controls, and 53 chronic schizophrenia patients and 47 demographically comparable controls. Outcome measures included total and subtest scores on 3 specialized measures of social cognition: (1) emotion processing assessed with the Mayer-Salovey-Caruso Emotional Intelligence Test, (2) ToM assessed with The Awareness of Social Inference Test, and (3) social relationship perception assessed the Relationships Across Domains Test. Social cognitive performance was impaired across all domains of social cognition and in all clinical samples. Group differences in performance were comparable across phase of illness, with no evidence of progression or improvement. Age had no significant effect on performance for either the clinical or the comparison groups. The findings suggest that social cognition in these 3 domains fits a stable pattern that has outcome and treatment implications. An accompanying article prospectively examines the longitudinal stability of social cognition and prediction of functional outcome in the first-episode sample.

The Evolution of Cognitive Behavior Therapy for Schizophrenia: Current Practice and Recent Developments

Sara Tai[1,2] and Douglas Turkington[3]

[2]School of Psychological Sciences, University of Manchester, Coupland Building, Manchester M13 9PL, UK; [3]School of Neurology, Neurobiology and Psychiatry, Newcastle University, Newcastle upon Tyne, UK

Cognitive behavior therapy (CBT) evolved from behavioral theory and developed to focus more on cognitive models that incorporated reappraisal of thinking errors and schema change strategies. This article will describe the key elements of CBT for schizophrenia and the current evidence of its efficacy and effectiveness. We conclude with a description of recent concepts that extend the theoretical basis of practice and expand the range of CBT strategies for use in schizophrenia. Mindfulness, metacognitive approaches, compassionate mind training, and method of levels are postulated as useful adjuncts for CBT with psychotic patients.

Schizophrenia Bulletin vol. 35 no. 5 pp. 865–873, 2009

Trattamenti inclusi nella denominazione di terza onda della terapia cognitivo – comportamentale:
acceptance and commitment therapy (ACT),
dialectical behavior therapy (DBT),
cognitive behavioral analysis system of psychotherapy (CBASP),
functional analytic psychotherapy (FAP),
integrative behavioral couple therapy (IBCT).

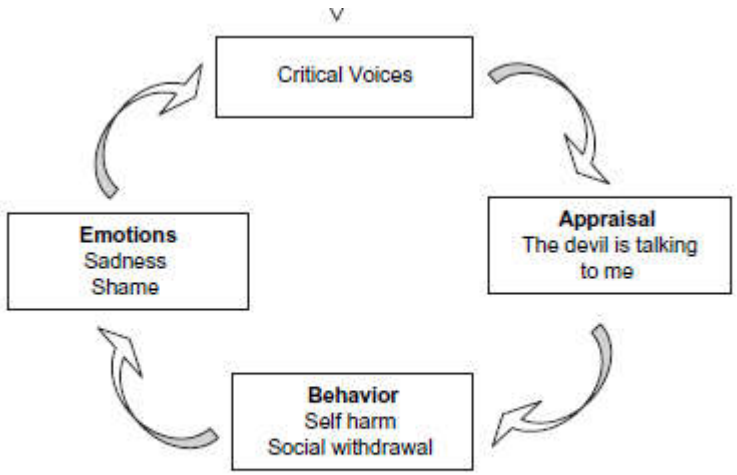


Fig. 1. Mini-formulation of Hallucination Maintenance.

Hallucinations and Delusions as Points on Continua Function

Rating Scale Evidence

John S. Strauss, MD, Bethesda, Md

PSYCHIATRIC symptom rating scales can be used for testing and reformulating clinical concepts as well as for categorizing patients. Hallucinations and delusions are two symptoms that take on new meanings when defined more operationally for use in such scales. It is especially important to conceptualize these symptoms adequately because they are key diagnostic criteria of the psychoses, especially of schizophrenia. Even those who classify hallucinations and delusions as "secondary" tend to use these symptoms to establish the diagnosis of psychosis since they are among the easier symptoms to identify clinically. Generally hallucinations and delusions are considered to be discrete and discontinuous, a patient either has them or he does not. The notion of the discreteness of these symptoms encourages the conception of psychosis and schizophrenia as states that are also discrete and discontinuous and the further conception that patients with these diagnoses are somehow qualitatively different from other people.

tive criteria for defining the continua are: (1) Degree of patient's conviction of the objective reality of the bizarre experience. (2) The degree of absence of direct cultural or stimulus determinants of an experience (eg, the absence of fundamentalist religious background in a person who thought that the devil was influencing her behavior.) (3) Amount of time spent preoccupied with the experience. (4) And implausibility of the experience (eg, seeing a man from Mars as compared to mistaking seeing a car outside one's house). In the process of refining these criteria we hope to make possible description of hallucinations and delusions as points on continua of function that can be used to develop more useful ways to study these key psychiatric functions and symptoms and the syndromes of which they are a part.

