Behavioural and Cognitive Psychotherapy, 2002, 30, 341–346
Printed in the United Kingdom DOI: 10.1017/S1352465802003089

Brief Clinical Reports

BATTLING BOREDOM: GROUP COGNITIVE BEHAVIOUR THERAPY FOR NEGATIVE SYMPTOMS OF SCHIZOPHRENIA

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Abstract. We conducted a pilot group intervention for negative symptoms, particularly targeting avolition/apathy. A baseline control design was used. Six patients were recruited, and four completed the group. The main inclusion criteria were clinically significant negative symptoms, plus associated distress and concern. The group involved 16 sessions, which were cognitive behavioural in approach. The main outcome measures were the Scale for the Assessment of Negative Symptoms, and the Subject Experience of Negative Symptoms Scale. Patients showed a reduction in avolition/apathy, and two patients reported reduced distress. These preliminary results suggest that group CBT is a possible intervention for negative symptoms.

Keywords: Group CBT, negative symptoms, schizophrenia.

Introduction

Negative symptoms of schizophrenia include restricted emotional expression, impoverished speech, lack of motivation, loss of pleasure, and poor attention (Hogg & Hall, 1992). They are associated with poor outcome, poor quality of life, and burden on family members (Provencher & Mueser, 1997). In terms of patients' subjective experience of negative symptoms, high levels of distress are most often attributed to avolition (Selten, Wiersma, & Van den Bosch, 2000). Medication is the primary mode of treatment for schizophrenia, but antipsychotic medications have been most successful in reducing positive symptoms, and may exacerbate negative symptoms. In recent years, psychological interventions have

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proved to be successful with this patient group, and studies have shown benefits of group cognitive behaviour therapy (CBT) for symptoms of schizophrenia (e.g. Gledhill, Lobban, & Sellwood, 1998). Psychological interventions specifically targeting negative symptoms include social skills training, cognitive rehabilitation and skills training. Two recent interventions have combined cognitive behavioural and group psychotherapy approaches (Daniels, 1998; Andres, Pfammatter, Garst, Teschner, & Brenner, 2000), and reported reductions in negative symptomatology.

This study examined whether group CBT would improve negative symptoms in patients with schizophrenia. The intervention focused primarily on the symptom of reduced motivation, and targeted both the objective aspect (levels of activity) and the subjective aspect (associated distress). A group format was used as it has particular benefits of offering social support, reducing isolation and stigma, and providing a forum for learning and receiving reinforcement from peers.

Method

Ethical approval was obtained from the local NHS ethics committee.

Participants

Referral was made by a mental health professional. The main inclusion criteria were:

a) DSM IV diagnosis of schizophrenia or schizoaffective disorder.
b) Persistent and clinically significant negative symptoms: a rating of more than 3 on the Avolition-Apathy section of the Scale for the Assessment of Negative Symptoms (SANS), and the symptom present for at least 6 months.
c) Distress and concern about these negative symptoms: a score of 2 or more on the Subjective Experience of Negative Symptoms (SENS) Scale.
d) No significant positive symptoms: a score of less than 4 on the Positive Scale of the Positive and Negative Syndrome Scale (PANSS).

Six patients met the inclusion criteria and agreed to participate, but two withdrew (one relapsed after ceasing Clozapine), leaving four group members who attended regularly. All the participants were male, and their median age was 33 years (range 29–45). All had a diagnosis of schizophenia, and the median duration of illness was 6 years (range 5–20). Two patients had their dose of medication reduced during the group. The group leaders were three clinical psychologists, and at least two attended each group.

Assessment measures

The Scale for the Assessment of Negative Symptoms (SANS) (Andreasen, 1984) and the Subjective Experience of Negative Symptoms Scale (SENS) (Selten, Sijben, Van den Bosch, Ornloo-Visser, & Warmerdam, 1993) were used to evaluate the group. The SENS is a self-rating scale based on the items of the SANS, and measures awareness of negative symptoms plus associated disruption and distress. The Calgary Depression Scale (Addington, Addington, & Maticka-Tyndale, 1993) and the Liverpool University Neuroleptic Side Effects Rating Scale (LUNSERS, Day, Wood, Dewey, & Bentall, 1995) were also

given to assess levels of depression and side effects of medication respectively, both of which can impact on negative symptoms. An independent assessor administered these measures on three occasions: pre-baseline (time 1), pre-intervention (time 2), and post-intervention (time 3). The baseline period was 5–7 weeks, and the final measures were administered within 2 weeks after the final session. The assessor also collected feedback on members' satisfaction with the group.

