The Frontline Reports column features short descriptions of novel approaches to mental health problems or creative applications of established concepts in different settings. Material submitted for the column should be 350 to 750 words long, with a maximum of three authors (one is preferred), and no references, tables, or figures. Send material to Francine Cournos, M.D., at the New York State Psychiatric Institute (fc15@columbia.edu) or Stephen M. Goldfinger, M.D., at SUNY Downstate Medical Center (steve007ny@aol.com).

Use of CBT to Treat Depression Among Patients on Hemodialysis

The rapid pace at which medical technologies are being developed and utilized is staggering, but responses to the mental health implications of these innovations often lag behind. Before hemodialysis, there were few treatment options for patients with kidney failure. Currently more than 275,000 Americans receive ongoing hemodialysis, which represents 80% of the population with end-stage renal disease (ESRD), or kidney function below 10%. Life on dialysis shares aspects of illness burden with other chronic disorders: threats to autonomy, burden of illness, and changes in functional status. However, there are also unique challenges faced by hemodialysis patients: the demanding schedule of treatment, dietary restrictions, and ongoing secondary medical complications.

Depression is second only to hypertension as a comorbid condition among ESRD patients, affecting 20% to 30%. Yet there has been little systematic investigation of treatment strategies. Although the newer antidepressants are generally considered to be safe for dialysis patients, both patients and physicians seem to believe that unless the mood problem is unbearable, it is better not to prescribe additional medication. Thus a hemodialysis center is an excellent place for psychosocial interventions.

Downstate Medical Center, located in central Brooklyn, New York, has a long and proud history in the treatment of hemodialysis patients. Downstate housed the first federally funded dialysis center in New York State and has continued to be an innovative force in the treatment of ESRD. However, staff social workers have administrative responsibilities and are often not afforded ample time to address all of the patients' clinical issues. We created a model in which social workers serve as liaisons between patients and consulting psychologists, identifying and referring patients in need.

Many models for the delivery of treatment were piloted, including appointments at the outpatient psychology service, meetings at the dialysis center on nondialysis days, appointments before or after the patients' treatments and, finally, meetings during dialysis. Clinical experience taught us that psychosocial intervention during dialysis represented the most effective model. With some adjustment, the dialysis center offered more privacy than most inpatient settings. Because of patients' medical severity and treatment burden, adding another weekly outpatient appointment was onerous, and intervening while patients were being dialyzed was both practical and appreciated by the patients. No patients were lost to follow-through—100% of those who consented to a consultation were evaluated, a significant improvement over the usual rates of follow-up on psychiatric referrals.

Over the first year of this program, beginning in 2005, about 75 dialysis patients were evaluated and 50 were engaged in group and individual treatment. Group treatments were conducted in a conference room at the dialysis center and typically consisted of six to ten people. The sessions were scheduled immediately preceding a shift, so that patients could come early to their appointments and attend the group. This timing enabled patients who required ambulette transportation to attend and also fostered supportive relationships between people on the same shift.

We chose cognitive-behavioral therapy (CBT) as our intervention. Its focus on symptom reduction and its time-limited nature made it palatable to patients, and CBT fits well into the medical model of treatment that patients are accustomed to. The initial phase of the program was spent identifying the psychological issues unique to this population. Two overarching themes emerged: patients believe that depression is part of the illness "package," and they believe that disability prevents them from enjoying life. Believing that depression is a necessary comorbid disorder is an example of "dysfunctional thinking" (70% to 80% of patients with ESRD are not depressed), and the belief is amenable to the CBT technique of cognitive restructuring.

The limitations that ESRD disability places on people are often a combination of both true physical limitations and depressed attitude. The goal was to have patients attempt modified versions of the activities that they used to enjoy, and a combination of cognitive restructuring and behavioral assignments was used. In a non-

Editor's Note: Cognitive-behavioral interventions, long used for treating depression, have begun to be more widely used for an array of disorders. These three reports, all representing work done by faculty at Downstate Medical Center, State University of New York, in Brooklyn, represent examples of using cognitive-behavioral interventions with medically ill patients—those with both psychiatric and substance use disorders and with histories of violence and psychosis.—STEPHEN M. GOLDFINGER, M.D.

standardized protocol, 16 ESRD patients who had major depression were treated individually with a 15-week CBT intervention that focused on the techniques of challenging distorted thoughts and encouraging behavioral activation. All patients showed a significant decrease in their Beck Depression Inventory (BDI-II) scores at the conclusion of treatment. The average BDI-II score fell from 28.9 to 18.5 at the end of treatment and to 18.8 at a three-month follow-up, indicating both a significant and sustained reduction in depressive affect. (Possible scores on the BDI-II range from 0 to 63, with higher scores representing more depression.)