Criteri per un continuum
- Grado di convinzione
- Pervasività

THEORETICAL PAPER

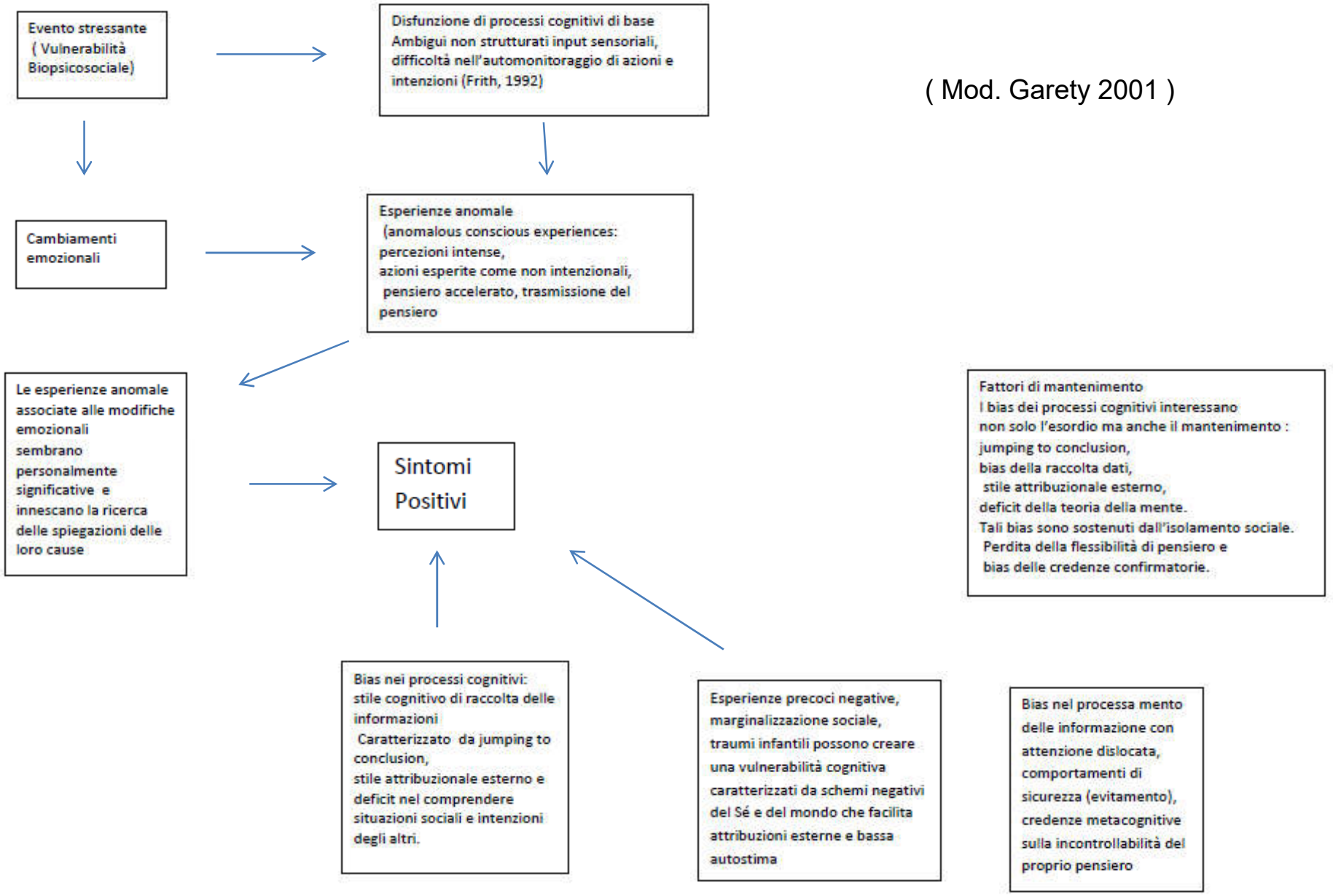
A cognitive model of the positive symptoms of psychosis

P. A. GARETY,[1] E. KUIPERS, D. FOWLER, D. FREEMAN AND P. E. BEBBINGTON

Psychological Medicine, 2001

Our cognitive model builds on the work of other researchers (e.g. Maher, 1988; Frith, 1992; Hemsley, 1993; Bentall *et al.* 1994; Chadwick & Birchwood, 1994; Morrison *et al.* 1995) and our own clinical and theoretical studies. The model is new in that it incorporates both disruptions in automatic cognitive processes and maladaptive conscious appraisals; it covers delusions and hallucinations in one framework; it posits a central role for emotion; and it considers how social factors may contribute to the origins, maintenance or recurrence of symptoms. The resulting cognitive model of psychosis is consistent with existing theoretical and therapeutic studies. It generates testable hypotheses and should lead to theoretical and therapeutic advances.

Furthermore, the anomalous experiences, being puzzling and associated with emotional changes, seem personally significant and trigger a search for explanation as to their cause (Maher, 1988). Here biased conscious appraisal processes are crucial: they contribute to a judgement that these confusing experiences (which feel external in any case) are in fact externally caused. Garety & Freeman (1999) have reviewed the evidence for biases in cognitive processes and found empirical support for an information gathering cognitive style characterized by jumping to conclusions, externalizing attributional biases, and deficits in understanding social situations and the intentions of others. It is likely that these biased appraisal processes are made worse by negative emotional states (e.g. anxiety, depression, anger).



(Mod. Garety 2001)

Jumping to Conclusions, a Lack of Belief Flexibility and Delusional Conviction in Psychosis: A Longitudinal Investigation of the Structure, Frequency, and Relatedness of Reasoning Biases

Suzanne H. So
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Daniel Freeman
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David Fowler
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Two reasoning biases, jumping to conclusions (JTC) and belief inflexibility, have been found to be associated with delusions. We examined these biases and their relationship with delusional conviction in a longitudinal cohort of people with schizophrenia-spectrum psychosis. We hypothesized that JTC, lack of belief flexibility, and delusional conviction would form distinct factors, and that JTC and lack of belief flexibility would predict less change in delusional conviction over time. Two hundred seventy-three patients with delusions were assessed over twelve months of a treatment trial (Garety et al., 2008). Forty-one percent of the sample had 100% conviction in their delusions, 50% showed a JTC bias, and 50%–75% showed a lack of belief flexibility. Delusional conviction, JTC, and belief flexibility formed distinct factors although conviction was negatively correlated with belief flexibility. Conviction declined slightly over the year in this established psychosis group, whereas the reasoning biases were stable. There was little evidence that reasoning predicted the slight decline in conviction. The degree to which people believe their delusions, their ability to think that they may be mistaken and to consider alternative explanations, and their hastiness in decision making are three distinct processes although belief flexibility and conviction are related. In this established psychosis sample, reasoning biases changed little in response to medication or psychological therapy. Required now is examination of these processes in psychosis groups where there is greater change in delusion conviction, as well as tests of the effects on delusions when these reasoning biases are specifically targeted.

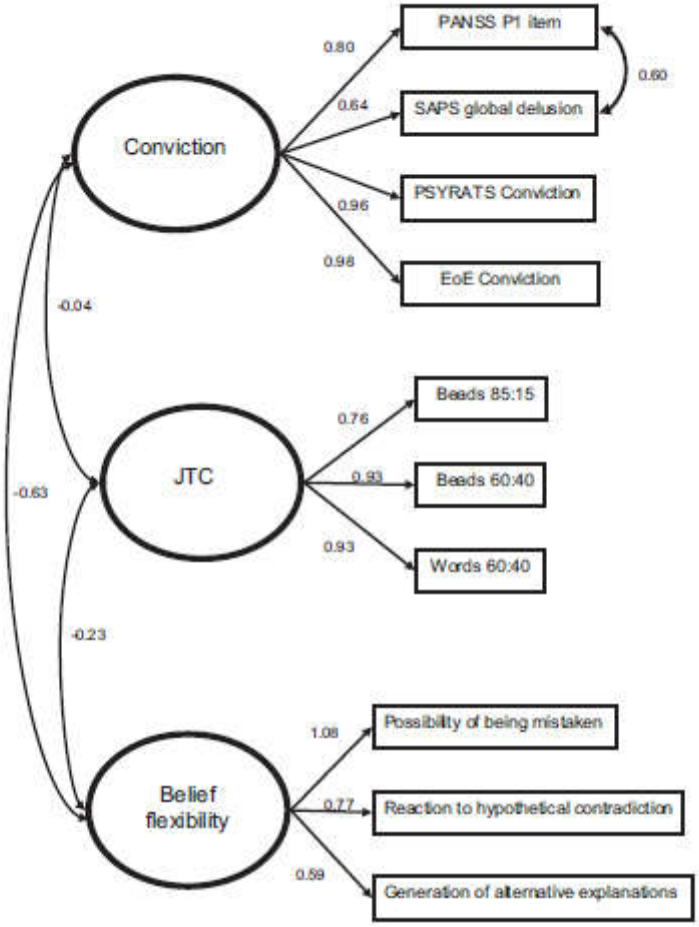

Figure 1. Final factor structure and loadings (standardized estimates) of conviction, JTC, and belief flexibility following confirmatory factor analysis.

