



Feasibility and effectiveness of the Integrated Psychological Therapy (IPT) in patients with schizophrenia: a preliminary investigation from India



A. Taksal^a, P.M. Sudhir^{b,*}, Keshav Kumar Janakiprasad^c, Deepashree Viswanath^d, Jagadisha Thirthalli^e

^a Assistant Professor, Centre for Human Ecology, Tata Institute of Social Sciences (TISS), Deonar Farm Road, Deonar, Mumbai, Maharashtra, India

^b Additional Professor, Department of Clinical Psychology, National Institute of Mental Health and Neurosciences, Bengaluru, Karnataka, India

^c Additional Professor, Department of Clinical Psychology, National Institute of Mental Health and Neurosciences, Bengaluru, Karnataka, India

^d Research Scholar, Department of Biostatistics, National Institute of Mental Health and Neurosciences, Bengaluru, Karnataka, India

^e Professor, Department of Psychiatry, National Institute of Mental Health and Neurosciences, Bengaluru, Karnataka, India

ARTICLE INFO

Article history:

Received 5 January 2015

Received in revised form 30 May 2015

Accepted 22 June 2015

Keywords:

Schizophrenia

Integrated Psychological Therapy

Neurocognition

Social skills

Social-functioning

ABSTRACT

Functional outcome is an important index of recovery in patients with Schizophrenia (SZ). Several factors impact social functioning, including neurocognition. The Integrated Psychological Therapy (IPT) has been effective in improving social-functioning in SZ patients, but needs to be evaluated for its feasibility and impact in the Indian subcontinent. The study examined the effectiveness of the IPT on neurocognition and social functioning in patients with SZ. An open label design with baseline, post-intervention and 3-month follow-up assessments was adopted. Twenty nine clinically stable out-patients with schizophrenia/schizo-affective disorder (DSM IV-TR) providing written informed consent were recruited, of whom 23 completed the intervention. Patients were assessed on tests of neurocognition, social functioning and symptomatology. Following baseline assessment, patients received 16–20, 1 h individual sessions of the IPT over 2.5–3 months. The structure and content of the IPT was modified to make it culturally appropriate for the Indian subcontinent. Therapy comprised of psycho education and the first four modules of the IPT. Repeated measures analysis of variance (RMANOVA) for the completers sample ($N = 23$) indicated significant improvement in social-functioning, symptom severity and certain domains of neurocognition following the intervention. Large effect sizes of 1.21 and 1.01 were obtained for scores on Social and Occupational Functioning Scale (SOFs) and Groningen Social Disabilities Schedule (GSDS) respectively at 3-month follow-up. The IPT was effective in improving social-functioning and neurocognition in Indian patients with SZ. The study demonstrated the durability of these improvements.

© 2015 Elsevier B.V. All rights reserved.

1. Introduction

Schizophrenia (SZ) is a chronic, debilitating condition. Functional outcome is an important index of recovery, essential for reducing burden related to disability adjusted life years (DALYs) (WHO, 2001). Associations between neurocognition and social functioning in SZ have been established (Brenner et al., 1993; Penadés et al., 2003). Pharmacological interventions contribute

little towards improvement in cognitive deficits and functional outcome (Green, 1996).

Integrated Psychological Therapy (IPT) is a cognitive-behavioral program based on the understanding that social dysfunction is maintained due to interactions between deficits in neurocognitive processes and higher order executive functions. IPT involves training in cognitive functions, social perception, verbal communication and social skills, important in improving functional outcome.

Little systematic effort has made to examine the relative contributions of neurocognitive, social cognitive and social skills deficits to the burden of disability in the Indian context. Research on psychological interventions for SZ in India has examined impacts on specific factors such as social skills (Kapse, 2011) and cognitive functions (Hegde et al., 2012). Given the increasing

* Corresponding author. Tel.: +91 80 26995184; fax: +91 80 26564830.

E-mail addresses: paulomi.sudhir@gmail.com, paulomi@nimhans.kar.nic.in (P.M. Sudhir).

importance and need for psychological interventions in this population and the large number of patients seeking treatment, it is important to evaluate cost and time effective integrated psychotherapeutic programs in improving social functioning. The IPT has been developed based on norms and social behaviors suitable for western society and is likely to differ across cultures. Hence, there is a need to have more culturally suitable components of IPT before testing its effectiveness in patients with SZ. The IPT has been evaluated across 12 countries in 36 independent studies (Roder et al., 2011). The present study was aimed at examining the feasibility of a culturally adapted IPT on patients with SZ from the Indian subcontinent and to examine its effectiveness in improving neurocognition and social-functioning. Families are an important aspect of patient care in the management of SZ and hence we included caregivers.

