Review: social skills training, supported employment programmes, and cognitive behaviour therapy improve some outcomes in schizophrenia

Bustillo JR, Lauriello J, Horan WP, et al. ***The psychosocial treatment of schizophrenia: an update.*** *Am J Psychiatry 2001 Feb;**158**:163–75.*

QUESTION: In patients with schizophrenia, does psychosocial treatment improve symptoms?

Data sources

English language studies were identified by searching Medline and PsycInfo from 1966 to March 2000, scanning the references of identified articles, and contacting experts in the field.

Study selection

Studies were selected if they were randomised controlled trials (RCTs) that used standardised rating instruments to assess the effectiveness of psychosocial interventions in schizophrenia. Pertinent less rigorously conducted studies were also included. The emphasis was on identifying studies that were published since the previous review in 1996.

Data extraction

Data were extracted on type of psychosocial intervention, study design, patient characteristics, duration of follow up, relapse rates, and primary and secondary outcomes.

Main results

18 studies published since the previous review were identified. 2 evaluated *family therapy*, 2 *case management*, 5 *social skills training*, 3 *supported employment programmes*, 5 *cognitive behaviour therapy (CBT)*, and 1 compared *individual with family therapy*. Studies published before 1996 showed the superiority of *family therapy* in reducing relapse rates (24% *v* 64% among those who received routine treatment); however, the 3 recently published studies evaluating *family therapy* did not find a reduction in relapse rates. Treatment intensity and format of *family therapy* did not appear to differentially affect outcome. The 2 recently published studies evaluating *assertive community treatment* (a form of *case management*) found no effect on readmissions to hospital. Previous reports found consistent effects for reduction in time spent in hospital and improvement in housing stability. Neither *family therapy* nor *assertive community treatment* had consistent effects on symptoms, overall social functioning, or ability to obtain competitive employment. The 5 studies evaluating the effectiveness of *social skills training* found improvements in social adjustment, independent living skills, cognitive measures, social competence, and skill acquisition with treatment. There were no clear effects on relapse prevention, psychopathology, or employment status. The 3 studies of *supported employment programmes* that used the "place and train" vocational model consistently showed higher competitive employment rates (65% *v* 26% for control conditions) but showed no benefit for non-vocational outcomes. Of the 5 RCTs evaluating *CBT*, some provided evidence for the effectiveness of *CBT* in reducing delusions and hallucinations in medication resistant patients and for its use as a complement to pharmacotherapy in acute psychosis. One study of *individual therapy* appeared promising in improving overall social adjustment.

Conclusion

Randomised controlled trials published since 1996 show that social skills training can improve social competence; supported employment programmes result in higher competitive employment rates; and cognitive behaviour therapy may reduce delusions and hallucinations in medication resistant patients.

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COMMENTARY

The principle of integrating psychosocial treatment approaches into overall care for patients with schizophrenia is well established; however, good outcome studies examining the merits of psychosocial treatments are new.

Bustillo *et al* have done an extensive literature review, updating the field. Their review is consistent with 2 recent Cochrane reviews in this area.[1 2] They included relevant information such as effectiveness of the approach in non-research conditions and cost effectiveness. This review would have been strengthened if the authors had supplied methodological ratings of the RCTs reviewed.

Although not conclusive, this review has some clear implications for nursing practice. Contrary to previous findings, Bustillo *et al* recommend that *family therapy* be offered to frequent relapsers who reside with family, and that *assertive community treatment* programmes be considered for patients with high rates of service use. They make these recommendations even though recent studies have been inconsistent with the large body of research supporting the efficacy of these treatments. The authors suggest that inclusion of low risk populations (eg, low baseline risk of relapse) and comparisons with control groups who received enriched packages contributed to the recent negative findings.

Positive effects were found for models of social skills training and vocational rehabilitation. Given the previously documented difficulty of generalisability of social skills in training programmes, clinicians are encouraged to explore problem solving approaches to social skills development. Furthermore, a cognitive remediation approach, used as a precursor to more traditional social skills training, may be beneficial for very ill patients with lengthy hospital stays. This review also suggests an alternative to the traditional graduated training model of vocational rehabilitation (eg, transitional or sheltered employment), which has had limited success in increasing competitive employment. Placing individuals in supported employment programmes with features such as minimal screening for employability, avoidance of preoccupational training, individualised placement, and time unlimited support, should be explored as viable alternatives. Finally, preliminary evidence exists that *CBT* reduces delusions and hallucinations in medication resistant patients and may complement pharmacotherapy in acute psychosis.

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1 Jones C, Cormac I, Mota J, *et al.* Cognitive behaviour therapy for schizophrenia. *Cochrane Database Syst Rev* 2000;(2):CD000524.
2 Pharoah FM, Mari JJ, Streiner D. Family intervention for schizophrenia. *Cochrane Database Syst Rev* 2001;(2):CD000088.