The Rubber Meets the Road

Implementing CBT for Psychosis at Riverview Psychiatric Center

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Disclosure

- No Microsoft products were voluntarily used in preparation of this presentation
- When ever possible open source programs were used in the preparation of this presentation
- No pixels were harmed during the production of The Rubber Meets The Road
- To protect confidentiality some details have been changed
- The author is solely responsible for the content

Why Add CBT?

- Psychopharmacology has limits
  - Relapse rates remain high even in fully med compliant cases
  - An estimated 40%-60% of patients continue to have positive symptoms when fully med compliant
  - Current treatment including pharmacological ones have small impact on negative symptoms, residual cognitive impairment & social functioning

What is Being Done Today

- We have developed some cognitive therapy groups which have encouraged discussion of psychotic symptoms
- We have developed specific groups intended to provide cognitive therapy with a focus on psychotic symptoms
- We have offered some individual cognitive therapy to selected patients with psychotic symptoms

A Few Moments in Time

- In the next few slides I will describe a few moments from group and individual therapy sessions that reflect applying cognitive behavioral therapy.
- We are not in a position to collect data that would measure the impact but the clinical experience is powerful

Introduction to the Group

This group will focus on helping people understand psychosis. Many clients at Riverview are told they have psychosis or are given a diagnosis like schizophrenia or schizoaffective disorder. They may experience hearing voices, have confusing experiences and be told they have delusional beliefs. The group will provide a safe place for participants to share and find meaning in their experiences. It will focus on understanding how these experiences may develop and how to manage them.

Patient A

- Reported the following experience in group
- Waking up in cold sweat
- Tasted alcohol despite not drinking in months
- Saw devil
- Believing she would die (80%)
- Believing she would be possessed by the devil if she could not engage in ordinary activity (100%)
- Experienced terror (SUDS 100)

Patient B

- Had not spoken in group previously, after hearing A's story reported he had seen the devil and believed he was possessed by a demon (100%)
- Reported he had not eaten or drank anything for 3 days because if he was uncomfortable the demon would be as well and would leave his body (100%)
- Reported terror (SUDS 100)

Patient C

- Reported experience of waking and hearing his cousin's voice from outside house
- Got up and looked but didn't see anyone
- Thought someone might be playing a trick on him or that his mind was not working right (going crazy) (60-70%)
- Experienced anxiety (SUDS 70)

Communicating with TV

- Four members of the group discussed their experiences involving communicating with the TV.
- Using the ABC format we looked at their beliefs about this experience and emotional reactions.
- Clients were able to talk about 'crazy' experiences and put them in perspective.

Patient D

- Seen in individual therapy
- Presented with paranoid ideation
- Discussed an event where when walking down the sidewalk someone coming the other way had spit on the ground but had later held a door open for the patient
- This event was used to develop alternatives about what others intentions might be and understand the effect of jumping to conclusions

Little Changes

- In each of the cases the individuals were able to talk about the distressing experiences and consider some alternative explanations
- Informally they reported or appeared less distressed by recalling these experiences and seemed to value the opportunity to talk about them

Group Development

- Began offering CBT for anxiety and distress
- Introduced discussion of “psychotic” experiences in anxiety group
- Introduced group focused on understanding psychosis
- Encourage open discussion of “psychotic” symptoms

Model for Group Developed From:

Bentall, R. (2003). *Madness explained: Psychosis and human nature.* New York: Penguin Books.

Nelson, H. (2005). *Cognitive-behavioral therapy with delusions and hallucinations: A practice manual.* Cheltenham UK: NelsonThornes Ltd.

Morrison, AP., Renton JC., French, P., & Bentall, RP. (2008) *Think your crazy? Think again.* New York: Routledge.

