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Integrated psychological therapy for schizophrenia

SIR: It is disappointing that Brenner *et al* (*Journal*, October 1992, **161** (suppl. 18), 154–163) could not report more encouraging results for their Integrated Psychological Therapy Programme for Schizophrenic Patients (IPT). This is especially disappointing given Brenner's pioneering work in attending to the cognitive deficits in schizophrenia in rehabilitation programmes.

While "favourable overall effects of IPT" are reported, the effects of Brenner's Cognitive Differentiation Module on both lower-order and higher-order functioning are questioned. Significantly, in our view, the Cognitive Module did not result in improvement in card sorting (a variant of the Wisconsin Card Sorting Test) or in attention (as measured by the D2-test).

It is possible that the IPT Cognitive Differentiation Module was not administered effectively. The training was brief, and given to groups of patients. Individual, one-to-one training may be necessary if cognitive strategies are to be imparted; strategies which could generalise to higher-order activities. Additionally, and as pointed out in the conclusion of the paper, programmes may need to be "more firmly based on comprehensive cognitive theories".

A variant of the IPT was introduced to Australia in 1988. Gains were achieved in measures of cognitive functions (such as certain subtests of the WAIS-R), and there were improvements in symptoms (as measured by the Expanded Brief Psychiatric Rating Scale) and in the skills of daily living (as measured by the Life Skills Profile). However, there were no gains in cognitive flexibility (as measured by the Wisconsin Card Sorting Test), nor in forward planning (as measured by the Tower of London).

This led us to abandon the IPT, and to concentrate on neurocognitive rehabilitation development as a 'front-end' to higher-order training, such as Communication Skills, Psycho-education, and Living Skills Modules. A computerised package, developed for patients with brain damage following head injury or stroke (Bracy, 1987), was administered to seven schizophrenic patients. Gains were recorded similar to those for the modified IPT, but again, there were no improvements in cognitive flexibility or forward planning.

A neurocognitive rehabilitation programme based on putative prefrontal/frontal executive functions, as subserved by distributed neural networks, was then developed, and called the Frontal/Executive Program. Improvements were recorded as for the ITP and for the Bracy computerised programs but, in addition, significant improvements in cognitive flexibility and forward planning were achieved (Morice & Delahunty, 1993).

Some 20 schizophrenic patients have now completed the Frontal/Executive Program, which comprises a two-week Cognitive Fexibility Module, and a six-week Planning Module, administered on a one-to-one basis. Results are encouraging, and suggest a generalisation to higher-order activities. Anecdotally, patients report clearer thinking and improved functioning, and their families quite often report marked changes in a range of behaviours.

We regard neurocognitive rehabilitation in schizophrenia as an important new adjunct to management, an innovation for which Brenner and colleagues are largely responsible. But possibly they have not been critical enough of their Cognitive Differentiation Module, have not developed it further on the basis of an adequate cognitive theory, and have not made sufficient modifications to it in the light of earlier results.

We encourage readers to remain more optimistic than the Bern originators of this approach to rehabilitation. While much more development and evaluation remains to be done, early results would seem to justify continuing optimism.

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AUTHORS' REPLY: Morice & Delahunty refer to the effects of IPT. IPT is a comprehensive group therapy consisting of five subprogrammes which proceed from functional cognitive skills to general behavioural

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planning and generalisation of skills acquired in training for real-world situations. It consists of standardised materials, techniques and therapeutic procedures. Also, Morice & Delahunty accomplished the interventions of the IPT. The fact that they assessed a modified version of the IPT rather than the original one might have contributed to their negative results concerning cognitive flexibility and forward planning.

Morice & Delahunty exclusively focus on the first IPT subprogramme 'Cognitive Differentiation'. They criticise this subprogramme as not effective enough for improving higher-order activities. In an isolated evaluation of the original version of the 'Cognitive Differentiation' subprogramme, however, Roder (1988) seized its effects on central cognitive functions. He used five measures: the card-sorting test, the verbal-concept test, the concept-formation test, the proverb test, and the D-2 test. No improvement was recorded for the D-2 test. But the verbal-concept, the concept-modification and the proverb test showed significant improvements, and the card-sorting test non-significant improvements. Also, the results of two other studies (Roder & Kienzle, 1991; Kraemer *et al*, 1991), indicating that the 'Cognitive Differentiation' subprogramme has a greater impact on more complex functions than on elementary functions of information processing. This led us to a cautious appraisal of the issue, since there are good reasons to suggest that for the optimal improvement of higher-order processes elementary dysfunctions would also have to be reduced as much as possible. Therefore, we are presently gaining experience with computerised pre-training procedures.

However, the foremost purpose of IPT is to reduce disordered metacognitions in schizophrenia, which coordinate and control the various levels of cognition and behaviour and are crucial for the transfer of therapy gains in everyday life rather than to treat isolated cognitive dysfunctions. The results of several IPT-evaluation studies in different centres suggest that this is only possible by means of integrated cognitive and social training procedures (cf. Brenner *et al*, 1993). No comprehensive effects on behaviour or on life-coping skills like those of the IPT or similar training programmes have been reported for neurocognitive rehabilitation training procedures to date. Isolated interventions such as the use of Cognitive Differentiation not embedded in the entire treatment programme can only have a limited effect. It would please us if the anecdotally reported behaviour changes of the Australian patients could also be shown by the use of control groups and standardised measures to enable the implementation of the Frontal/Executive Programme.

In summary, we share Morice & Delahunty's point of view that a great deal more development and evaluation remains to be done to justify their optimism.

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Epidemiology of vascular dementia

SIR: We have read with interest Dr Brayne's paper (*Journal*, April 1993, 439–446), but we feel that the problems arising from epidemiological studies of vascular dementia (VaD) are not discussed in sufficient depth by the author despite this being considered the second most common cause of age-related dementia in the Western countries. We hope that our comments will complement Dr Brayne's article.

The diagnosis of 'case' in VaD has been rather difficult, mainly because of: the lack of a 'working' classification of subtypes of VaD widely accepted by clinicians and researchers (Serra-Mestres & López-Pousa, 1992; Román, 1993); the absence of operational diagnostic criteria for VaD and for each of its subtypes; the lack of pathological homogeneity, and disagreement in the significance of certain types of lesions; the absence of a specific neuropsychological battery of tests that optimally shows the cortical and subcortical deficits of VaD (Román, 1993); and lack of studies correlating clinical, neuropsychological, imaging, and pathological data.

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