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Acute treatment of inpatients with psychotic symptoms using Acceptance and Commitment Therapy: Pilot results

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Abstract

Cognitive behavior therapy (CBT) has been demonstrated in a number of randomized controlled trials to be efficacious as an adjunctive treatment for psychotic disorders. Emerging evidence suggests the usefulness of CBT interventions that incorporate acceptance/mindfulness-based approaches for this population. The current study extended previous research by Bach and Hayes (2002. The use of Acceptance and Commitment Therapy to prevent the rehospitalization of psychotic patients: A randomized controlled trial. *Journal of Consulting and Clinical Psychology*, *70*, 1129–1139) using Acceptance and Commitment Therapy (ACT) in the treatment of psychosis. Psychiatric inpatients with psychotic symptoms were randomly assigned to enhanced treatment as usual (ETAU) or ETAU plus individual sessions of ACT. At discharge from the hospital, results suggested short-term advantages in the ACT group in affective symptoms, overall improvement, social impairment, and distress associated with hallucinations. In addition, more participants in the ACT condition reached clinically significant symptom improvement at discharge. Although 4-month rehospitalization rates were lower in the ACT group, these differences did not reach statistical significance. Decreases in the believability of hallucinations during treatment were observed only in the ACT condition, and change in believability was strongly associated with change in distress after controlling for change in the frequency of hallucinations. Results are interpreted as largely consistent with the findings of Bach and Hayes and warrant further investigations with larger samples.

Keywords: Acceptance and Commitment Therapy; Mindfulness; Acceptance; Cognitive behavior therapy; Psychotic disorders; Acute treatment; Hospitalized patients

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Introduction

Schizophrenia and other psychotic disorders are typically chronic and debilitating conditions (Pratt & Mueser, 2002). Many patients experience residual symptoms and comorbid psychiatric problems even when treatment compliance is not an issue (Curson, Patel, Liddle, & Barnes, 1988; Johnstone, Owens, Frith, & Leavy, 1991). Furthermore, the continued experience of positive symptoms is one of the best predictors of rehospitalization (Tarrier, Barrowclough, & Bamrah, 1991). Therefore, the development of efficacious and effective psychosocial treatments is imperative for treating patients with psychotic-spectrum disorders.

Over the past decade, cognitive behavior therapy (CBT) has been found in a number of randomized clinical trials (RCTs) to be efficacious for the treatment of schizophrenia and related psychotic disorders (Gaudiano, 2005; Gould, Mueser, Bolton, Mays, & Goff, 2001; Pilling et al., 2002; Rector & Beck, 2001). The majority of RCTs to date have examined the efficacy of CBT for treating the residual symptoms of psychosis in outpatient samples (e.g., Kuipers et al., 1997). Results show large effect size gains for CBT compared to treatment as usual (TAU), but less robust and specific benefits when CBT is compared to non-specific-supportive interventions (Sensky et al., 2000; Tarrier et al., 1998).

Effective psychosocial treatments may be especially important to implement in the acute phase of psychosis,[1] as subsequent psychotic episodes tend to be associated with increased functional impairment and residual symptoms (Shepherd, Watt, Falloon, & Nigel, 1989). Unfortunately, few studies to date have investigated CBT for treating inpatients with psychosis. In one of the few RCTs with inpatients, Dury, Birchwood, Cochrane, and MacMillan (1996) allocated 40 patients in an acute psychosis to routine care plus group and individual CBT or routine care plus recreational activities. Patients receiving CBT showed superior change on positive symptom measures and faster rates of improvement at post-treatment compared to those receiving recreational therapy.

In a more recent study, Lewis et al. (2002) randomized 315 patients with schizophrenia in acute treatment (inpatient or day treatment program) to routine care alone, routine care plus supportive counseling, or routine care plus CBT for 5 weeks. Results during the acute-treatment phase of the study showed faster improvement in the CBT group compared to routine care (4 vs. 6 weeks, respectively). Eighteen-month follow-up that included booster sessions showed continued advantages on psychotic symptom measures for the CBT group relative to those who received supportive counseling (Tarrier et al., 2004).

In the Dury et al. (1996) study, CBT consisted of 12 weeks of individual and group therapy (approximately 8 h/week). Lewis et al. (2002) provided 15–20 h of treatment over 5 weeks plus outpatient booster sessions. The clinical implications of such results may be limited, as the duration of inpatient psychiatric hospitalization is often no more than 1 week in the US (National Association of Psychiatric Health Systems, 2002). In addition, most studies that have treated inpatients have continued treatment on an outpatient basis following discharge (e.g., Startup, Jackson, & Bendix, 2004). However, up to 75% of psychiatric patients do not follow through consistently with outpatient treatment following discharge from the hospital (Boyer, McAlpine, Pottick, & Olfson, 2000; Nelson, Maruish, & Axler, 2000). This raises the question of whether

[1]The term "psychosis" is used throughout the paper to describe individuals with psychotic-spectrum disorders in general, including but not limited to patients with schizophrenia.