Lecomte, T., Leclerc, C. & Wykes, T. (2001).*CBT cognitive behavioral therapy: Clinician's supplement.*

Lecomte, T., Leclerc, C. & Wykes, T. (2001).*CBT cognitive behavioral therapy: Participant's workbook.*

For more sources on CBT and psychosis see

- http://docs.google.com/Doc?id=dcvqtmbr_0d7qw5txr&hl=en

Engagement

- The goal of this phase is to join the patient in working on understanding their experiences, and on reducing distress and dysfunction associated with them

Normalization

- Normalization is an effort to put symptoms into an understandable context and to understand that symptoms represent a point on a continuum that includes normal experiences
- Patient A reported that following the event described she attended an alcohol treatment program where she was told it was normal to have dreams about drinking. This served to normalize her experience and make it not threatening

What We See

- Group attendance at CBT groups is high and consistent
- Spontaneous comments from patients indicate that they find the groups helpful
- Patients who have been silent begin talking about their frightening and distressing experiences such as hallucinations and distressing beliefs we would label delusions

The ABCs of Psychosis

- Using the ABC model originally developed by A. Ellis as a way to explain a cognitive model
- A is the Antecedent or Activating Event
- B is the Belief or Automatic Thoughts about A
- C is the Consequence or Emotional and Behavioral Reaction to A mediated by B

Basic Assumptions

- 'What disturbs men's minds is not events but their judgments on events' Epictetus
- At any given time everyone is doing the best they can with the information and resources they have
- We are continuously trying to explain our experiences
- Psychotic experiences are on a continuum with normal experiences

A Cognitive Model of Psychosis

- We present a stress diathesis model
- This integrates the idea that we each bring predispositions to develop certain types of responses and that stressful life events precipitate development of specific symptoms
- This development and often the specific symptoms can be understood, re-conceptualized, made manageable and less distressing

A Representative Study

- Drury, V., Birchwood, M., Cochrane, R,, & MacMillian, F. (1996). Cognitive therapy and recovery from acute psychosis: a controlled trial I. Impact on psychotic symptoms. *British Journal of psychiatry, 169, 593-601.*
- Drury, V., Birchwood, M., Cochrane, R,, & MacMillian, F. (1996). *Cognitive therapy and recovery from acute psychosis: a controlled trial II Impact on recovery time. British Journal of psychiatry, 169, 602-607.*
- Methodology Cognitive therapy vs control group receiving matched hours of recreation therapy
  - Subjects inpatients at urban psychiatric hospital, with current psychosis, stratified sampling on variable such as age of onset, random assignment to treatment or control group
  - Symptoms rated weekly with Psychiatric Assessment Scale and self-report measure of delusions, present state exam, and other questionnaires
  - Treatment as adjunct to routine hospital care
  - Final sample 20 per group, all received antipsychotic medication, prescriber blind to treatment group

Results

- Both groups showed reduction in positive sx in 12 wks following admission, significantly greater and faster change for CT group
- Significant reduction in conviction and preoccupation with delusions with significantly greater drop in conviction in CT group
- Significant reduction in disorganization in both groups
- Significant reduction in negative symptoms in both groups

Nine Month Follow-up

- CT group significantly fewer positive sx
- 95% of CT group, 44% control group reported no or minor hallucinations or delusions
- Similar outcome on more detailed measures of delusional conviction and preoccupation
- No differences on disorganization

Impact on Recovery Time

- Using 3 different definitions of recovery CT showed between 25-50% reduced recovery time
- Failure to recover at 6 months 0.4 for CT group, 0.75 for control group
- Time to discharge approximately 50% shorter for CT group
- Dysphoria, insight and subclinical psychotic thinking all responded to CT

5 Year Followup

- Drury, V., Birchwood, M., & Cochrane, R. (2000). Cognitive therapy and recovery from acute psychosis: A controlled trial. *British Journal of Psychiatry,* 177, 8-14.
- "Perhaps the most interesting finding of this follow-up study was that, as predicted, cognitive-behavioral therapy led to significant and enduring clinical benefits, provided that the experience of relapse could be avoided or minimized. Both the observer-rated and self-rated delusional beliefs were significantly lower in the CT group than in the ATY group, in those individuals who had suffered no relapses or only one. If we assume that the risk factors for relapse (e.g. environmental factors such as life events) are random occurrences that impinge on both groups with the same probability, it appears that the CT group was never the less protected against the return of persistent psychotic symptoms to a greater degree than the ATY group, providing they had no more than one relapse."

