

A Pilot Study of Cognitive Behavior Therapy for Depression in Early Psychosis

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Depression is a significant problem in early psychosis, yet there are few effective treatments available. The purpose of this open clinical trial was to examine the feasibility of cognitive behavioral therapy for depression in a sample of 10 depressed patients with early psychosis. Patients received between 16 and 22 sessions of cognitive therapy delivered by a certified cognitive therapist. They completed baseline and posttreatment assessments on clinical rating scales and self-report questionnaires. Group results suggest that participants demonstrated significant reductions in depression, negative symptoms, and general psychopathology. They also reported less hopelessness, beliefs about loss, dysfunctional attitudes, and increased self-esteem. Clinical case descriptions are also discussed. Results demonstrate that CBT may be a feasible treatment for depression in psychotic disorders, but more rigorous research is needed. Clinical and research implications are discussed.

Depression is a significant problem in early psychosis, as up to 50% of patients with acute schizophrenia experience depressive symptoms (Birchwood, Iqbal, Chadwick, & Trower, 2000; Ram, Jandorf, Dixon, & Bromet, 1995). The prevalence of postpsychotic depression ranges from 22% to 75%, depending on the criteria used and the chronicity of the sample (Birchwood, Iqbal, & Upthegrove, 2005). Comorbid depression in psychosis is a poor prognostic indicator of recovery and reintegration into the community (Conley, Ascher-Svanum, Zhu, Faries, & Kinon, 2007), and is associated with psychiatric hospitalization, psychotic relapse, worsening quality of life, and increased risk for suicide (Conley et al., 2007). Depression is also both a precursor and concomitant feature of hopelessness and suicidal thinking in schizophrenia (Nordentoft et al., 2002; Siris et al., 2001). Suicide is especially problematic in young or early psychotic patients (Palmer, Pankratz, & Bostwick, 2005), and the risk of suicide in schizophrenia is between 4% and 13%, depending on the methodology employed (Pompili et al., 2007). Given the high rate of depression in psychosis, and the burden of this comorbid disorder, there is a need for

treatment that focuses on reducing depression and its related symptoms in this population.

Preliminary evidence suggests that first-episode patients are likely to develop depression following a psychotic episode (Addington, Addington, & Patten, 1998; Iqbal, Birchwood, Chadwick, & Trower, 2000). One hypothesis is that the preponderance of postpsychotic depression in first-episode patients is related to the appraisals they make about their psychosis (Iqbal et al., 2000). For example, in a sample of patients with psychosis, Iqbal et al. found that those who eventually developed postpsychotic depression perceived a greater loss of autonomy and valued social role, greater humiliation, and entrapment as a result of their disorder, and they were more likely to blame themselves for their psychosis. Furthermore, these appraisals were more negative in the group that developed depression, both before and after the development of depression, as compared to those who did not develop depression during the 1-year follow-up period. In addition, during postpsychotic depression, patients reported greater insight into their illness and lower self-esteem when compared to patients who did not develop depression (Iqbal et al.). These findings suggest a cognitive vulnerability contributes to the onset of depression in early psychosis, and that psychological treatments for depression in this population are needed.

Attempts to account for the onset of depression in psychosis (cf. Birchwood et al., 2000) include the social rank theory (Birchwood et al., 2005). This theory proposes a possible pathway from the cognitive appraisals in early psychosis to depression. Birchwood et al. (2000)

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view psychosis as a major life event, which results in limitations in interpersonal and achievement domains and leads to loss of valued roles and/or goals. According to Birchwood et al. (2005), individuals lose their sense of identity and perceive themselves to be of “lower” social rank. Falling short of desired goals also results in perceptions of humiliation, entrapment, loss, and self-blame, which is hypothesized to lead to depression. For example, a patient who had always excelled academically may find that he is unable to perform at the same capacity that he had prior to an episode of psychosis. His goal to complete law school may be lost, leading to the perception that he no longer has the ability to have a successful career. This perception of loss may lead to feelings of humiliation as a result of psychosis, in addition to feelings of being trapped by his psychotic disorder (entrapment), which may lead to depression.

