



What is Recovery-Oriented Cognitive Therapy

- Fusion of Cognitive Therapy and Recovery
- "Helping the patient draw on his own problem-solving apparatus" (Beck, 1976)
- Extension of CBT for psychosis
- Privileging the negative symptoms



BMJ Open Negative symptoms in schizophrenia: a study in a large clinical sample of patients using a novel automated method

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ABSTRACT

Objectives: To identify negative symptoms in the clinical records of a large sample of patients with schizophrenia using natural language processing and assess their relationship with clinical outcomes.

Design: Observational study using an anonymised electronic health record case register.

Setting: South London and Maudsley NHS Trust (SLaM), a large provider of inpatient and community mental healthcare in the UK.

Participants: 7678 patients with schizophrenia receiving care during 2011.

Main outcome measures: Hospital admission, readmission and duration of admission.

Results: 10 different negative symptoms were ascertained with precision statistics above 0.80. 41% of patients had 2 or more negative symptoms. Negative symptoms were associated with younger age, male gender and single marital status, and with increased likelihood of hospital admission (0R 1.24, 95% Cl 1.10 to 1.39), longer duration of admission (β-coefficient 20.5 days, 7.6–33.5), and increased likelihood of readmission following discharge (0R 1.58, 1.28 to 1.95).

Conclusions: Negative symptoms were common and associated with adverse clinical outcomes, consistent with evidence that these symptoms account for much of the disability associated with schizophrenia. Natural language processing provides a means of conducting research in large representative samples of patients, using data recorded during routine clinical practice.

Strengths and limitations of this study

- This is the largest known study (over 7000 participants) to investigate the relationship of negative symptoms with clinical outcomes in people with schizophrenia. Our findings demonstrate that negative symptoms are present in a substantial number of people with schizophrenia and are associated with increased hospital admission, readmission and duration of inpatient stay.
- To our knowledge, this is the first published study to use an automated information extraction method to acquire data on negative symptoms from electronic health records. This approach permits rapid acquisition of negative symptom data which is representative of everyday clinical practice in secondary mental healthcare.
- Our findings are based on data recorded by clinicians delivering routine mental healthcare who were not specifically ascertaining negative symptoms. It is therefore possible that negative symptoms were not comprehensively documented in the electronic health records from which they were identified leading to an inaccurate estimate of their prevalence in the analysed sample.

psychosocial functioning³ and a reduced likelihood of remission.^{4–9} The aetiology and pathophysiology of negative symptoms are unknown, and there are no effective





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An examination of neurocognition and symptoms as predictors of post-hospital community tenure in treatment resistant schizophrenia



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ABSTRACT

Neurocognition and psychopathology are robust predictors of community functioning and relapse/re-hospitalization in schizophrenia. Existing studies are however limited because they have ignored the most chronic, treatment-resistant patients. Moreover, the prediction of functional outcomes has yet to be extended to the duration of community tenure, an indicator of the capacity of chronically-hospitalized patients to gain traction in the community. The current study examined neurocognition and symptom severity at discharge as potential predictors of community tenure in chronically-hospitalized treatment-resistant patients. The study recruited 90 people with treatment-resistant schizophrenia who received services on an inpatient unit. Participants completed measures of psychopathology and neurocognition prior to discharge. Following discharge, participants were tracked at current residences six months and one year post-discharge to assess community tenure. The percentage of individuals who continued to live in the community at 12-month follow-up was 51%. Severe negative symptoms but not neurocognitive impairment or positive symptoms was a significant predictor of shorter post-hospital community tenure. Of the negative symptoms domain, anhedonia-asociality proved to be the most relevant predictor of community tenure in the sample. The capacity to elicit goal-directed behaviors in response to an-



Negative Symptoms

Worry about Persecution

Increased Distressing Voices

Low Motivation Connection

Increased Stress

REDUCTION
IN NEW
DATA



Translation of Negative Symptoms

Negative Symptom	Underlying Problems
Avolition	Defeatist beliefs
	Conservation of Energy
Asociality	Asocial beliefs
Anhedonia	Negative expectancies
Alogia	Negative expectancies



