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Cognitive behaviour therapy for psychosis can be adapted for minority ethnic groups: A randomised controlled trial☆

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ABSTRACT

Cognitive behavioural therapy (CBT) is recommended in treatment guidelines for psychotic symptoms (NICE, 2009) but clients from some minority groups have been shown to have higher dropout rates and poorer outcomes. A recent qualitative study in ethnic minority groups concluded that CBT would be acceptable and may be more effective if it was culturally adapted to meet their needs (Rathod et al., 2010).

Aim: This study assessed the effectiveness of a culturally adapted CBT for psychosis (CaCBTp) in Black British, African Caribbean/Black African and South Asian Muslim participants.

Method: A randomised controlled trial was conducted in two centres in the UK (n = 35) in participants with a diagnosis of a disorder from the schizophrenia group. Assessments were conducted at three time points: baseline, post-therapy and at 6 months follow-up, using the Comprehensive Psychopathological Rating Scale (CPRS) and Insight Scale. Outcomes on specific subscales of CPRS were also evaluated. Participants in the treatment arm completed the Patient Experience Questionnaire (PEQ) to measure satisfaction with therapy. Assessors blind to randomisation and treatment allocation conducted administration of outcome measures. In total, n = 33 participants were randomly allocated to CaCBTp arm (n = 16) and treatment as usual (TAU) arm (n = 17) after (n = 2) participants were excluded. CaCBTp participants were offered 16 sessions of CaCBTp with trained therapists and the TAU arm continued with their standard treatment.

Results: Analysis was based on the principles of intention to treat (ITT). This was further supplemented with secondary sensitivity analyses. Post-treatment, the intervention group showed statistically significant reductions in symptomatology on overall CPRS scores, CaCBTp Mean (SD) = 16.23 (10.77), TAU = 18.60 (14.84); p = 0.047, with a difference in change of 11.31 (95% CI:0. 14 to 22.49); Schizophrenia change: CaCBTp = 3.46 (3.37); TAU = 4.78 (5.33) diff 4.62 (95% CI: 0.68 to 9.17); p = 0.047 and positive symptoms (delusions; p = 0.035, and hallucinations; p = 0.056). At 6 months follow-up, MADRAS change = 5.6 (95% CI: 2.92 to 7.60); p < 0.001. Adjustment was made for age, gender and antipsychotic medication. Overall satisfaction was significantly correlated with the number of sessions attended (r = 0.563; p = 0.003).

Conclusion: Participants in the CaCBTp group achieved statistically significant results post-treatment compared to those in the TAU group with some gains maintained at follow-up. High levels of satisfaction with the CaCBTp were reported.

1. Introduction

Cultural influences are reported in the clinical manifestation, prevalence, treatment access and outcomes for individuals with schizophrenia. Cantor-Graae and Selten (2005) meta-analysis of 18 studies demonstrated a significantly increased risk of schizophrenia in migrant groups from developing countries with variation of risk by both host countries and countries of origin.

Cognitive Behavioural Therapy (CBT) for schizophrenia is an evidence-based adjunct to medication and recommended internationally (Dixon et al., 2009; NICE, 2009). However, clients from some black and minority ethnic (BME) groups e.g. the African Caribbean and Black African groups have shown higher dropout rates and poorer outcomes compared with the White group (Rathod et al., 2005). Cultural adaptation and understanding of ethnic, cultural and religious interpretations remains an underdeveloped area (Rathod et al., 2008).

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Griner and Smith (2006) have shown an effect size of 0.45 for culturally adapted evidence based interventions in comparison to traditional treatments (Wykes et al., 2008) whilst the meta-analysis by Huey and Polo (2008) was inconclusive. Evidence from small pilot studies suggests that locally adapted CBT with minority populations has been successful (Carter et al., 2003; Kubany et al., 2003; Hinton et al., 2004, 2005; Patel et al., 2007; Rojas et al., 2007; Rahman et al., 2008). Rathod et al. (2010) following a recent qualitative study reported that in principle, culturally adapted CBT for psychosis would be acceptable to BME clients. The recommendations from this study were incorporated into a CBT manual (Kingdon and Turkington, 2005) using Tseng et al.'s (2005) framework of cultural adaptations of psychological therapies. The authors considered several adaption models (including Bernal et al., 1995; Domenech Rodriguez and Weiling, 2004; Barrera and Castro, 2006; Hays & Iwamasa, 2006; Hwang, 2006; Leong and Lee, 2006) and agreed that Tseng's framework would allow fidelity to the core principles of CBT with adequate flexibility for adapting the therapy to cultural beliefs, thereby preserving validity to the original treatment. The authors acknowledged that in practice, even if desirable, it may not be feasible to develop a different CBT for every cultural group and subgroup within them as every cultural group and subgroup had their own uniqueness and could not be considered as one.