Cognitive behavioral therapy (CBT) is the recommended psychological treatment for early psychosis (Addington et al., 2005), and there is an emerging body of research to support its effectiveness (Kingdon & Turkington, 2005). In a review of the literature on CBT for schizophrenia, the mean effect sizes for positive and negative symptoms were .37 ($n = 32$) and .44 ($n = 23$), respectively (Wykes, Steel, Everitt, & Tarrier, 2008). Of the 34 studies examined, 15 studies provided mood outcomes (mean effect size .36, $p < 0.05$) and four studies provided outcomes for hopelessness (mean effect size $-.19$, $p = ns$). These results suggest that mood may improve even when it is not the target problem, but that CBT approaches may not improve other outcomes and may even increase distress (i.e., hopelessness). Although studies have shown some optimism with regard to CBT’s effectiveness for psychotic symptoms, there is a need for treatments aimed at reducing emotional dysfunction (Birchwood & Trower, 2006).

Although there are some promising findings regarding depression and CBT for psychosis, no study has examined depression as the primary treatment and outcome target of CBT; thus, they have not directly assessed whether CBT is an effective intervention for depression in psychosis. We acknowledge that there is much overlap between CBT for negative symptoms and CBT for depressive symptoms (e.g., behavioral activation, problem-solving training; for an example, see Klingberg et al., 2011). Thus, we are not proposing an entirely novel treatment, but a first evaluation of CBT for depression in early psychosis. Furthermore, due to the potential role of cognitive appraisals in depression in early psychosis, the effectiveness of cognitive interventions that modify dysfunctional beliefs about the self and negative appraisals about psychosis deserves investigation.

The aim of the present study was to develop and test a cognitive therapy (CT) protocol for treating comorbid

depression in early psychosis, based on an adaption of cognitive therapy for depression (Beck, Rush, Shaw, & Emery, 1979) for the needs of an early psychosis population. The goals of this study were as follows: (a) to develop a guide to conduct CBT in early psychosis patients with depression; (b) to evaluate the major clinical outcomes in the treatment of depression; and (c) to examine the feasibility of CBT (i.e., attrition rate and patient satisfaction with the treatment).

Method

Participants

Depressed patients were recruited from the Early Psychosis Treatment Service (EPTS), a multidisciplinary treatment service in Calgary, Alberta, that treats first-episode patients for 3 years following a first episode of psychosis. The inclusion criteria were: (a) outpatients age 18 or over who have completed at least 3 months but less than 2 years of treatment in EPTS (this criterion was chosen because depression can develop slowly after the onset of a psychotic disorder and because the program itself was 3 years long and thus we did not want attrition due to program termination); (b) a DSM-IV diagnosis of psychotic disorder based on the Structured Clinical Interview for DSM-IV (SCID) during the EPTS clinic intake assessment; (c) a score of 6 or greater on the Calgary Depression Scale for Schizophrenia (CDSS; Addington, Addington, & Maticka-Tyndale, 1993), indicative of depression in patients with psychosis; and (d) treatment with antipsychotic medication for at least 3 months, as medication is typically stabilized by this time. The exclusion criteria were: (a) inability to communicate (due to cognitive or language barriers); (b) currently meets the DSM-IV-TR criteria for substance abuse or dependence; (c) presently taking part in another trial (to avoid burden); and (d) currently receiving any other psychosocial treatment (e.g., group or family therapy).

Ten patients (7 males, 3 females) met the eligibility criteria and were enrolled in the study. Diagnoses included schizophrenia (2), schizophreniform disorder (2), schizoaffective disorder (1), brief psychotic episode (1), delusional disorder (2), and psychosis NOS (2). Participants were either Caucasian (7) or East Asian (3) and ranged in age from 19 to 57 years old. Their years of education varied from 10 to 18 years. The duration of the current depressive episode ranged from 4 to 182 weeks. The SCID (First, Spitzer, Williams, & Gibbon, 1997) was completed by the attending psychiatrist at intake into EPTS and used to establish diagnoses. Four patients met the criteria for major depressive disorder in addition to their psychosis diagnosis. All participants were taking atypical antipsychotic medication, and half were taking antidepressant medication. Participants were reimbursed \$10 for each session that they completed in the study.

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