ESRD patients have great need for psychiatric services and are often underserved. Individual treatment that is conducted by consulting therapists "chair-side" at the hemodialysis center is a novel method of psychotherapeutic intervention that alleviates many of the obstacles of traditional referral-based outpatient services. CBT promises to be a good treatment choice for treating depression among ESRD patients.

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CBT for Psychosis for Long-Term Inpatients With a Forensic History

In New York State individuals who commit felony assault or homicide and who are judged not guilty by reason of insanity are typically admitted to a high-security inpatient facility and then transferred to a lower-security hospital for continued treatment and assessment. This patient group is diagnostically diverse, although most have a diagnosis of chronic paranoid schizophrenia. Some in this group have not committed acts of violence in many years, and some have not been violent at all since the felony that prompted their original admission.

To be discharged from the hospital facility, patients must pass through a series of stepwise increases in hospital "privileges" approved by clinical staff and the Forensic Committee. Despite good pharmacological treatment and good behavior, some patients fail to progress toward discharge because they lack insight into their disorder, remaining confined years longer than they would have had they been convicted of a felony and served jail time. Our facility sought an intervention that might increase insight in this group and revitalize progress toward discharge.

In the past two decades in Great Britain cognitive-behavioral therapy (CBT) has been adapted to the treatment of psychosis by Kingdon and Turkington and others and has been shown to increase insight among patients with psychosis. It builds on familiar CBT techniques but employs specialized interventions tailored to the psychotic patient. It departs from traditional conceptualizations of psychosis in assuming a continuum between psychosis and ordinary mind, which allows the therapist to foster a therapeutic alliance by "normalizing" aspects of the patient's experience. Using a patient-centered approach, the patient and clinician identify experiences that are sources of distress to the patient and identify patients' beliefs about these events. Then as "coinvestigators," they examine "evidence" for and against the patient's beliefs.

Eight patients, all of whom had been hospitalized for more than ten years, were the focus of a pilot intervention in 2006 that employed CBT for psychosis in individual sessions. In most cases, sessions occurred once a week for 45 minutes, continuing for an average of 20 sessions. Experienced therapists trained in CBT for psychosis treated most of the patients, but other experienced staff were recruited to the effort by providing a weekly seminar and peer supervision focused on CBT for psychosis.

A number of obstacles to implementation were immediately apparent. All psychotherapy requires an atmosphere of trust and openness between patient and therapist. This is difficult to achieve in a forensic setting. Patients expressed concern that what they said might be used as "testimony" against them in court. Furthermore, most psychiatrists in state facilities are biologically oriented, with limited training in individual psychotherapies. Even when interested in psychotherapy, psychiatrists occupied with large caseloads have little time for individual psychotherapy. Psychology and social work staff with prior training in CBT for depression and anxiety disorders may see CBT for psychosis as nothing new despite their lack of familiarity with advances in techniques specific to a psychotic population. In a system with limited resources, lonely patients are so hungry for individual attention that in some cases a time-limited CBT treatment was difficult to terminate. Patients who improved may have been responding both to nonspecific supportive aspects of the treatment and to the CBT intervention itself.

Results were encouraging. Despite the chronicity of illness, six of eight patients were judged to have benefited from the CBT intervention. In the case of Mr. A, the improvement was dramatic. Fifteen years ago he had committed a double homicide while in an acute psychotic state, but he had little prospect of discharge because he lacked insight into his disorder. He believed that a cult group had cast a spell on him, which led to the murders. He showed no interest in exercising off-ward privileges and thought frequently of suicide. As a result of the CBT intervention, Mr. A came to doubt his cult delusion and to acknowledge that mental illness may have played a role in the murders. He was able to express feelings of guilt, remorse, and worthlessness.

