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Low intensity cognitive behavioural therapy for psychosis: A pilot study

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ABSTRACT

Background and objectives: The dissemination and delivery of psychological therapies for people with psychosis has been limited by workforce and organisational factors. 'Low Intensity' (LI) delivery, whereby staff are trained to deliver brief, focused, manualised interventions, may be one way of improving access. In this study, we piloted a new LI intervention specifically for people with psychosis, aimed at helping people to reach a personal recovery goal, whilst targeting anxious avoidance or depression-related inactivity. Frontline mental health workers were trained to deliver the intervention. We report here on the impact of the intervention on therapeutic outcomes.

Methods: Twelve people with psychosis and either anxious avoidance or low mood, who wanted to work towards a personal goal, completed the intervention and a battery of assessments of mood, functioning and psychotic symptoms.

Results: Eleven out of the twelve participants achieved their personal goals. The results of a series of Friedman K related sample tests revealed significant improvements in depression, clinical distress, activity levels, negative symptoms and delusions across the three time points, and no change in hallucinations, or anxious avoidance. Staff and participant satisfaction was high.

Limitations: The study is a small uncontrolled pilot study. Outcomes should therefore be interpreted with caution, pending replication.

Conclusions: The new LI intervention shows preliminary evidence of effectiveness and is a feasible model of therapy delivery for people with psychosis. The results suggest that frontline mental health workers can be trained relatively easily to deliver the intervention. A larger, randomised controlled trial is warranted to determine the effectiveness of the intervention and training programme.

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1. Introduction

It is estimated that over half a million people in the UK alone suffer from psychosis. For many, recovery is impeded by high levels of distress, often resulting from persisting psychotic symptoms, stigma and social exclusion (Garety, Kuipers, Fowler, Freeman, & Bebbington, 2001; Slade, 2009a). UK and international clinical guidelines recommend that patients with schizophrenia are offered cognitive behavioural therapy for psychosis (CBTp) as part of routine clinical practice (National Institute for Health and Clinical Excellence (NICE) 2002; Update 2009; US Schizophrenia Patient Outcomes Research Team (PORT), Kreyenbuhl, Buchanan, Dickerson, & Dixon, 2010). There is evidence that CBTp reduces

symptom severity, reduces the number and duration of hospital admissions, improves social functioning, and is cost-effective (NICE, Update 2009). However, despite its efficacy, people with schizophrenia and other psychoses still have 'poor access' to talking therapies (Berry & Haddock, 2008; Kuipers, 2011; Rethink, 2010; Tarrier, Barrowclough, Haddock, & McGovern, 1999). Identified barriers to implementation include lack of staff time to consider appropriate referrals, 'pessimistic views of recovery of psychosis' and a lack of skilled therapists able to work therapeutically with clients with psychoses (Pilling & Price, 2006; Prytys, Garety, Jolley, Onwumere, & Craig, 2011). Fig. 1

CBTp is a particularly complex therapy and requires advanced and specific engagement, assessment and intervention skills (Dunn et al., 2011; Fowler, Garety, & Kuipers, 1995; Rollinson et al., 2007; 2008). Training to competence requires close supervision and can be lengthy and expensive: routine mental health services are not

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CONSORT Flow Diagram

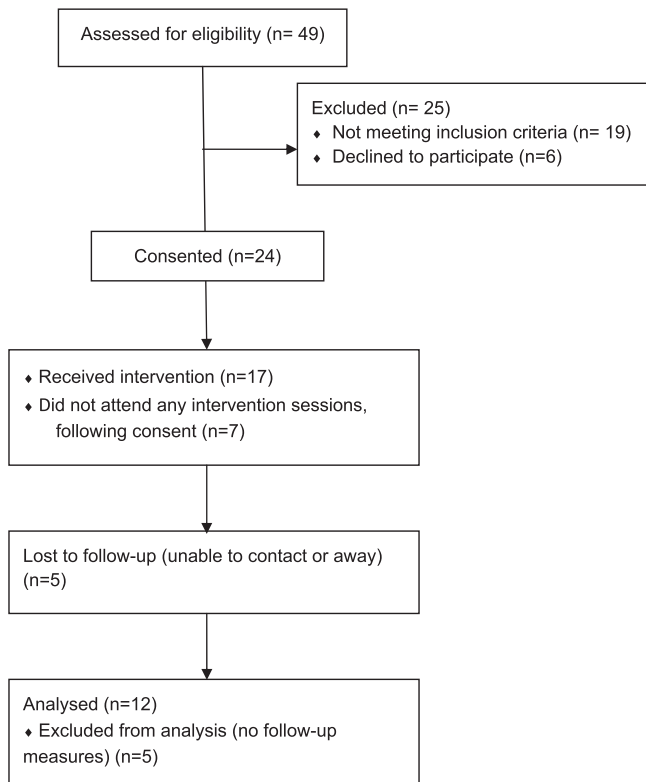


Fig. 1. CONSORT flow diagram.

resourced to sustain delivery of CBTp at the level required by the NICE guidance (Prytys et al., 2011; Rakovshik & McManus, 2010; Shafran et al., 2009). Attempts to meet demand by disseminating CBTp skills across the frontline mental health workforce have met with limited success, tending to change attitudes rather than practice (Brooker & Brabban, 2004). We therefore need to develop new ways of increasing access to effective psychological therapies for this client group.