Journal of Abnormal Psychology
2012, Vol. 121, No. 1, 129–139

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Correlation Between Factor Scores at Each Time Point

	Conviction			Jumping to conclusions			Belief flexibility		
	Baseline	3 months	12 months	Baseline	3 months	12 months	Baseline	3 months	12 months
Conviction									
Baseline									
3 months	.53**								
12 months	.31**	.55**							
Jumping to conclusions									
Baseline	.03	.05	.07						
3 months	.09	.07	.04	.88**					
12 months	.10	.05	.07	.84**	.93**				
Belief flexibility									
Baseline	−.40**	−.40**	−.30**	−.14*	−.12	−.14*			
3 months	−.34**	−.51**	−.33**	−.11	−.11	−.13	.87**		
12 months	−.29**	−.43**	−.47**	−.11	−.10	−.12	.79**	.86**	

* $p < .05$. ** $p < .01$.

Modelli cognitivi della sintomatologia psicotica

- Modello del continuum tra normalità e patologia delle psicosi
- I bias cognitivi nelle psicosi
- Il modello stress-vulnerabilità delle psicosi

(Riccardi, Rossi, Carcione 2012)

I modelli cognitivi della sintomatologia positiva della schizofrenia (Riccardi, Rossi, Carcione 2012)

- Il modello della spiegazione delle percezioni aberranti
- Il modello di Beck
- Il modello di Garety et al.
- Il modello di Freeman
- Il modello di Morrison
- Bentall: il modello dell'attribuzione/auto-rappresentazione
- Il modello di Birchwood

Psychological Medicine (2009), **39**, 179–195. © 2008 Cambridge University Press
doi:10.1017/S0033291708003814 Printed in the United Kingdom

INVITED REVIEW

A systematic review and meta-analysis of the psychosis continuum: evidence for a psychosis proneness–persistence–impairment model of psychotic disorder

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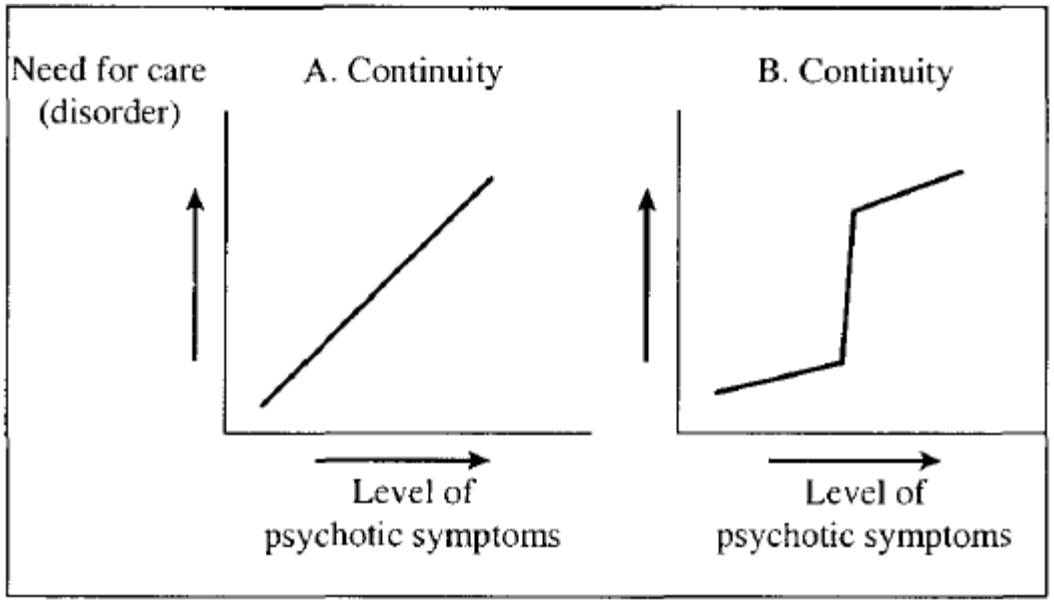
A systematic review of all reported incidence and prevalence studies of population rates of subclinical psychotic experiences reveals a median prevalence rate of around 5% and a median incidence rate of around 3%. A meta-analysis of risk factors reveals associations with developmental stage, child and adult social adversity, psychoactive drug use, and also male sex and migrant status. The small difference between prevalence and incidence rates, together with data from follow-up studies, indicates that approximately 75–90% of developmental psychotic experiences are transitory and disappear over time. There is evidence, however, that transitory developmental expression of psychosis (psychosis proneness) may become abnormally persistent (persistence) and subsequently clinically relevant (impairment), depending on the degree of environmental risk the person is additionally exposed to. The psychosis proneness–persistence–impairment model considers genetic background factors impacting on a broadly distributed and transitory population expression of psychosis during development, poor prognosis of which, in terms of persistence and clinical need, is predicted by environmental exposure interacting with genetic risk.

Is there a continuum of psychotic experiences in the general population?

JIM VAN OS

Epidemiologia e Psichiatria Sociale, 12, 4, 2003

Figure 4. – *Relationship between psychotic symptoms and psychotic disorder.*



In fig. 4, there is a continuous relationship between level of psychotic symptoms and need for care. In figure B, the initial increase is weak, but after a certain threshold the risk increase es disproportionally.

therefore suggests that a symptomatic coping style predicts decreased experience of control and results in need for care. Attribution of locus of control and a more submissive style vis à vis the psychotic experience may contribute to becoming a mental health patient.

Teoria della tecnica

- Le tecniche cognitivo-comportamentali vengono impiegate per agire sui sintomi psicotici, condividendo la caratteristica di mirare ad identificare e riconoscere i contenuti mentali legati ai sintomi (allucinazioni, idee deliranti) e ad agire sui processi di pensiero ad essi collegati.