Beliefs: Motivation

Conservation of Energy:

- I can't do it until I get the energy
- Response: Inactivity and lowered motivation



Beliefs: Motivation

Defeatist Performance Belief:

- Why try, it won't work out.
- A little mistake is as bad a catastrophe
- I'm broken
- Response: Under trying and lowered motivation



Beliefs: Connection

Social Disinterest Attitudes

- Time with others isn't worth the effort.
- Response: Avoid socializing and conclude it wouldn't have been worth the effort



Clinical Trial of Recovery-Oriented Cognitive Therapy

ORIGINAL ARTICLE

ONLINE FIRST

Randomized Trial to Evaluate the Efficacy of Cognitive Therapy for Low-Functioning Patients With Schizophrenia

Paul M. Grant, PhD; Gloria A. Huh, MSEd; Dimitri Perivoliotis, PhD; Neal M. Stolar, MD, PhD; Aaron T. Beck, MD

ARCH GEN PSYCHIATRY

PUBLISHED ONLINE OCTOBER 3, 2011

WWW.ARCHGENPSYCHIATRY.COM

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Summary of CT-R Clinical Trial

Compared to the ST patients, CT+ ST patients had:

- Better functioning (d = 0.56)
- Reduced avolition-apathy (d = -0.66)
- Reduced positive symptoms (d = -0.46)

(Grant et al., 2014, Archives of General Psychiatry)



Clinical Trial Follow-up

*Follow-up to Grant et al., 2012; N = 60

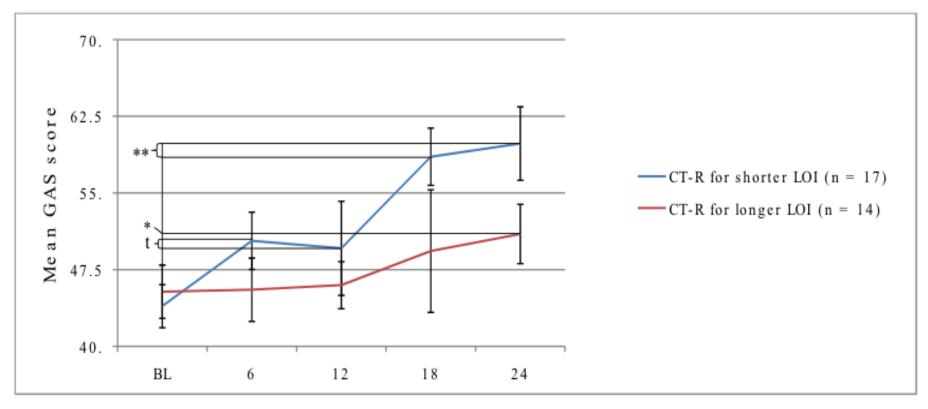
Gains maintained over the course of 6-month follow-up in which no therapy was delivered:

- Better Functioning (d = 0.53)
- Reduced Negative Symptoms (d = -0.60)
- Reduced Positive Symptoms (d = -1.36)

(Grant et al, 2017)



Clinical Trial Follow-up



NOTE: ^t p < .10, * p < .05, ** p < .01

(Grant et al, 2017)



Antipsychotic drugs versus cognitive behavioural therapy versus a combination of both in people with psychosis: a randomised controlled pilot and feasibility study



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Summary

Background Little evidence is available for head-to-head comparisons of psychosocial interventions and pharmacological interventions in psychosis. We aimed to establish whether a randomised controlled trial of cognitive behavioural therapy (CBT) versus antipsychotic drugs versus a combination of both would be feasible in people with psychosis.

