ADVANCES IN COGNITIVE THERAPY FOR PSYCHOSIS

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CBT for psychosis: a brief history of development

Techniques are based on the general principles of CBT that were initially developed for the treatment of depression.

Developed for schizophrenia against a backdrop of intense scepticism because of past failures of other individual psychotherapies.

CBT added to antipsychotic medication is now a first-line treatment for schizophrenia.

CBT, cognitive behavioural therapy
CBT for psychosis: key elements that contrast with other approaches

Psychosis is viewed on a continuum between normal and ill, rather than all or nothing: ‘normalising’
Everybody gets stressed … it’s just the way we react that differs.

- Some people get depressed, some anxious, others drink too much, or get confused.

- The reaction depends on your make-up, e.g. personality, family history or childhood experiences; your current circumstances, e.g. available supports, and the nature of the stress you are experiencing.

(Kingdon, 2009)
Everybody gets stressed ... it's just the way we react that differs.

- Just as we all get physical problems at some time in our life, e.g. a cold or flu, so we can get stressed through overwork or become sad after bereavement. At the other extreme we can experience a heart attack or arthritis – or psychosis – and just as it is possible to make a recovery or learn to cope with such physical problems so recovery or coping is possible with psychosis and other mental health problems.

- Minor, transient; problem ... ‘cope with it’
- Moderate/severe; illness ... ’treatment/sick role’
- Persistent; disability .. ‘treatment/rehabilitation’
CBT for schizophrenia: key elements that contrast with other approaches

Psychosis is viewed on a continuum between normal and ill, rather than all or nothing

Does not require acceptance of schizophrenia diagnosis or biologic model of illness causation
Early-onset ‘Sensitivity’ Psychosis

Post ‘Traumatic Stress Psychosis’

Late-onset ‘Anxiety’ Psychosis

Drug-related Psychosis

Schizoid Personality

‘Borderline personality disorder’

Aspergers

PTSD

Depressive Psychosis

Bipolar disorder

Delusional disorder

OCD

Schizophrenia

Social anxiety

Antisocial Personality

Royal College of Psychiatrists WHO ICD-11 Consultation Summary, 2009

Background and method. A summary statement reflecting the views of College Members was requested. Leads of Faculties, Divisions and Groups conferred and College members were then consulted by email with questions on their experience of ICD-10 and views on how its successor should be developed. The findings were summarised and discussed.

Overarching principles.
There was little support for wholesale change in broad categories (i.e. F0, F1, F2 etc.) but widespread support for reorganisation and fewer rather than more specific categories in ICD-11 compared with its predecessor.
ICD-11 Diagnostic System

Mental illness or not

<table>
<thead>
<tr>
<th>Psychosis unspecified</th>
<th>Common Mental Disorders</th>
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<tbody>
<tr>
<td><strong>Neuropsychiatric</strong></td>
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<td><strong>Psychosis</strong></td>
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<td><strong>Affective psychoses</strong></td>
<td><strong>Affective disorders</strong></td>
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<td><strong>Anxiety disorders</strong></td>
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<td><strong>Substance disorders</strong></td>
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<td><strong>Developmental disorders</strong></td>
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</table>

Dimensional subgroups, e.g. cognitive, affective.

Specifiers:
- personality
- life cycle (early/late)
- childbirth-related
- intellectual ability
- coexisting drug misuse
- trauma

Specifiers:
- personality
- life cycle
- childbirth-related
- int. ability

Specifiers:
- personality
- life cycle
- childbirth-related
- int. ability

Specifiers:
- personality
- life cycle

Include/rename ‘borderline' PD

[Possible implications of Royal College of Psychiatrists Summary Response to ICD11 consultation, 2009]
A DIAGNOSTIC SYSTEM USING BROAD CATEGORIES WITH CLINICALLY RELEVANT SPECIFIERS: LESSONS FOR ICD-11

CBT for schizophrenia: key elements that contrast with other approaches

Psychosis is viewed on a continuum between normal and ill, rather than all or nothing.

Does not require acceptance of schizophrenia diagnosis or biologic model of illness causation.