- Tali protocolli utilizzano modelli esplicativi e normalizzanti dell'esperienza psicotica, unitamente a tecniche di problem solving e di coping dei sintomi

Metacognizione, ToM

- Le abilità generali di mindreading attengono a diverse aree di ricerca e vengono definite:
- **Teoria della mente** (Baron-Cohen, Frith, Leslie)
- **Funzione riflessiva o mentalizzazione** (Fonagy, Target, Bateman)
- **Metacognizione** (Carcione, Semerari, Di Maggio, Lysaker, Nicolò)

La metacognizione si riferisce all'insieme di abilità che permettono agli umani di

- A) identificare e attribuire, a sé e agli altri, stati mentali;
- B) pensare, riflettere e ragionare sugli stati mentali propri (autoriflessività) e pensare, riflettere e ragionare sugli stati mentali altrui (comprensione della mente altrui);
- C) utilizzare le conoscenze e le riflessioni sugli stati mentali propri e altrui per prendere decisioni, risolvere problemi o conflitti psicologici e interpersonali e padroneggiare la sofferenza soggettiva (mastery)

Carcione, Di Maggio, Conti 2010

Journal of Consulting and Clinical Psychology
2002, Vol. 70, No. 5, 1129–1139

0022-006X/02/$5.00 DOI: 10.1037//0022-006X.70.5.1129

The Use of Acceptance and Commitment Therapy to Prevent the Rehospitalization of Psychotic Patients: A Randomized Controlled Trial

Patricia Bach and Steven C. Hayes
University of Nevada, Reno

The present study examined the impact of a brief version of an acceptance-based treatment (acceptance and commitment therapy; ACT) that teaches patients to accept unavoidable private events; to identify and focus on actions directed toward valued goals; and to defuse from odd cognition, just noticing thoughts rather than treating them as either true or false. Eighty inpatient participants with positive psychotic symptoms were randomly assigned to treatment as usual (TAU) or to 4 sessions of ACT plus TAU. ACT participants showed significantly higher symptom reporting and lower symptom believability and a rate of rehospitalization half that of TAU participants over a 4-month follow-up period. The same basic pattern of results was seen with all participant subgroups except delusional participants who denied symptoms.

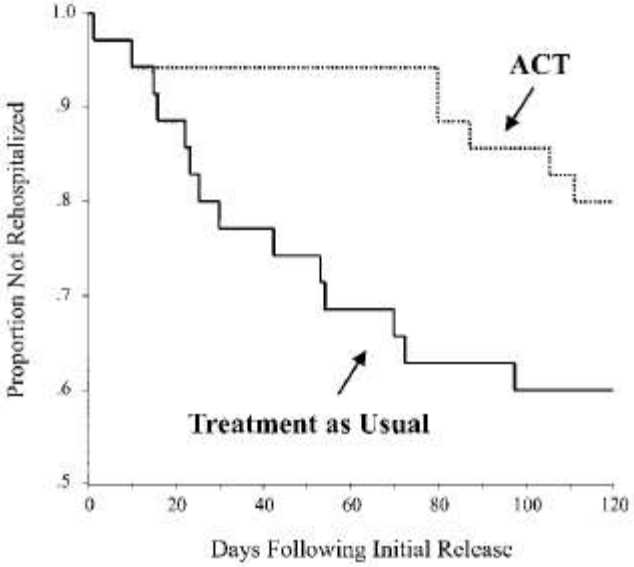


Figure 1. Daily percentages of participants in the acceptance and commitment therapy (ACT) and treatment-as-usual conditions remaining out of the hospital over the 4-month period following initial release.

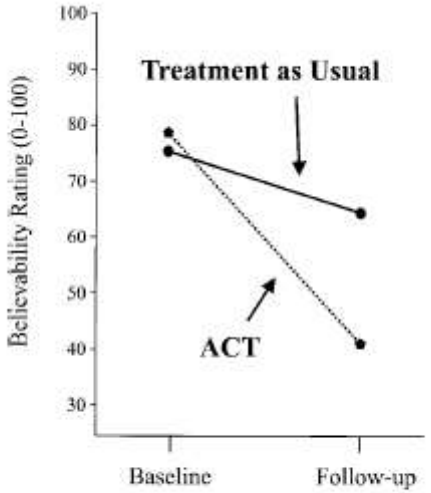


Figure 4. Self-rated believability of hallucinations and delusions for participants in the acceptance and commitment therapy (ACT) and treatment-as-usual conditions during baseline and follow-up.

Acceptance and Commitment Therapy: Model, processes and outcomes

Steven C. Hayes[a,*], Jason B. Luoma[a], Frank W. Bond[b], Akihiko Masuda[a], Jason Lillis[a]

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Received 4 June 2005; accepted 30 June 2005

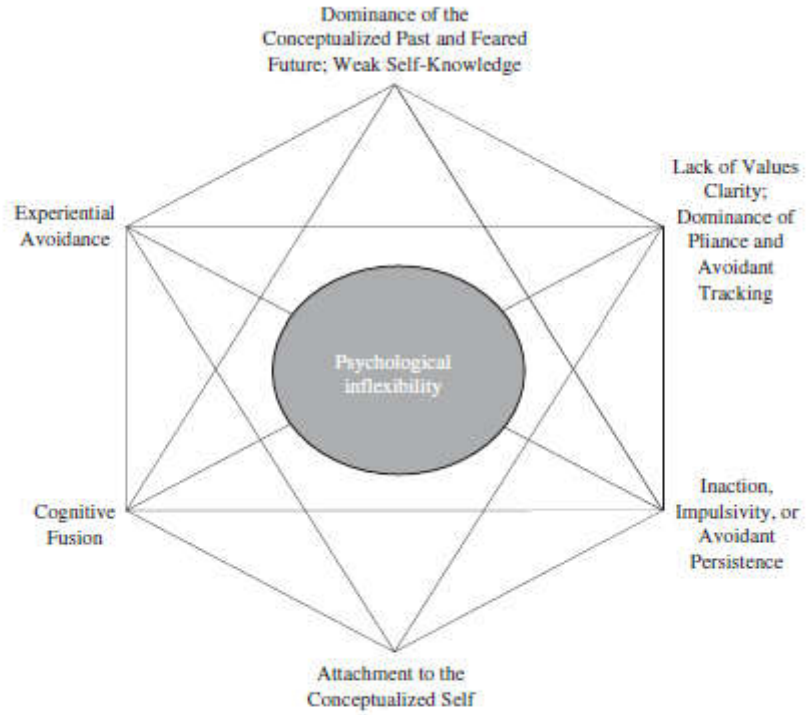

Fig. 1. An ACT/RFT model of psychopathology.

