



The cognitive behavioural prevention of suicide in psychosis: A clinical trial



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ABSTRACT

Background: Suicide behaviour in psychosis is a significant clinical and social problem. There is a dearth of evidence for psychological interventions designed to reduce suicide risk in this population.

Aims: To evaluate a novel, manualised, cognitive behavioural treatment protocol (CBSPp) based upon an empirically validated theoretical model.

Methods: A randomly controlled trial with independent and masked allocated and assessment of CBSPp with TAU (n = 25, 24 sessions) compared to TAU alone (n = 24) using standardised assessments. Measures of suicide probability, and suicidal ideation were the primary outcomes and measures of hopelessness, depression, psychotic symptoms, functioning, and self-esteem were the secondary outcomes, assessed at 4 and 6 months follow-up.

Results: The CBSPp group improved differentially to the TAU group on two out of three primary outcome measures of suicidal ideation and suicide probability, and on secondary outcomes of hopelessness related to suicide probability, depression, some psychotic symptoms and self-esteem.

Conclusions: CBSPp is a feasible intervention which has the potential to reduce proxy measures of suicide in psychotic patients.

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1. Introduction

Suicide and suicide behaviour are of substantial public and social concern. It is well established that risk of suicide is considerably elevated in those suffering from schizophrenia and psychotic disorders (Caldwell and Gottesman, 1990; Cohen et al., 1994; Hawton et al., 2005; Bolton et al., 2007). Suicide ideation and suicide attempts are common with up to 50% of patients experiencing suicidal ideation at any point in time or having a history of previous attempts (Hawton et al., 2005; Palmer et al., 2005). It is assumed that there is a progressive continuum from ideation, intent, action and completion (Bolton et al., 2007). Thus, suicidal ideation is a risk factor for self-harm and completed suicide and a legitimate clinical target in its own right.

A meta-analysis of cognitive-behavioural interventions (CBT) to reduce suicide behaviour (Tarrier et al., 2008) demonstrated that individual, but not group, CBT, was effective in significantly reducing suicide behaviour in adults, although not adolescents, in the short and

medium term. This result held despite considerable variability both in the target populations and in the CBT interventions. There is, however, a paucity of studies which have attempted to diminish suicide behaviour in psychosis, despite the well established high risk in this group. Cognitive behaviour therapy for psychosis (CBTp) reduces positive and negative symptoms of psychosis, depression, and anxiety but has less effect on hopelessness (Wykes et al., 2008) and suicidality (Tarrier et al., 2006).

Psychological interventions are most likely to be successful when they are clearly derived from a theoretical understanding of underlying mechanisms (Bolton et al., 2007; Johnson et al., 2008a). Advances in understanding the cognitive architecture underpinning suicidality have resulted in the development of empirically validated theoretical models, such as, the Schematic Appraisal Model of Suicide (SAMS) (Johnson et al., 2008a,b) which was modified from the Cry of Pain model (Williams, 1997). The SAMS has three core psychological components, namely, the presence of negative information processing biases, extensive 'suicide schema', and a negative and suicide focused appraisals system (Johnson et al., 2008a). To date, empirical evidence supports a multi-tiered appraisals system together with the operation

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of suicide schema in people experiencing suicidality, psychosis, and post traumatic stress disorder (Pratt et al., 2010; Taylor et al., 2010b,c; Panagiotti et al., 2012c).

The Cognitive Behavioural Prevention of Suicide in psychosis protocol (CBSPp) (Tarrier et al., 2008; Tarrier et al., 2013) was founded on the SAMS. Thus, the specific cognitions targeted by CBSPp are information processing biases, and appraisals of defeat, entrapment, emotional dys-regulation, social isolation, and poor interpersonal problem solving (Tarrier et al., 2013). Although CBSPp arose from work with psychosis and post-traumatic stress disorder, it has the potential to be applied trans-diagnostically (Tarrier et al., 2013).

The aim of this study was to evaluate the CBSPp protocol. As far as we are aware this is the first evaluation of a suicide prevention intervention that has been intentionally derived from an empirically validated theoretical model of suicide (Johnson et al., 2010a,b; Pratt et al., 2010; Taylor et al., 2010b,c; Johnson et al., 2011; Taylor et al., 2011; Panagiotti et al., 2012a,b,c).

Specifically, it was hypothesised that CBSPp in addition to Treatment As Usual (TAU) would have significant advantages over TAU alone in reducing 1) measures reflecting suicidal behaviour including hopelessness, and, 2) measures associated with other symptom clusters of psychosis including depression, thought disorder, and low self-esteem.

2. Method

This was a single blind randomised control trial, which aimed to test the feasibility and potential efficacy of a novel intervention (CBSPp) designed to reduce suicidal behaviours in those suffering from schizophrenia spectrum disorders. Participants assigned to the Treatment condition plus TAU were compared to those allocated to a TAU condition alone.