What This Tells Us

- The intervention in these studies amounted to an average of about 10 hours of treatment. The effects while possibly considered modest appear to have lasted for years
- There is reason to believe that more CBT and/or continuing treatment would have greater effect
- The control was essentially recreation therapy, suggesting a modification of what is offered may have substantial impact on outcome

Cost Effectiveness

- There is now substantial evidence that CBT is a cost effective treatment approach for a range of disorders including anxiety disorders, and major depression
- There is some evidence that CBT for psychosis is cost effective and may significantly reduce length of stay, readmission rates, improve medication compliance, and improve global function

Meta-analysis of CBT and Psychosis

- Grech, E. (2002). A review of the current evidence for the use of psychological interventions in psychosis. *The International Journal of Psychosocial Rehabilitation, 6, 78-88.*
- Lawrence, R., Bradshaw, T., & Mairs, H. *(2006). Group cognitive behavioural therapy for schizophrenia: A systematic review of the literature. Journal of Psychiatric and Mental Health Nursing, 13, 673-681.*
- Pfammatter, M., Junghan, U. M., & Brenner, H. D., *(2006). Efficacy of psychological therapy in schizophrenia: Conclusions from meta-analyses. Schizophrenia Bulletin, 32, S1, s64-s80.*
- Rector, N. A., & Beck A. T. *(2001). Cognitive behavioral therapy for schizophrenia: An empirical review.The Journal of Nervous and Mental Disease, 189, 278-287.*
- Tarrier, N. *(2005). Cognitive behaviour therapy for schizophrenia – A review of development, evidence and implementation. Psychotherapy and Psychosomatics, 74, 136-144.*
- Turkington, D., & Dudley R. *(2004). Cognitive behavioral therapy in the treatment of schizophrenia. Expert Review of Neurotherapeutics , 4, 861-868.*
- Trukington, D., Kingdon, D., & Weiden, P.J. *(2006). Cognitive behavior therapy for schizophrenia. American Journal of Psychiatry, 163, 365-373.*
- Wykes, T., Steel, C., Everitt, B & Tarrier, N. *(2007). Cognitive behavioral therapy for schizophrenia: Effecct sizes, clinical models and methodological rigor. Schizophrenia Bulletin, 34, 523-537.*

A Summary of the Findings from a Typical Meta-analysis

- A meta-analysis including 17 RCTs found consistent significant benefits
- Compared with control treatment CBT leads to substantial decline in psychopathology and attains a stable decrease in positive symptoms

What CBT Offers

- On the average studies comparing combined psychopharmacological & psychological treatment to pharmacological alone find an effect size of 0.39 favoring combined treatment
- This indicates that the average patient getting combined treatment does better than 65% of those getting pharmacological treatment alone

Who Can Offer CBT?

- At this point in the US there are relatively few people trained in or familiar with CBT for psychosis
- Experience and research in the UK has shown that this treatment can be effectively delivered in a variety of settings ranging inpatient to community by a range of people including nurses and community workers

Minimally Trained Therapists

- Lecomte et al (2008) compared social skills training with CBT
- Therapists had 2 day intensive training in CBT for psychosis
- Treatment in groups following a manual
- CBT had significant and clinically important effects on positive, negative, overall symptoms, self-esteem, etc. and lower drop out that social skills group

Is it Soup Yet

- In the UK the official policy is that CBT should be made available to all people treated for schizophrenia by the NHS
- Is there a reason not to initiate broad training and implementation of CBT for psychosis at Riverview?
- CBT can be integrated into treatment planing and unit milieu design