The present article presents and reviews the model of psychopathology and treatment underlying Acceptance and Commitment Therapy (ACT). ACT is unusual in that it is linked to a comprehensive active basic research program on the nature of human language and cognition (Relational Frame Theory), echoing back to an earlier era of behavior therapy in which clinical treatments were consciously based on basic behavioral principles. The evidence from correlational,

Perché i meccanismi di funzionamento patogenetici, sul piano comportamentale, emozionale, cognitivo, che traggono origine dalla psicologia sperimentale di base, trovano risposte efficaci nelle strategie e tecniche terapeutiche, il cui obiettivo è di mirare ad estinguere o attenuare l'effetto delle disfunzioni …

Disfunzioni e Risposte (Filograno, 2014)

Meccanismi patogenetici

1. Ansia, evitamento
2. Impotenza appresa
3. Assenza di abilità sociali
4. Ruminazioni, worring, incertezza
5. Fusione cognitiva (costruzioni verbali che si sovrappongono alla realtà)
6. Stigma, autosvalutazione
7. Bias cognitivi (attenzione selettiva, locus of control esterno, inferenze arbitrarie, jumping to conclusions)
8. Io concettualizzato (“malattia”)

Tecniche d’intervento

1. Esposizione (graduale, prolungata)
2. Attivazione comportamentale
3. Social Skills Training, Assertività
4. Implosion, Problem-solving
5. Defusione cognitiva (contestualizzare i comportamenti)
6. Normalizzazione
7. Ristrutturazione cognitiva, dialogo socratico
8. Fare contestualizzato (“autonomia”), funzionamento psicosociale

Evitamento

Quadri di inattività, ritiro e isolamento sociale possono essere il correlato di esperienze di evitamento di situazioni circostanti, marcate emotivamente in modo aversivo.

L'evitamento funzionale può quindi derivare, ad un tempo, da esperienze psicotiche, depressive e ansiogene.

"Almeno in parte la bassa motivazione, l'avolizione, l'anedonia si possono leggere come esperienze cognitive ed emozionali di evitamento.

Evitamento e ritiro sarebbero comportamenti protettivi per gestire l'ansia e i sintomi psicotici" (Meneghelli e Fowler, 2012)

Evitamento funzionale

Sonia, che ha un'intelligenza normale, preferisce studiare con il sostegno dell'educatrice. Dilaziona continuamente il momento di inizio dello studio, consapevole di dovere affrontare una fatica insormontabile, quando non si disperde in mille approfondimenti. Non si confronta mai con le sue naturali capacità che teme insufficienti.

Mario è isolato in casa. Fa uso costante di cannabinoidi. Nel corso di un viaggio con gli amici, due anni prima, vive un intenso stato di depersonalizzazione, forse innescato da droghe. Di poco precedente, la separazione dei genitori, quella con la sua ragazza e una bocciatura a scuola. Il mondo che potrebbe incontrare all'esterno è iniquo e fonte di prevaricazione e quindi rifiutato.

Andrea ha smesso di prendere la terapia. Per l'ennesima volta sta tentando di evitare l'idea di avere un disturbo psicotico e di essere "malato, diverso, inferiore". Come gli altri amici vuole fumare e bere, senza porsi problemi. Da qualche tempo, ha smesso di andare a scuola, evitando che i suoi comportamenti sopra le righe lo mettano a disagio. *(Filograno, 2014)*

Perché la formulazione di progetto terapeutico si basa sull'osservazione delle funzioni delle unità comportamentali (emozioni, cognizioni, comportamenti) individuali e sulle verifica sperimentale delle scelte strategiche del terapeuta, mirando ad ampliare i contesti ambientali e le opportunità di azione, in modo idiografica, ovvero rispettando e valorizzando le specificità di ogni soggetto

Comportamentismo e Analisi funzionale

L'analisi funzionale del comportamento ha come oggetto di osservazione la **triade di elementi, che si costituiscono in sequenza comportamentale**:

Antecedente – Unità Comportamentale – Conseguente

Tali elementi sono in relazione non casuale e fanno riferimento alla **"funzione**", corroborata dagli effetti del rinforzo.

L'oggetto di osservazione può essere non solo un comportamento, ma un significato, una connotazione, un modo di percepirsi, rinforzato anche da aspetti di significato e interpersonali.

In adolescenza, come in patologia, l'oggetto di osservazione può essere la funzione d'Identificazione, che si manifesta con risposte che sottolineano uguaglianza, dipendenza (essere come) o diversità, opposizione (distinguersi da) e che si riverberano sulla connotazione attribuita alla propria Identità.

Strategia terapeutica

L'obiettivo di cambiamento può consistere nel lasciare **inalterata la funzione d'Identificazione,**

ampliando le opportunità di azione, nel senso di occasioni d'intervento liberamente scelte e autodeterminate,

da corredare con strumenti e competenze, comportamentali ed emotive, che facilitino **l'adattamento ai contesti** e ai principi esistenziali desiderati,

in collegamento con un passato garante di un senso, che veda il soggetto autore del proprio divenire.

In questa prospettiva, è più facile ragionare sulla **valenza di "autonomia"**, che la scelta di coinvolgersi verso il raggiungimento di un obiettivo può apportare, piuttosto che relegare l'impegnarsi nelle iniziative ad una funzione di "conformismo" o di "opposizione".

“L’incompresa”: un caso di UHR **(Filograno, 2014)**

Mara ha 16 anni. Ricoverata in due occasioni presso reparti psichiatrici, in seguito a tentativi di suicidio, avvenuti per eccesso di ingestione di farmaci.

A fronte di circostanze caratterizzate da percepito “abbandono” (conflitto con i genitori, “tradimento” delle amiche) Mara soffre, dando adito con gesti autolesivi all’evitamento dell’esperienza di dolore, evocando l’attenzione degli altri.

Quando fa ingresso nel centro per gli esordi psicotici, la ragazza lamenta percezioni persecutorie da parte dei compagni di scuola, fino a dismettere completamente la frequenza scolastica e versare in una totale “morte emozionale”.

Un clima restrittivo regna in famiglia fin dall’infanzia. Le interazioni veicolano ansie di insicurezze materiali, accuse reciproche, delusioni e tristezza, scotomizzando gli affetti. Mara cerca ansiosamente un appiglio e comprendendo come sia molto facile deludere le aspettative altrui, ma anche essere dimenticata, intravede nel raggiungimento dell’eccellenza la possibilità di essere apprezzata, esistere.

Ma quando tale funzionamento non sortisce più i suoi effetti, le rivendicazioni e le condotte autolesive evocano un disperato desiderio di legittimazione ad un esistere affettivo e sociale.

Essere la prima, come anche non soggiacere alle altrui regole hanno la stessa funzione di visibilità e controllo (Difference), che la distanziano dall’anonimato e la sottraggono all’altrui indifferenza e Incontrollabilità. **arginando il rischio di “*non essere vista*”**, e quindi dimenticata, abbandonata.

Non può esserci un “Io” senza un “Tu”: dalla lotta al confronto (Filograno, 2014)

Mara desidera fortemente riprovare ad esperire le “sue” emozioni. Analogamente, ritiene di non potere astenersi dal frequentare la scuola, esito che preluderebbe all’esclusione dalla società, anche se sperimenta l’esperienza in modo opprimente.