1.1. 'Low Intensity' CBT for psychosis?

It is well documented that there is an increased prevalence of both anxiety and depression in people with a diagnosis of psychosis, across all stages of the illness, in comparison with the general population (see Achim et al., 2011; Buckley, Miller, Lehrer, & Castle, 2009; for reviews). Anxiety and depression are closely linked with psychotic symptoms, and may play a causal role in the onset and maintenance of psychosis, as well as arising in reaction to an episode (Birchwood, Iqbal, & Uptegrove, 2005; Birchwood, Trower, Brunet, Iqbal, & Jackson, 2007; Fowler, Hodgskins, et al., 2011; Fowler, Rollinson, & French, 2011; Freeman & Garety, 2003). Persisting affective disturbance impedes subjective and functional recovery, and increases the rate of relapse and of suicide (Funahasi et al., 2000; Hawton, Sutton, Haw, Sinclair, & Deeks, 2005; Huppert, Weiss, Lim, Pratt, & Smith, 2001; Johnson, 1988; Pokos & Castle, 2006). Reducing depression and anxiety for people with psychosis is therefore a primary goal of psychological interventions, and CBTp frequently includes work on, and achieves change in, affective disturbance (e.g. Fowler et al., 1995; Freeman, Bentall, & Garety, 2008; Garety et al., 2008; NICE, 2009; Peters et al., 2010). There is emerging evidence that brief interventions can achieve

positive change for people with psychosis by specifically targeting affect (Foster, Startup, Potts, & Freeman, 2010). Furthermore, by focussing on a specific target, attempts to disseminate interventions into the frontline mental health workforce can be more effective, even in psychosis services (Malik, Kingdon, Pelton, Mehta, & Turkington, 2009; Turkington, Kingdon, Turner, & Insight into Schizophrenia Research Group, 2002).

It is plausible, therefore that two of the mainstays of low intensity (LI) work for people with anxiety and depression, graded exposure and behavioural activation, would also be suitable for people with psychosis, and that their provision by frontline mental health staff would offer a solution to the problem of 'poor access'. The emerging evidence of the positive effects of training frontline workers to deliver these interventions, suggests that the pitfalls of previous training efforts in psychosis services, whereby training has not resulted in increased delivery or improved outcomes, could potentially be averted.

1.2. The present study

This study was designed to pilot an LI CBTp intervention and examine the feasibility of the delivery by frontline mental health professionals. The intervention targeted symptoms of co-morbid depression and anxiety, specifically inactivity and anxious avoidance, through behavioural activation and graded exposure respectively.

Behavioural activation (BA) reduces depression by helping clients to increase their levels of rewarding activity, in a structured way. It focuses on changing behaviours rather than explicitly identifying and challenging negative thoughts. In a meta-analysis of this approach, Mazzucchelli, Kane, and Rees (2009) identified 34 studies in participants with major depression. They found no significant differences between BA and full CBT in terms of effectiveness and concluded that it is a well-established treatment for depression. BA can be delivered effectively in a brief format (Lejuez, Hopko, Acierno, Daughters, & Pagoto, 2011) and by trained, 'non-specialists' (Ekers, Richards, McMillan, Bland, & Gilbody, 2011). A recent pilot study has also found positive preliminary results of BA for negative symptoms in clients with psychosis (Mairs, Lovell, Campbell, & Keeley, 2011).

Graded exposure (GE) targets anxious avoidance of a particular feared situation. Clients develop a hierarchy of increasingly feared situations, and approach each situation one step at a time with the support of the therapist. Clients are encouraged to work towards approaching situations which are likely to be rewarding in the long-term. In a meta-analysis of 33 studies, Wolitzky-Taylor, Horowitz, Powers, and Telch (2008) found good evidence for GE in reducing anxious avoidance, with the best results achieved following multiple sessions, using *in vivo* exposure. In a review of exposure-based treatments of agoraphobia, Mattick, Andrews, Hadzi-Pavlovic, and Christensen (1990) reported that therapies based on GE had the best effects for reducing avoidance, which was sustained after long follow-up periods. A single case study reported by Dudley, Dixon, and Turkington (2005) found the technique to be successful in reducing both avoidance of the feared situation and improving positive symptoms in a person with psychosis.

This study therefore had the following aims:

- To evaluate the therapeutic effects of a new intervention incorporating BA and GE in patients with psychosis, particularly in terms of goal attainment, anxious avoidance, depression, wellbeing, and activity levels;
- To derive estimated effect sizes to inform a future randomised controlled trial;
- To examine the feasibility of an 'LI' model of therapy delivery in local mental health service settings; and

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