When Psychopharmacology Is Not Enough: Using Cognitive Behavioral Therapy Techniques for Persons With Persistent Psychosis

Rebekka Lencer, MD; Margret S. H. Harris, PhD; Peter J. Weiden, MD; Rolf-Dieter Stieglitz, MD; and Roland Vauth, PhD. Hogrefe Press, Cambridge, MA, and Gottingen, Germany, 2011, 125 pages, $39.80 (paperback, with summary cards).

This is a very worthwhile book. The first version (the German edition) was published in 2006 and written by only 2 of the 5 authors of the current edition (Vauth and Stieglitz). This 2011 American version has been enlarged (including much of the earlier work in its chapters 3–6) but remains small and pithy even with the added material. The new (American) authors are or were affiliated with the University of Illinois, at Chicago. Despite its chimeric structure, the new combined work reads nicely as a unified treatise.

Peter Weiden is a well-known and highly regarded psychiatrist in this country, and Margret Harris is a specialist in the treatment of first-episode psychotic patients with cognitive-behavioral therapy (CBT). For psychiatrists who are not experts in CBT (myself included), the book will prove especially eye-opening as it clearly elucidates how invaluable its techniques are when employed in conjunction with pharmacotherapy.

There are only 10 short chapters in the book plus an appendix that includes many useful tables and scales as well as 4 removable and plasticized strategy, checklist, and "guided exploration" pull-out cards. The chapters contain many useful tables and figures summarizing data, and the work is well-referenced. Many internationally renowned cognitive therapists are cited (eg, D. Turkington and D. Kingdon). Chapter 1 reviews treatment approaches for psychosis; chapter 2 addresses moving beyond a biological model. The third chapter reviews evidence supporting the use of CBT for psychoses, and chapter 4 looks at general aspects of treatment. The fifth chapter deals with CBT strategies for chronic auditory hallucinations, and the sixth does the same for chronic delusions. Chapter 7 discusses why psychopharmacology may not be enough, while the eighth chapter focuses on CBT for psychosis and medication adherence. Chapter 9 addresses CBT strategies for specific patient needs (eg, first-episode patients, dual-diagnosis patients, group therapy), and the tenth, and final, chapter presents 3 short

but useful case examples. Interestingly, virtually every paragraph is accompanied by a bold-print marginal comment or two (which come in handy when looking for reference points or summary guides). This plethora of highly useful scales and tables is unusually complete and practical.

I took issue with only one stance in the book. The authors suggest that it is best for the CBT therapist not to share "confidential information about medication non-adherence with the prescribing clinician," following the principle that "whatever happens in the adherence assessment should not compromise the therapeutic alliance" (p 73, Table 22). I hope that the authors mean that it *may* be better to keep the non-adherence confidential so long as it does not appear unsafe (for the patient as well as others—the "duty to warn" as decided in the Tarasoff case). Despite that, a few pages later, regarding treating first-episode schizophrenia, they note that "non-adherence to medication regimens is a greater obstacle to the successful treatment of first-episode schizophrenia than any limitations in efficacy of the newer medications." As someone more likely to be a prescriber than a therapist (in a split-treatment scenario), it is my belief that split treatment is a team effort and the more each treater knows about what the other is doing and what is going on with the patient, the better. I am often surprised by how frequently, in such dual situations, the treaters do not even know each other, let alone frequently compare notes. A patient's medication non-adherence should be shared, and the patient should know that this information will be shared (lest the "therapeutic alliance" be preserved at the cost of the patient's life). Furthermore, a failure to have communicated non-compliance with medications, should a suicide occur, is likely to be viewed by juries as below an acceptable medical standard.

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