A clear improvement in mood ensued as these feelings were dealt with in therapy. Mr. A expressed an interest in exercising his pass privileges but feared he would be attacked by other patients if he left his ward. Patient and therapist conducted a behavioral experiment in which they walked together around the hospital grounds. No threat occurred on the

walk and on subsequent walks. His "safety behavior" of socially isolating himself gave way to an active interest in passes and off-ward activity. He is currently making progress toward discharge.

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Let's Get Organized: An Intervention for Persons With Co-occurring Disorders

An intervention for individuals with co-occurring emotional and substance use disorders was conducted in 2006 at the Starhill facility of Palladia, a residential therapeutic drug facility located in the Bronx, New York. The program, The Occupational Therapy—Let's Get Organized Life Skills, was sponsored by Target Needs Funding from the United Way of New York City to establish a Lifeline/Life Support Program. Interventions were designed to educate participants in time management and daily organizational skills and trial-and-error learning strategies.

Participants were individuals who had difficulty managing their daily routines. Three screening tools were used to identify potentially eligible participants: the Educational and Health Survey from *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities* (number 29 of the Treatment Improvement Protocol Series), the Kohlman Evaluation of Living Skills, and the Allen Cognitive Level Screen.

Participants were selected on the basis of Allen's cognitive model level 5, whereby an individual is capable of new learning, although he or she may have difficulty planning ahead or anticipating consequences of actions. Interventions for groups at cognitive level 5 (exploratory learning) should include multiple means of sensory stimuli and engagement to tap the learner's attention. In the Let's Get Organized group, wall clocks, calendars, file folders, and bulletin boards containing popular articles were in the training room.

The Let's Get Organized group was designed as a ten-week module consisting of two one-hour sessions per week to provide consistency and repetition to ensure integration and generalization of new learning and establish proper habit formation. Each group session followed a specific six-stage format.

In stage 1 clients used the sign-in sheets in an individualized file folder for their work sheets, attendance sheet, and emotion sheet. In stage 2 appointment books were distributed and personalized. At each subsequent session, participants reviewed and entered new information into their appointment books, proudly sharing various ways of personalizing them through the use of color coding, family photographs, Post-Its, and alligator clips. Habit-building experiences and resistance to using the appointment book were discussed.

In stage 3 time management and organization activity work sheets from Precin's *Living Skills for Recovery Workbook* were used with modifications of the activities to conform to Allen's level 5. In stage 4 discussion of the completed worksheet or activity by clients reassured members that using trial and error to correct mistakes was an acceptable and valuable learning tool. The group norm "mistakes are OK" promoted respect for each other's efforts, lowered clients' performance anxiety, and encouraged willingness to try out new behaviors. Clients were encouraged to notice their own and others' learning style.

In stage 5 clients were given homework. The homework was to use their appointment books daily, and this new habit was reinforced in the residential community at large. Homework was also stimulated by the worksheets or activities. The sixth and final stage, closing, included a general clean-up of materials and return of worksheets to files. Clients were informed of the next group topic, which created anticipation and motivated future participation. The group ended with the Serenity Prayer.

The 16 participants completed two pretest and posttest outcome measures, at the beginning of the first group session and at the end of the final session. The measures were the time management knowledge scale and the time management behavior scale, which were designed specifically for use with this therapeutic group. Paired-sample t tests were used to compare pre- and posttest scores. Scores on the time management knowledge scale showed significant improvement after participation in the group intervention ($t=4.06$, $df=15$, $p=.001$). Results support the efficacy of group intervention for improving knowledge related to time management. The lack of a statistically significant improvement on the time management behavior scale may be due to type II errors with a small sample and the limited number of items on the scale.

Punctuality improved over time. All participants kept their appointment books beyond the ten-week program. They commented on how many appointments they used to miss before they began using their appointment books.

Few interventions address the cognitive needs of this population. This occupational therapy intervention provided practical skills needed in everyday living and directed the focus of recovery to creating stable routines, keeping track of time and appointments, becoming organized, and following through with responsibilities in a supportive, novel, and exploratory atmosphere of shared learning.

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