Procedure

Two weeks before the group, each patient was seen individually by a therapist to facilitate engagement and develop a preliminary formulation of their problems. There were 16 group sessions in total: 14 weekly, session 15 after a fortnight, and session 16 (follow-up) one month later. The group was held in the afternoon at a local community resource centre. Each session lasted between $1\frac{1}{2}$–2 hours, including a break. Patients were collected by car and dropped off after the group by the therapists.

The group content included: psychoeducation and understanding negative symptoms; clarification of patients' problems within a cognitive-behavioural framework; attaining behavioural goals; strategies to deal with negative thoughts; coping with stressors; medication issues; and maintenance of goal achievements. Details of the session content are available from the first author on request. Each session followed a CBT format, including agenda, summaries, and homework. A handout of the main points was produced for each session. There was a combination of group discussion, and work in pairs or individually with a therapist. We aimed to provide a formulation-led intervention within the group setting.

Results

Figure 1 shows the SANS and SENS scores pre- and post-intervention. Wilcoxon signed ranks tests were used to compare pre-baseline and pre-intervention scores, and pre- and post-treatment scores. The test of significance was 1-tailed for the pre- / post-intervention comparison since an improvement in patients' scores was expected.

SANS scores

Total score: This is the sum of the 5 global ratings on the SANS. There was no difference in scores between time 1 and time 2 ($z = -1.1$, ns). Three of the four participants had a lower total score following the group, but this just failed to reach significance ($z = -1.6$, $p = .055$).

Avolition score: There was no difference in scores over the baseline period ($z = -1.4$, ns). There was a significant reduction pre- and post-intervention ($z = -1.8$, $p = .03$): scores fell from 4 to 3 in three participants and from 3–4 to 2 in one participant.

SENS avolition scores

Perceived problem: A low score indicates a greater impairment. There were no significant differences across the baseline period or before and after the group intervention.

https://doi.org/10.1017/S1352465802003089 Published online by Cambridge University Press