2. Aims

This study aimed to:

a) Assess the feasibility of the culturally adapted CBT for psychosis (CaCBTp) with specified BME groups.
b) Further modify CaCBTp in accordance with emerging findings.

3. Methodology

3.1. Study design

This was a single blind multi-site randomised trial of CaCBTp for ethnic minority participants compared to treatment as usual (TAU) with a 6 month follow-up period after completion of intervention.

3.1.1. Study centres

The study was conducted at two sites in the UK—Hampshire (Southampton/Portsmouth) and London (Central and North West London).

3.2. Participants

3.2.1. Inclusion criteria

Participants were eligible if they were:

1. Between ages 18 and 65 with a diagnosis of schizophrenia, schizoaffective disorder or delusional disorders using ICD-10 Research Criteria.
2. From the following groups:

   - Black British, Black Caribbean or African Caribbean (all three terms usually refer to people of Caribbean origin with Caribbean origin parents and heritage, even if they are born in the UK themselves).
   - South Asian Muslim (Pakistani and Bangladeshi—refer to people of Muslim religion who either have their origins in South Asia or their parents and heritage are).

The rationale for choosing the specified ethnic groups has been discussed in a publication of the previous study (Rathod et al., 2010).

3. Willing to participate in the interview and/or be tape recorded.
4. Had mental capacity to consent and participate.
5. Able to speak English or were willing to participate with interpreters.

3.2.2. Exclusion criteria

1. Severe illness which would affect ability to participate in assessments or therapy e.g. very thought disordered or distressed by symptoms.
2. Lacked mental capacity or denied consent.
3. The treating clinical team thought was inappropriate. For e.g. if they were due to receive CBT through their services as standard treatment and being in the trial could mean they may be randomised to TAU arm.

3.2.3. Recruitment of participants

Power calculations used previous pilot studies (e.g. Turkington and Kingdon, 2000). This study aimed to recruit forty participants to ensure that after the expected loss to follow-up, there would be at least 12 participants per group for analysis to be able to make reasonable estimates of the treatment effects (FDA guidance http://www.fda.gov/cder/guidance/5356fnl.pdf). Recruitment was conducted from May 2009 to December 2010 through Community Mental Health Teams (CMHTs), specialist services including Early Intervention in Psychosis (EIP) teams, Assertive Outreach Teams (AOT), Rehabilitation and Inpatient services. Permission to approach suitable potential participants was obtained from consultant psychiatrists and clinical teams. Participant information sheets were given by the consultant and/or care co-ordinators who explained the study in detail.

3.3. Ethical considerations

Ethics approval was obtained from Southampton Committee (B); REC: 08/0504/5—Trial number: ISRCTN95603741. Research and Governance approval was granted at all sites. Confidentiality was protected by anonymisation of data, and only where written informed consent was unambiguously given, participants were enrolled in the trial. Data was collected in an overtly non-coercive manner. The research team included registered practitioners who were CRB (Criminal Records Bureau) approved.

Written informed consent was obtained following assessment of mental capacity to consent specifically to the research study. This was a requirement by the Ethics committee. Assessment of capacity was based on the five core principles of the Mental Capacity Act (2005) Section 3 (Department of Constitutional Affairs, 2007). Capacity to consent was specific to the research study.

The Consultant and/or Care co-ordinator was encouraged to take necessary steps to help patients make decisions. These steps included recognising language and cultural differences, giving right amount of detail, pacing the information, checking for understanding and repeating if necessary and/or involving an advocate. The consultant or care co-ordinator recorded a summary of the capacity assessment in the participant's clinical notes.

3.4. Randomisation

Once written informed consent was obtained, baseline assessments were conducted by assessors blind to allocation followed by randomisation conducted at a remote location by an independent administrator who was contacted by the researcher from the specific site. Block randomisation with randomly permuted block size was used to ensure similar numbers of participants were allocated to each arm of the trial (Altman and Bland, 1999). Randomisation was stratified by centre and ethnic group.

3.5. Intervention and treatment as usual

The intervention group was offered 16 sessions of CaCBTp over a period of 16 to 20 weeks by trained CaCBTp therapists (PP, LW, AS). Each session varied in duration from 40 min to 1.5 h and settings varied based on participant preferences in line with recommendations from