Interest in personal understanding of symptoms.
Therapeutic process of CBT

- There is a strong focus on *individualised* engagement of the patient building on good psychiatric practice
- Agendas are less explicit, feelings are elicited with great care and homework is used sparingly
- Assessment is based on clinical practice
- Emphasis is placed on understanding the first episode in detail, which may hold the key to current beliefs
- Information on current beliefs and how they were arrived at is assembled into a formulation
A formulation for making sense of patients’ beliefs and experiences
Overall aim of CBT for schizophrenia

AIM
To reduce distress and disability

Work with delusions (systematised & high conviction)

Work with hallucinations (persistent/abusive)

Work with negative symptoms
Worry intervention for delusions
(Freeman et al, in press)

- Psychoeducation about worry,
- Reviewing of positive and negative beliefs about worry,
- Increasing awareness of the initiation of worry and identification of individual triggers,
- Learning to ‘let go’ of worry,
- Use of worry periods,
- Substituting problem-solving in place of worry,
- Relaxation exercises.

- A simple individualised formulation of each person’s worry was developed and homework between sessions was agreed.
- Written information was provided in the form of a leaflet called ‘winning against worry’.
Mindful awareness
(Chadwick at al, 2009)

‘Mindfulness is a new relationship with experience, where we

- Accept/Welcome all experience
- Experience it with full awareness
- Understand that it is just a fleeting object of awareness, so do not define self by it (not me, not mine)
- Let it go
- Judge neither it nor self’
Efficacy of CBT and befriending interventions in schizophrenia resistant to medication

SANS – Scale for Assessing Negative Symptoms

Turkington et al, 2008
Brief CBT Intervention Study
Results: at 1 yr (n=336)

Brief CBT significantly reduced time spent in hospital for those who relapsed (CBT mean 47 days vs TAU mean 80 days) and delayed time to rehospitalisation (OR, 1.837, 1.108, 3.04, p=0.018). Turkington et al, 2006
# CBT in ‘dual diagnosis’

A randomised study in patients with comorbid alcohol or substance abuse

<table>
<thead>
<tr>
<th></th>
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<tr>
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<td>10.2*</td>
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<td>52.2</td>
<td>62.3</td>
<td>65.5</td>
<td>58.5</td>
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</table>

GAF, Global Assessment of Functioning scale  * p<0.05 integrated vs routine care

† Integrated care = routine care + CBT + motivational interviewing + family intervention

Barrowclough et al 2001; Haddock et al 2003
Randomized Trial of Cognitive–Behavioral Therapy for Chronic Posttraumatic Stress Disorder in Adult Female Survivors of Childhood Sexual Abuse

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Dartmouth Medical School and Norwich, Vermont

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Yale University School of Nursing

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Dartmouth Medical School and National Center for Posttraumatic Stress Disorder

Monica Descamps  
Norwich, Vermont

The authors conducted a randomized clinical trial of individual psychotherapy for women with posttraumatic stress disorder (PTSD) related to childhood sexual abuse ($n = 74$), comparing cognitive–behavioral therapy (CBT) with a problem-solving therapy (present-centered therapy; PCT) and to a wait-list (WL). The authors hypothesized that CBT would be more effective than PCT and WL in decreasing PTSD and related symptoms. CBT participants were significantly more likely than PCT participants to no longer meet criteria for a PTSD diagnosis at follow-up assessments. CBT and PCT were superior to WL in decreasing PTSD symptoms and secondary measures. CBT had a significantly greater dropout rate than PCT and WL. Both CBT and PCT were associated with sustained symptom reduction in this sample.
Cognitive therapy for command hallucinations: randomised controlled trial

PETER TROWER, MAX BIRCHWOOD, ALAN MEADEN, SARAH BYRNE, ANGELA NELSON and KERRY ROSS

Results  Large and significant reductions in compliance behaviour were obtained favouring the cognitive therapy group (effect size = 1.1). Improvements were also observed in the CTCH but not the control group in degree of conviction in the power and superiority of the voices and the need to comply, and in levels of distress and depression. No change in voice topography (frequency, loudness, content) was observed. The differences were maintained at 12 months’ follow-up.