2.1. Participants

Ethical approval was obtained from Stockport Research Ethics Committee (08/H1012/97).

Between April 2009–October 2010 Community Mental Health Teams (CMHT), Early Intervention (EI) teams, and Assertive Outreach (AO) teams across four National Mental Health Service trusts including, Greater Manchester West, Manchester Mental Health and Social Care, Pennine Care and Five Boroughs in the North West of England, were approached to facilitate recruitment.

Participants were recruited into the study if they were: (a) aged between 18 and 65; (b) had a DSM IV diagnosis of schizophrenia, schizophreniform disorder, schizoaffective disorder, delusional disorder or psychotic disorder not otherwise specified; (c) identified as having previous suicide attempts or experiencing current suicidal ideation; (d) under the care of an appropriate clinical team and currently in contact with mental health services; (e) receiving appropriate anti-psychotic medication; and, (f) not currently receiving CBT or other empirically validated psychological treatments. Participants were excluded if they: (a) currently suffered serious suicidal intent and were currently considered a danger to themselves; (b) had a primary diagnosis of bipolar depression or substance induced psychosis; and, (c) suffered from an organic brain disease.

2.2. Procedure

Mental health staff identified potential participants on their case load who met the recruitment criteria. Once diagnosis was confirmed and written consent was obtained, the baseline assessments were administered by research assistants (RAs) independent of therapy. Following the baseline assessment, participants were randomised using a clinical data management system and allocated to either the experimental treatment group where participants were to receive CBSPp plus TAU or the control group where participants were to receive

only TAU. Randomisation was controlled by staff not directly linked to the trial to ensure independence and blindness to the trial allocation arms.

Participants were informed of the randomisation outcome via a letter, which also contained a note reminding them not to disclose any information about their care or treatment during assessments which would break the blind requirement. In cases where the RAs were unblinded, protocols were followed whereby unblinding was documented and the assessment packs were scored by another RA. Masking was further maintained by ensuring that therapists and RAs were located in different offices so that therapy files and assessment data were stored separately. In addition, clinical staff were repeatedly instructed not to disclose any knowledge of therapy or group allocation to assessors. Participants who were allocated to the treatment arm were then contacted by one of the trial therapists to arrange their first session. Therapists were given a copy of the completed baseline assessments prior to starting therapy sessions to aid their clinical formulations and prevent unnecessary repetition of questioning of participants.

Participants were assessed at baseline, then at 4 and 6 month follow up time points. Prior to each assessment point, care coordinators were approached by a member of the research team to obtain a comprehensive risk assessment.¹

A routine telephone follow up call was made the day after each assessment and seven days later to ensure that the assessments had not caused any distressing after-effects for the participant.

2.3. Measures/assessments

Standardised measures consisting of a short semi-structured clinical interview and self-report questionnaires were used.

2.3.1. Primary outcome measures

These were measures of suicidal thoughts and behaviours as follows:

- 1) The Beck Scale for Suicidal ideation; BSS (Beck and Steer, 1991). The BSS is a 21-item questionnaire with three response options assessing suicidal ideation, planning and intent in the past week, and previous attempt history.
- 2) The Adult Suicidal Ideation Questionnaire; ASIQ (Reynolds, 1991). The ASIQ is a 25 item scale, assessing suicidal intent in adults. Respondents report the frequency of thoughts about death in the last month using a 7 point Likert scale.
- 3) The Suicide Probability Scale; SPS (Cull and Gill, 1982). The SPS consists of 36 statements with 4 subscales (hopelessness, suicidal ideation, negative self-evaluation, and hostility). Responses are measured on a 4 point Likert scale.

2.3.2. Secondary outcome measures^{2,3}

These were included to reflect mood and psychotic symptoms.

- 1) Calgary Depression Scale (Addington et al., 1990).
- 2) The Beck Anxiety Scale (Beck et al., 1988).
- 3) The Beck Hopelessness Scale (Beck et al., 1974).
- 4) The Positive and Negative Symptom Scale; PANSS (Kay et al., 1987).
- 5) The Psychotic Symptoms Ratings Scales; PSYRATS (Haddock et al., 1999).
- 6) Self Esteem Rating Scale (Lecomte et al., 2006).
- 7) Global Assessment of Functioning; GAF (DSM (IV), 1994) which provides a total score and two sub-scales of symptoms and disability, scores.

¹ History of self-neglect, environmental risk, relapse risk, self-harm, and harm to others.

² We acknowledge that primary and secondary outcome measures may be correlated as is often found in mental health research.

³ Other measures relating to recovery were included in this pilot trial but have not been included in this data analysis because they were not relevant to suicidality. These were the Subjective Experiences of Psychotic Symptoms Scale and an unpublished scale about the process of recovery.

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