Smussare la funzione d’Identificazione per Diversità, per individuare l’Autonomia

- **Validare le espressioni emozionali**, partendo dalla acceptance dell’assenza di emozioni, con il duplice obiettivo di associare legittimità e credibilità alle emozioni e al soggetto

- **Proporre una transizione che dall’affermazione di un concetto di Sé, pervenga ad una conoscenza e ad una gestione dei contesti.** Defondere dall’idea del “non avere emozioni, sia attraverso la compilazione di un diario giornaliero sulla descrizione di circostanze ed emozioni stesse, sia “nominando” le emozioni nel loro accadere.

- **Trattare comportamenti, emozioni, pensieri come elementi diversi,** sì da proporre osservazioni funzionali**,** problem-solving e potenziale modificazione dei comportamenti, per esempio evitando gli evitamenti (tornare a scuola)

- **Decondizionare dall’“essere come”**, proponendo equivalenze adattive, per es. tra le emozioni e il contatto umano, in modo da eludere l’idea che isolarsi dagli altri aiuti a risolvere i propri problemi.

- **Introdurre il Sé come Prospettiva:** nella narrazione dei fatti, incentivare “*il mettersi al posto di*”.

Cognitive–behavioural therapy and family intervention for relapse prevention and symptom reduction in psychosis: randomised controlled trial†

Philippa A. Garety, David G. Fowler, Daniel Freeman, Paul Bebbington, Graham Dunn and Elizabeth Kuipers

Background
Family intervention reduces relapse rates in psychosis. Cognitive–behavioural therapy (CBT) improves positive symptoms but effects on relapse rates are not established.

Aims
To test the effectiveness of CBT and family intervention in reducing relapse, and in improving symptoms and functioning in patients who had recently relapsed with non-affective psychosis.

Method
A multicentre randomised controlled trial (ISRCTN83557988) with two pathways: those without carers were allocated to treatment as usual or CBT plus treatment as usual, those with carers to treatment as usual, CBT plus treatment as usual or family intervention plus treatment as usual. The CBT and family intervention were focused on relapse prevention for 20 sessions over 9 months.

Results
A total of 301 patients and 83 carers participated. Primary outcome data were available on 96% of the total sample. The CBT and family intervention had no effects on rates of remission and relapse or on days in hospital at 12 or 24 months. For secondary outcomes, CBT showed a beneficial effect on depression at 24 months and there were no effects for family intervention. In people with carers, CBT significantly improved delusional distress and social functioning. Therapy did not change key psychological processes.

Conclusions
Generic CBT for psychosis is not indicated for routine relapse prevention in people recovering from a recent relapse of psychosis and should currently be reserved for those with distressing medication-unresponsive positive symptoms. Any CBT targeted at this acute population requires development. The lack of effect of family intervention on relapse may be attributable to the low overall relapse rate in those with carers.

Declaration of interest
None. Funding detailed in Acknowledgements.

BRITISH JOURNAL OF PSYCHIATRY **(2000), 177, 516–521**

Cognitive approach to depression and suicidal thinking in psychosis

I. Ontogeny of post-psychotic depression†

MAX BIRCHWOOD, ZAFFER IQBAL, PAUL CHADWICK and PETER TROWER

Method One hundred and five patien with ICD–10 schizophrenia were followe up on five occasions over 12 months following the acute episode, taking measures of depression, positive symptoms, negative symptoms, neuroleptic exposure and side-effects.

Results Depression accompanied acute psychosis in 70% of cases and remitted in line with the psychosis; 36% developed PPD without a concomitant increase in psychotic symptoms.

Conclusions The results provided support for the validity of two of the thre course patterns of depression in schizophrenia, including PPD. Post-psychotic depression occurs *de novo* without concomitant change in positive c negative symptoms.

Published criteria for recovery from schizophrenia

Variable	Study			
	Harding et al., 1987 (20)	Liberman et al., 2002 (24)	Torgalsboen et al., 2002 (38)	Whitehorn et al., 2002 (37)
Psychopathology	Symptom free and not taking psychotropic medications	BPRS score of 4 or less on all positive and negative psychosis items[a]	No psychiatric hospitalizations for five years	PANSS score of 4 or less on all scales[b]
Psychosocial functioning	Social life indistinguishable from that of neighbors; holding a job for pay or volunteer	At least half-time work or school; independent management of funds and medications; once weekly socializing with peers	GAF score of more than 65[c]	GAF score of more than 50[c]
Duration	None listed	Two years	Five years	Two years

[a] Brief Psychiatric Rating Scale. Possible scores range from 24 to 168, with higher scores indicating more symptoms.

[b] Positive and Negative Syndrome Scale. Possible scores range from 30 to 210, with higher scores indicating more symptoms.

Psychological Medicine (2009), **39**, 1627–1636. © Cambridge University Press 2009
doi:10.1017/S0033291709005467 Printed in the United Kingdom

ORIGINAL ART

Cognitive behaviour therapy for improving social recovery in psychosis: a report from the ISREP MRC Trial Platform study (Improving Social Recovery in Early Psychosis)

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Background. This study reports on a preliminary evaluation of a cognitive behavioural intervention to improve social recovery among young people in the early stages of psychosis showing persistent signs of poor social functioning and unemployment. The study was a single-blind randomized controlled trial (RCT) with two arms, 35 participants receiving cognitive behaviour therapy (CBT) plus treatment as usual (TAU), and 42 participants receiving TAU alone. Participants were assessed at baseline and post-treatment.

Method. Seventy-seven participants were recruited from secondary mental health teams after presenting with a history of unemployment and poor social outcome. The cognitive behavioural intervention was delivered over a 9-month period with a mean of 12 sessions. The primary outcomes were weekly hours spent in constructive economic and structured activity. A range of secondary and tertiary outcomes were also assessed.

Results. Intention-to-treat analysis on the combined affective and non-affective psychosis sample showed no significant impact of treatment on primary or secondary outcomes. However, analysis of interactions by diagnostic subgroup was significant for secondary symptomatic outcomes on the Positive and Negative Syndrome Scale (PANSS) [$F(1, 69) = 3.99$, $p = 0.05$]. Subsequent exploratory analyses within diagnostic subgroups revealed clinically important and significant improvements in weekly hours in constructive and structured activity and PANSS scores among people with non-affective psychosis.

Conclusions. The primary study comparison provided no clear evidence for the benefit of CBT in a combined sample of patients. However, planned analyses with diagnostic subgroups showed important benefits for CBT among people with non-affective psychosis who have social recovery problems. These promising results need to be independently replicated in a larger, multi-centre RCT.

L'ISREP MRC Trial Platform Study

L'ISREP MRC Trial Platform Study è uno studio randomizzato controllato, che suddivide 77 soggetti in un gruppo sperimentale a cui viene somministrata SRCBT (Social Recovery Cognitive Behavioral Therapy) e in gruppo di controllo, che usufruisce di TAU.