Method  A total of 38 patients with command hallucinations, with which they had recently complied with serious consequences, were allocated randomly to CTCH or treatment as usual and followed up at 6 months and 12 months.
Background
Aggression and violence are serious problems in schizophrenia. Cognitive–behavioural therapy (CBT) has been shown to be an effective treatment for psychosis although there have been no studies to date evaluating the impact of CBT for people with psychosis and a history of violence.

Aims
To investigate the effectiveness of CBT on violence, anger, psychosis and risk outcomes with people who had a diagnosis of schizophrenia and a history of violence.

Method
This was a single-blind randomised controlled trial of CBT v. social activity therapy (SAT) with a primary outcome of violence and secondary outcomes of anger, symptoms, functioning and risk. Outcomes were evaluated by masked assessors at 6 and 12 months (trial registration: NRR NO50087441).

Results
Significant benefits were shown for CBT compared with control over the intervention and follow-up period on violence, delusions and risk management.

Conclusions
Cognitive–behavioural therapy targeted at psychosis and anger may be an effective treatment for reducing the occurrence of violence and further investigation of its benefits is warranted.

Declaration of interest
None. Funding detailed in Acknowledgements.
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.
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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² CAMEO, Cambridgeshire and Peterborough Mental Health Partnership NHS Trust, UK
³ Norfolk Early Intervention Service, Norfolk and Waveney Mental Health NHS Foundation Trust, UK
⁴ Department of Psychiatry, University of Cambridge, Cambridge, UK

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.

Received 14 March 2008; Revised 23 January 2009; Accepted 4 February 2009; First published online 1 April 2009

Key words: Cognitive behaviour therapy, psychosis, social recovery.
Studies (ongoing)

- MRC MIDAS (dual diagnosis) – completed
- MRC EDIE (early psychosis) – results awaited
- MRC COMMAND – recruiting (2-300)
- US Veteran’s Admin RCT – commencing (10/120)
- Texas RCT - recruiting
- Beijing RCT – good early results
- DIALOG+ - patient feedback + CBT response
- NIMH RAISE – Early intervention ‘package’
Meta-analysis of RCTs [7+1] (Wykes et al, 2007 - Schizophrenia Bull)

- Average effect size for target symptom (33 studies*) = .40 (95% CIs: .25 - .55)
- Average effect size for “rigorous” RTCs (12 studies) = .22 (95% CIs: .02 - .43)
- Significant effects (ranging from .35 – .44) for:
  - Positive symptoms (32 studies)
  - Negative symptoms (23 studies)
  - Functioning (15 studies)
  - Mood (13 studies)
  - Social anxiety (2 studies)

*20 from UK, 5 from USA, 2 from Germany, Australia, Netherlands, 1 from Canada, Italy, Israel; 27 individual CBTp, 7 group CBTp
Current evidence supporting the efficacy of CBT in schizophrenia

- Under 18
- 18-65
- Over 65
- Caucasian
- Non-Caucasian
- Prodromal
- Early
- Persistent
- Acute wards
- Community
- Forensic

Legend:
- None
- Case
- 1-2 randomised controlled trials
- Meta-analyses / randomised controlled trials
Developing culturally-sensitive CBT for psychosis

David Kingdon, Peter Phiri & Farooq Naeem
University of Southampton

Shanaya Rathod
Hampshire Partnership NHS Trust
Qualitative results – UK

- Differing help seeking pathways/behaviours
- Access and referral routes differ – imams, faith healers, etc: effective or impact on early intervention
- Collaboration/individualisation does not compensate for lack of understanding of cultural background
- Language/terminology – e.g. patois in AC
- Individualism vs collectivism (family) – esp. SA Muslim
- Religion – impact in SAM & African-Caribbean
- Gender & family issues
- Interpreters – family complications, confidentiality
- Supernatural vs Scientific
- Expectations of therapist
- Self-disclosure: key for AC – not so for SAM

(Rathod et al, 2010)
Schizophrenia

Core interventions in the treatment and management of schizophrenia in primary and secondary care