Methods We did a single-site, single-blind pilot randomised controlled trial in people with psychosis who used services in National Health Service trusts across Greater Manchester, UK. Eligible participants were aged 16 years or older; met ICD-10 criteria for schizophrenia, schizoaffective disorder, or delusional disorder, or met the entry criteria for an early intervention for psychosis service; were in contact with mental health services, under the care of a consultant psychiatrist; scored at least 4 on delusions or hallucinations items, or at least 5 on suspiciousness, persecution, or grandiosity items on the Positive and Negative Syndrome Scale (PANSS); had capacity to consent; and were help-seeking. Participants were assigned (1:1:1) to antipsychotics, CBT, or antipsychotics plus CBT.

Lancet Psychiatry 2018; 5: 411–23

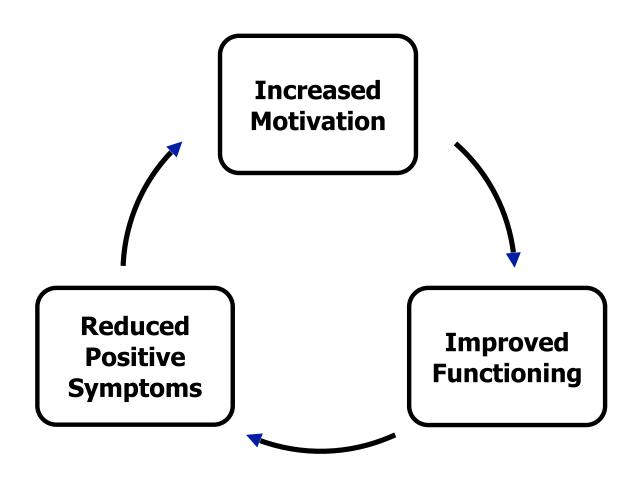
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See Comment page 381

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Cycle of Recovery





Adaptive vs. Patient Mode

Adaptive mode:

- Individual mode where symptoms and other obstacles are dramatically reduced or limited in presence

- Individual at his/her best
- Patient mode
 - High presence of deactivation or symptom impairment
 - Can be elicited by the practitioner.





CT-R: The overview

- Activation and the individual's aspirations are the core
- The individual sets the aspirations for recovery
 - Aspirations are broken down, steps are concrete
 - Obstacles to the aspirations are the therapy targets
 - Conceptualization is the key to the obstacles
 - Achieving the aspirations reinforces the curative beliefs
- For teams. The team is the therapist



CT-R: Overview

Activation Aspirations Action



CT-R: Engagement & Activation

- Systematically activate the adaptive mode.
 - Inoculates against symptoms
 - Increases access to cognitive resources
 - Focuses individual on alternative hypothesis
- Outcome: Eliciting of aspirations



CT-R: Aspirations

- Personal, Meaningful, Valued
 - Internal source of engagement when vividness is developed
 - Orients treatment
 - Rationale for treatment
 - Reason for action
 - Relapse prevention
- Outcome: Motivation for action, Ongoing engagement topic



CT-R: Action

- Plan and Evaluate increased activity
 - Action leads to
 - increased energy/motivation
 - decreased psychosis
 - steps towards aspirations
- Outcome: Schedule of action and learn lessons about benefits of activity



CT-R: Obstacles

- Addressed as they interfere with the protocol
 - Start with a generic formulation
 - Tailor with new information
 - Obstacles are addressed in the context of the aspiration
- Plan ahead for potential interference.
- Outcome: Obstacle is permanently neutralized



Beliefs about voices

Belief	Behavior
Control	Isolate
Credible	Listen for Message
Powerful	Comply or Neutralize
External	Stay Vigilant



CT-R: Experiential Learning

- Restructuring through action
 - Identify the exact cognition
 - Check the cognition
 - Correct to make helpful or accurate
 - Change behavior based on the new cognition
- Outcome: Restructure maladaptive beliefs and strengthen positive beliefs



CT-R: Protocol

Activation Aspirations Action



These slides are not to be used without the expressed written consent of Dr. Aaron P. Brinen



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