Le misure di outcome principale sono caratterizzate da ore di attività costruttive e strutturate, mentre quelle degli outcomes secondari sono rappresentati dai sintomi e dalla perdita di speranza. I mediatori riguardano credenze su di sé e sugli altri, elementi schizotipici.

L'esito della ricerca è consistito:

a) nell'impiego anche a due anni del 25% dei soggetti del gruppo SRCBT, rispetto a quello di controllo;

b) la riduzione della perdita di speranza, con un effect size pari a 0.6 sulle credenze positive su di sé e sugli altri (Meneghelli e Fowler, 2012)

A Disappearing Heritage: The Clinical Core of Schizophrenia

Josef Parnas*,1,2

Schizophrenia Bulletin vol. 37 no. 6 pp. 1121–1130, 2011
doi:10.1093/schbul/sbr081

This article traces the fundamental descriptive features of schizophrenia described in the European continental literature form Kraepelin and Bleuler, culminating with the creation of the International Classification of Diseases (ICD)-8 (1974). There was a consensus among the researchers that the specificity and typicality of schizophrenia was anchored to its "fundamental" clinical core (with trait status) and not to positive psychotic features, which were considered as "state", "accessory" phenomena. The clinical core of schizophrenia was, in a diluted form, constitutive of the spectrum conditions ("schizoidia" and "latent schizophrenia"). The fundamental features are manifest across all domains of consciousness: subjective experience, expression, cognition, affectivity, behavior, and willing. Yet, the specificity of the core was only graspable at a more comprehensive Gestalt-level, variously designated (eg, discordance, autism, "Spaltung"), and not on the level of single features. In other words, the phenomenological specificity was seen as being expressive of a fundamental structural or formal change of the patient's mentality (consciousness, subjectivity). This overall change transpires through the single symptoms and signs, lending them a characteristic phenomenological pattern. This concept of schizophrenia bears little resemblance to the current operational definitions. The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*, and ICD-10 seem to diagnose a subset of patients with chronic paranoid-hallucinatory variant of schizophrenia.

Metacognitive Capacities for Reflection in Schizophrenia: Implications for Developing Treatments

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Schizophrenia Bulletin Advance Access published March 17, 2014

Models of schizophrenia, which focus exclusively on discrete symptoms and neurocognitive deficits, risk missing the possibility that a core feature of the disorder involves a reduced capacity to construct complex and integrated representations of self and others. This column details a new methodology that has been used to assess deficits in the metacognitive abilities that allow persons to form complex ideas about themselves and others and to use that knowledge to respond to psychosocial challenges in schizophrenia. Evidence is summarized supporting the reliability and validity of this method, as well as links this work has revealed between metacognition and psychosocial outcomes. It is suggested that this work points to the need to develop interventions which move beyond addressing symptoms and specific skills, and assist persons to recapture lost or atrophied metacognitive capacity and so form the kind of ideas about themselves and others needed, to move meaningfully toward recovery.

Measuring the Complexity of Representations of Self and Others in Schizophrenia

To assess the capacity to form complex representations of self and others and to use that knowledge, an interview has been developed that asks persons about their life history and struggles with emotional challenges (the Indiana Psychiatric Illness Interview).[16] This method considers this elicited narrative as a sample of how persons think about their mental states and those of others in a deeply personal context as opposed to an impersonal laboratory task (eg, guessing the emotions of persons in photographs). The complexity of metacognitive acts within the narrative is rated using the 4 scales of the Metacognitive Assessment Scale Abbreviated[10,17] (MAS-A): "Self-reflectivity," the comprehension of one's own mental states; "Understanding the Mind of the Other," the comprehension of other individuals' mental states; "Decentration," the ability to see the world as viewable from multiple perspectives; and "Mastery," the ability to use metacognitive knowledge to address social and psychological dilemmas. Higher scores on the MAS-A subscales reflect greater abilities to construct integrated representations of self and others and to use that knowledge to respond to social and psychological challenges. A more detailed description of the scales has been offered elsewhere.[18]

Metacognitive training in schizophrenia: from basic research to knowledge translation and intervention

Steffen Moritz[a] and Todd S. Woodward[b,c]

Current Opinion in Psychiatry 2007, 20:619–625

Purpose of review

There has been a marked increase in the study of cognitive biases in schizophrenia, which has in part been stimulated by encouraging results with cognitive–behavioral interventions in the disorder. We summarize new evidence on cognitive biases thought to trigger or maintain positive symptoms in schizophrenia and present a new therapeutic intervention.

Recent findings

Recent studies indicate that patients with paranoid schizophrenia jump to conclusions, show attributional biases, share a bias against disconfirmatory evidence, are overconfident in errors, and display problems with theory of mind. Many of these biases precede the psychotic episode and may represent cognitive traits. Building upon this literature, we developed a metacognitive training program that aims to convey scientific knowledge on cognitive biases to patients and provides corrective experiences in an engaging and supportive manner. Two new studies provide preliminary evidence for the feasibility and efficacy of this approach.

Summary

The gap between our advanced understanding of cognitive processes in schizophrenia and its application in clinical treatment is increasingly being narrowed. Despite emerging evidence for the feasibility and efficacy of metacognitive training as a stand-alone program, its most powerful application may be in combination with individual cognitive–behavioral therapy.

Module	Target domain
(1) Attribution: blaming and taking credit	Self-serving bias versus depressive attributional style
(2) Jumping to conclusions: I	Jumping to conclusions/liberal acceptance/bias against disconfirmatory evidence
(3) Changing beliefs	Bias against disconfirmatory evidence
(4) To empathize: I	Theory of mind first order
(5) Memory	Overconfidence in errors
(6) To empathize: II	Theory of mind second order/ need for closure
(7) Jumping to conclusions: II	Jumping to conclusions/ liberal acceptance
(8) Mood and self-esteem	Mood and self-esteem

Sowing *the seeds of doubt*: a narrative review on metacognitive training in schizophrenia

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Clinical Psychology Review 34 (2014) 358–366

The present article provides a narrative review of empirical studies on metacognitive training in psychosis (MCT). MCT represents an amalgam of cognitive-behavioral therapy (CBT), cognitive remediation (CRT) and psychoeducation. The intervention is available in either a group (MCT) or an individualized (MCT+) format. By sowing the *seeds of doubt* in a playful and entertaining fashion, the program targets positive symptoms, particularly delusions. It aims to raise patients' awareness for common cognitive *traps* or biases (e.g., jumping to conclusions, overconfidence in errors, bias against disconfirmatory evidence) that are implicated in the formation and maintenance of psychosis. The majority of studies confirm that MCT meets its core aim, the reduction of delusions. Problems (e.g., potential allegiance effects) and knowledge gaps (i.e., outcome predictors) are highlighted. The preliminary data suggest that the individual MCT format is especially effective in addressing symptoms, cognitive biases and insight. We conclude that MCT appears to be a worthwhile complement to pharmacotherapy.