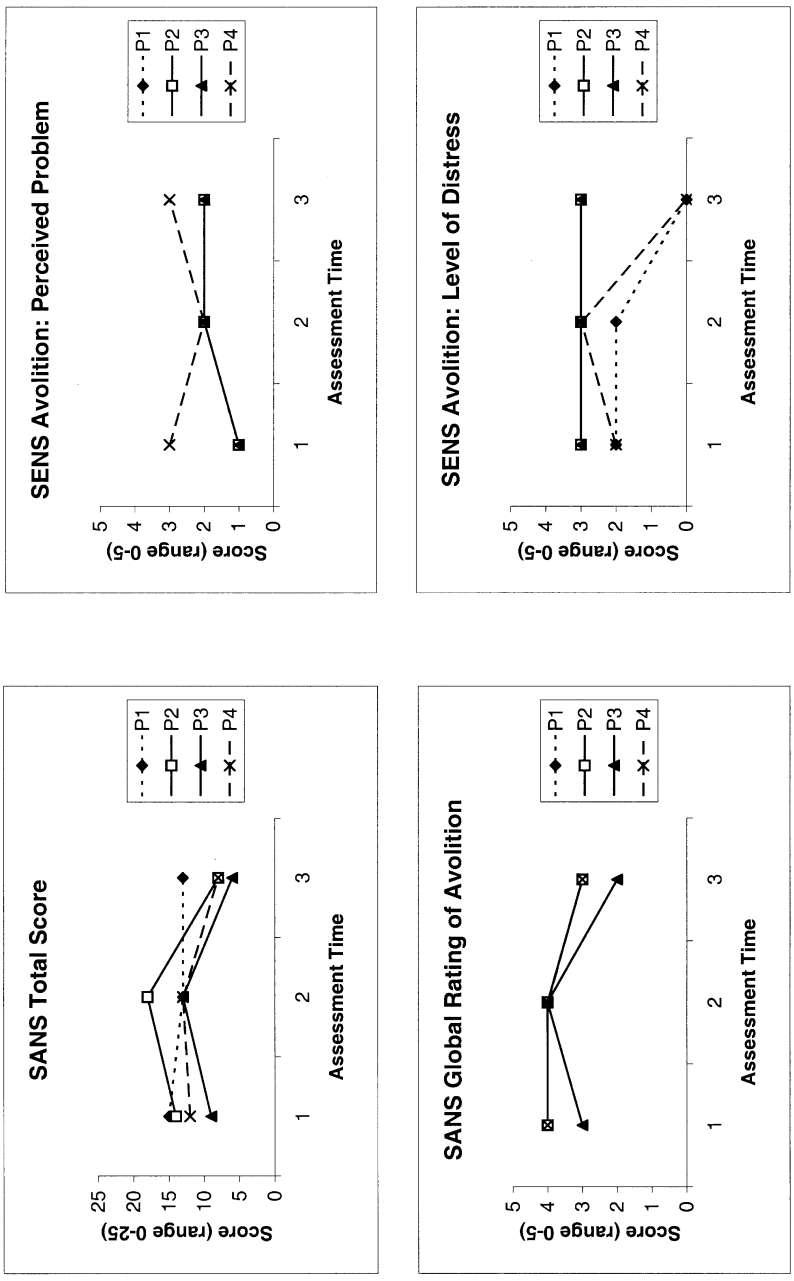

Figure 1. SANS and SENS scores pre- and post-intervention.
The SANS comprises 5 subscales: affective flattening, alogia, avolition-apathy, anhedonia-asociality, attention. Each is given a global rating, which reflects the overall severity of the symptom complex. The scores are: 0 (no symptom), 1 (questionable), 2 (mild), 3 (moderate), 4 (marked), 5 (severe). The SENS contains the same subscales as the SANS. The person is first asked to rate himself on a 5-point scale. For example: How motivated are you to do things? Very little = 1, Little = 2, Average = 3, A lot = 4, Very much = 5. If the answer is 1 or 2, he is asked whether this distresses him. 0 = No, Very little = 1, A little = 2, Quite a lot = 3, A lot = 4, Very much = 5.

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Associated distress: A high score indicates a greater level of distress. There were no significant group differences in scores over the baseline period or following the intervention, although two participants reported a reduction in their levels of distress after the group.

Additional measures

Depression and side-effects of medication were assessed over course of the intervention. The group median scores on the Calgary Depression Scale were 8 at time 1, 10.5 at time 2, and 6.5 at time 3; and there were no significant differences between assessment points. The group median scores on the LUNSERS were 55.5 at time 1, 44.0 at time 2, and 49.5 at time 3; and there was no significant change between assessment points.

Satisfaction with the group

All group members reported they were satisfied with the group, and would recommend the group to others with similar problems. All but one member reported that the group had been helpful. Comments regarding what was helpful included: being offered the chance to discuss problems in a relaxed atmosphere; sharing common experiences and knowing that other people had similar problems; and receiving information about negative symptoms. The CBT approach of breaking down problems into thoughts, feelings and behaviour received mixed feedback: two members found this useful, but one found it required a lot of effort.

Discussion

This pilot study examined the effectiveness of group CBT for negative symptoms, particularly lack of motivation, in schizophenia. Following the group, there was a significant reduction in patients' level of avolition and a trend for a reduction in overall level of negative symptoms as measured by the SANS. Despite statistical significance, the changes on the SANS were modest. However, patients' self-reports indicated some clinically significant improvements and achievement of behavioural goals: one member was applying for a job, and two members were engaged in more leisure activities. There was no change in participants' subjective experience of avolition as measured by the SENS, but two participants reported a reduction in associated distress. The lack of change in patients' perceived level of negative symptoms is probably because the SENS asks respondents to compare themselves with people of the same age who have not been admitted to a psychiatric hospital. Thus the group members continued to perceive they had difficulties in comparison with non-psychiatric patients. All participants expressed satisfaction with the group. The following factors emerged as particularly helpful: discussing and sharing common experiences, which reduced feelings of isolation; and receiving information from professionals and other group members, which increased their understanding of negative symptoms and helped them to cope with criticism from friends and family, for example, that they were being lazy. These comments correspond with previously reported benefits of a group format for this patient group (Gledhill et al., 1998).

The study is very preliminary and the number of participants is small. Nevertheless, it utilizes a novel approach in the treatment of negative symptoms, and the results indicate

https://doi.org/10.1017/S1352465802003089 Published online by Cambridge University Press

some therapeutic gains. It also contributes to our understanding of the sorts of service provision that can be offered and may benefit these clients.

Acknowledgements

We are grateful to the patients who took part in the study, and we thank Lindsey Simpson for entering the data. The study was conducted at the University of Manchester.

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