2. Methods

2.1. Sample

Twenty nine clinically stable patients with SZ ($n = 27$) or Schizoaffective Disorder ($n = 2$) (American Psychiatric Association, DSM IV TR, 2000), meeting specified inclusion and exclusion criteria were recruited from the outpatient services of National Institute of Mental Health and Neurosciences (NIMHANS), Bengaluru (Table 1). All patients provided written informed consent. Patients aged between 18 and 50 years (mean age = 33.66 years \pm 7.2 years), with minimum of grade 5 education, having a caregiver with whom they were in regular contact, were recruited. Patients with co-morbid neurological conditions, mental retardation, history of head injury, current substance dependence (except nicotine dependence), severe depression with psychotic symptoms, having undergone neuropsychological assessment and/or electroconvulsive therapy in the preceding six months, having received cognitive remediation, structured psychological therapy and/or social skills training in past one year, were excluded.

2.2. Study design

An open label design with baseline, post-intervention and follow-up assessment was adopted (Fig. 1). The study was reviewed and approved by the Institute Ethics Committee and was carried out between 2012 and 2013. The study was registered under the Indian Council for Medical Research (ICMR) clinical trials registry (CTRI/2014/12/005338).

2.3. Measures

2.3.1. Psychopathology

Positive and Negative Syndrome Scale (PANSS) (Kay et al., 1987) consists of 30 items, divided into 3 parts: Positive, Negative and

General Psychopathology scale, with a 7-point Likert scale (1 = symptom is absent to 7 = extreme severity). Adequate reliability is reported for the positive ($\alpha = 0.73$), negative ($\alpha = 0.83$) and general psychopathology ($\alpha = 0.79$) scales.

2.3.2. Intelligence

The Revised Bhatia's Short Battery of Performance Tests of Intelligence for Adults (Verma et al., 1988) consisting of Koh's Block Design and Pass along Test was used to assess fluid intelligence. It provides an estimated intelligence quotient and has been developed and standardized on Indian sample.

2.3.3. Tests of attention and working memory

Digit Span Forward and Backward (Wechsler, 1955) were used to assess immediate attention and verbal working memory respectively. Spatial working memory was assessed using Spatial Span (SP) (Wechsler, 1999) in which the patient taps cubes on a board in the same sequence, either forward or backward.

2.3.4. Tests of speed of processing

Digit Symbol Substitution Test (DSST) (Wechsler, 1981), was used to assess speed of processing. numbers 1–9 are paired with a symbol, and the digit is to be substituted with the paired symbol. Lesser time indicates better speed of processing.

Colour Trails 1 (CT1) (D'Elia et al., 1996): consists encircled numbers (1–25), that are to be connected in the correct sequence. For both tests total time taken was calculated.

2.3.5. Test of cognitive flexibility

Colour Trails 2 (CT 2) (15): In CT2, the patients were instructed to connect a series of numbered circles (1–25) appearing in pink and yellow in the ascending order. Each consecutive number has to be of the alternative colour (e.g., 1 (Pink), 2 (Yellow), 3 (Pink), 4 (Yellow)). Lesser time taken indicates greater cognitive flexibility.

2.3.6. Test of verbal fluency

Phonemic fluency was assessed using Controlled Oral Word Association Test (COWAT) (Benton and Hamsher, 1989). Patients were asked to generate as many words as possible starting with letters F, A and S in 1 min. Indian consonants Ka, Pa and Ma were used for patients, not fluent in English. The average of admissible words was the score. Higher scores indicate better fluency.

Animals Names Test (ANT) (Lezak, 1995) was used to assess category fluency. Patients were instructed to generate as many animal names as possible in 1 min. Both tests are standardized on the Indian population (Rao et al., 2004).

2.3.7. Tests of learning and memory

Ray's Auditory Verbal Learning Test (RAVLT) (Rao et al., 2004; Schmidt, 1996) was used to assess verbal learning and memory. Two lists, A and B, with 15 words in each with five learning trials were given. Immediate recall of words and a delayed recall, 20 min later, for List A were assessed. Total words recalled on the five learning trials, and words on immediate and delayed recalls were taken as scores.

Ray's Complex Figure Test (RCFT; Osterrieth, 1944) was used to assess visual learning and memory. Patients at first copied the abstract design from the card and then reproduced the figure from memory, and were assessed on immediate recall and after 30 min for delayed recall.

2.3.8. Test of abstraction

Abstraction was assessed using Similarities and Differences (Kumari, 2007). Twelve pairs of words were presented and patients provided similarities and differences between them. Abstract, functional and concrete responses received scores of 3, 2 and 1 respectively. A response was scored as abstract if the response

Table 1

Showing clinical description of the sample at baseline ($N = 29$).

Variable	Mean (SD)
Age at onset (AAO) (years)	22.34 (\pm 7.23)
Duration of untreated psychosis (DUP) (months)	9.48 (\pm 12.51)
Duration of illness (years)	11.28 (\pm 8.04)
	N (%)
Psychiatric comorbidity	14 (45)
Family history of schizophrenia	7 (24)
Family history of other psychiatric disorders	17 (59)
Paranoid SZ	19 (16)
Undifferentiated SZ	6 (21)
Disorganized SZ	1 (3)
Residual SZ	1 (3)
Schizoaffective disorder	2 (7)

SZ = Schizophrenia.

Download English Version:

<https://daneshyari.com/en/article/316978>

Download Persian Version:

<https://daneshyari.com/article/316978>

[Daneshyari.com](https://daneshyari.com)