Detecting and defusing cognitive traps: metacognitive intervention in schizophrenia

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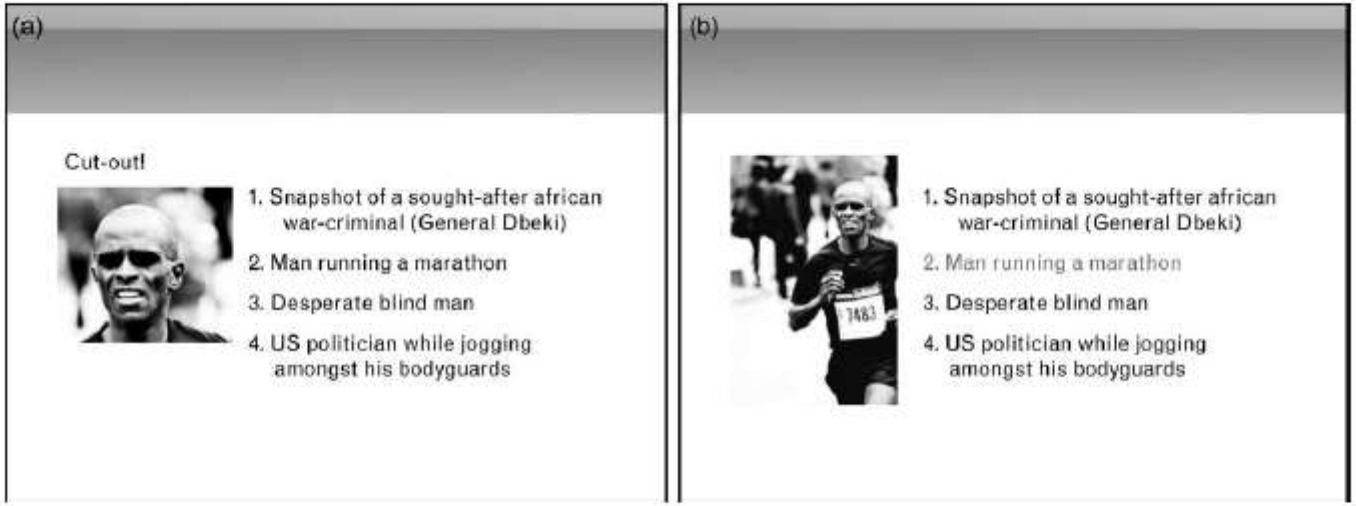
Current Opinion in Psychiatry 2010, 23:561–569

Figure 2 Exercise from module 4



(a and b) Detection of facial expression/situation without content information easily prompts errors (photographer is acknowledged on the MCT website, www.uke.de/mkt).

Recent findings

This review introduces new evidence on cognitive biases involved in the pathogenesis of schizophrenia and demonstrates how the MCT raises the patients' (metacognitive) awareness to detect and defuse such 'cognitive traps'. At the end, a new individualized variant entitled MCT+ is presented targeting individual delusional ideas. Finally, empirical results are summarized that speak in favour of the feasibility and efficacy of MCT.

Psychology and Psychotherapy: Theory, Research and Practice (2015)

The British Psychological Society

www.wileyonlinelibrary.com

Metacognitive training for young subjects (MCT young version) in the early stages of psychosis: Is the duration of untreated psychosis a limiting factor?

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Objectives. The treatment program 'Metacognitive training for patients with schizophrenia' (MCT) addresses cognitive biases assumed to play a crucial role in the pathogenesis of delusions (e.g., jumping to conclusions, theory of mind deficits). The aim of our study was to examine the effectiveness and the feasibility of this intervention targeted to early phases of psychosis (MCT young version).

Design. An experimental design included two groups of subjects on the basis of their duration of untreated psychosis (DUP) 'short' (less or equal than 12 months) and 'long' DUP (longer than 12 months), assessed at baseline and after the 4-month intervention.

Methods. Fifty-six young subjects affected by early psychosis were assessed on psychopathology, social functioning, neurocognitive, and metacognitive measures. The primary outcome was the reduction of psychopathology. Secondary outcomes included reduction of cognitive and emotional dysfunction and improvement of social functioning.

Results. At the end of the 4-month MCT, both groups showed significant improvements in many variables: positive symptoms, cognitive functions, as verbal memory, attention and mental flexibility, and metacognitive functions, as cognitive insight. Significant and positive changes were found in theory of mind abilities and social perception.

Conclusions. The difference in DUP between the two groups of young subjects of our sample did not seem to influence the intervention outcomes, still taking into account that the average difference between the two groups in terms of DUP is 12.6 months.

Isr J Psychiatry Relat Sci - Vol. 51 - No 1 (2014)

Metacognition in Schizophrenia Spectrum Disorders: Methods of Assessment and Associations with Neurocognition, Symptoms, Cognitive Style and Function

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ABSTRACT

Deficits in metacognitive capacity in schizophrenia can be conceptualized as existing along a spectrum from more discrete to more synthetic activities. While each represents an equally important focus of study, synthetic metacognitive activities may be more difficult to measure given they are more a matter of assessing complexity of thought rather than concrete accuracy; and therefore have received less attention. This review summarizes research on synthetic metacognition using a paradigm in which metacognitive capacity is rated within personal narratives. Results across the work reviewed here provides evidence that these deficits are detectable in patients with schizophrenia and that deficits are related to, but not reducible to, symptom severity and poorer neurocognitive function. Independent of symptoms and neurocognition, deficits in synthetic metacognition are related to a range of mental activities including reasoning style, learning potential and insight. These deficits may also play a role in long term outcome via their impact on the ability to function in work settings and to think about and sustain social connections.

MAS-A : metacognition assessment Scale
Autoriflessività
Comprensione della mente altrui
Decentramento
mastery

To quantify metacognitive capacity within IPII narratives, we have used a modified version of the Metacognition Assessment Scale – Abbreviated (MAS-A; 17). The MAS-A contains four scales: "Self-reflectivity," or the comprehension of one's own mental states, "Understanding of others' minds," or the comprehension of other individuals' mental states, "Decentration," which is the ability to see the world as existing with others having independent motives, and "Mastery," which is the ability to use one's mental states to respond to social and psychological dilemmas. It is assumed

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Punteggi elevati nella autoriflessività
Correlano con performance migliori nella
Memoria visiva e verbale, e
nella velocità di elaborazione
Migliori capacità nella comprensione della
Mente altrui e nella mastery correlano con
Punteggi più elevati nella memoria verbale