Clinical Guideline 1
December 2002
Developed by the National Collaborating Centre for Mental Health
<table>
<thead>
<tr>
<th>Criterion</th>
<th>Standard</th>
<th>Exception</th>
<th>Definition of terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Cognitive behavioural therapy (CBT)</td>
<td>100% of individuals with schizophrenia who are experiencing persisting psychotic symptoms should be offered CBT.</td>
<td>The individual with schizophrenia who is not able to participate in an informed discussion with the clinician responsible for treatment at the time and an advocate or carer is not available.</td>
<td>The notes should indicate that the clinician responsible for treatment has discussed the process and benefits of CBT, or that the individual was not capable of making a choice at the time. The term ‘persisting symptoms’ refers to positive or negative symptoms, which persist, with limited or no response to antipsychotic medication.</td>
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<tr>
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<td>All individuals who receive CBT should be offered treatment lasting for over 6 months and including more than 10 planned sessions.</td>
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CBT is offered to any individual with schizophrenia, and especially to the individual who is experiencing persistent psychotic symptoms. The course of CBT offered should normally be of more than 6 months’ duration and include more than 10 planned sessions.

Revised (2009) now 16 sessions recommended
| Area of recommendation | AT  | AU  | CA1 | CA2 | CZ  | DE  | DK  | ES  | FI  | FR  | GBI | GB2 | LT  | LV  | NL  | NO  | SG  | SI  | US1 | US2 | US3 | US4 | US5 | ZA  |
|-------------------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| Recommendation for psychological therapy: |  | + | NR  | NR  | NR  | +  | NR  | +  | +  | +  | +  | NR  | NR  | +  | NR  | NR  | NR  | NR  | NR  | NR  | NR  | NR  |    |
Clinical limitations of the CBT approach

- Availability is a limitation:
  - when available, 49% (69 of 142) patients with schizophrenia were referred

Frequency Graph of Reasons for Non-referral

Kingdon & Kirschen, 2006
Training

● 'Expert': (nurse, SW, psychiatrist, psychologist, OT)
  - Diploma (1 yr teaching)/MSc (1 yr research)
    - CBT for severe mental illness [1-2 days/wk]
  - Clinical psychologists

● 'Therapist': (nurse, SW, OT)
  - Diploma in Psychosocial Interventions
    - includes CBT & Family work [1 yr - 1-2 days/wk]
  - 'Insight' training: 10 days CBT

● 'Practitioner': (nurse, SW, psychiatrist, psychologist, OT)
  - 5 day courses, day-workshops, lectures
  - General mental health training
  - Mental Health Practitioner programme
The Insight CBT Partnership offers cutting edge Cognitive Behavioural Therapy training to NHS Clinical Practitioners, providing on site or online e-learning events and seminars. Supported by a rich online portal of professionally and community generated content.

What is Insight?
The background behind our cutting edge CBT research and training.

Why do I need it?
The background behind our cutting edge CBT research and training.

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Register your interest and receive FREE limited access to our resource portal.

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During the year 2000: Insight finally focussed years of research into training six mental health nurses and the wider community of mental health teams and home carers in CBT for patients with severe nervous and schizophrenic breakdowns. Treating a total of 257 patients.

The results were perfectly clear: this new approach to the treatment of psychosis using Insight CBT has proven clinical benefits: Patients and carers alike responded positively to the methodology and subsequent bed days for the severely mentally ill were dramatically reduced.

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Take advantage of our multi-user licence pack. Provide your staff with FULL access to our portal.
£395 per year
Mental Health & Learning Disability Care Pathway

(prototype)

Mental Health & Learning Disability Care Pathway

Self-help & Caring

Primary care

Other agencies

Psychological Therapy Services (IAPT)

Mental health alcohol & drug services

General hospital services

Care pathways

Service Pathways

Hants Oxon Berks

Exit from services

Coping with daily living problems

Coping with daily living problems

Mental Health Research Network

Commissioning for Mental Health

NHS South Central

time to change

let’s end mental health discrimination
Conclusions

- CBT techniques continue to evolve in the treatment of psychosis
- Aims of CBT
  - reduce the distress and disability caused by persistent symptoms
  - improve medication adherence
  - empower & enhance recovery
- Further dissemination requires increased availability of training and availability of care pathways