A Family Group Work Application of Cognitive Behavioral Therapy of Psychosis for Community Mental Health Settings

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Recent interest in a recovery model for severe and persistent mental illness (SPMI) has opened doors for implementing psychosocial interventions with this population and their families. Cognitive behavioral therapy of psychosis (CBTp) is one such intervention that has extensive empirical support. Community mental health (CMH) providers offer a potential venue for incorporating aspects of CBTp into treatment planning for adults with SPMI diagnoses. Including a family-oriented group work component of CBTp in CMH settings could both reduce family stress and simultaneously enhance available support for clients. This article reviews relevant psychosis-specific strategies of CBTp and describes how these might be combined to develop a psychoeducational program for adults with SPMI diagnoses and their family members.

IMPLICATIONS FOR PRACTICE

- The implicit assumption in CBTp that reduced distress correlates with symptom reduction needs to be presented alongside psychoeducational material that normalizes the psychotic experience as an experience anyone could have under certain types of extreme stress.

Severe and persistent mental disorders, particularly those with psychotic features, take a tremendous toll on clients and families (Torrey, 2006). This article explores selected psychosis-specific strategies of cognitive behavioral therapy of psychosis (CBTp), and proposes a cost-effective way to integrate two of these strategies into community mental health (CMH) settings in the United States. This material is of interest to social workers, as well as to professionals and paraprofessionals of any discipline, who work with clients and the families of clients who experience psychotic symptoms. Garety et al. (2008) observe that while family interventions reduce relapse, CBTp “improves positive symptoms but effects on relapse rates are not established” (p. 412). This article suggests ways to incorporate selected CBTp strategies into family psychoeducational group work in order to address both relapse and positive symptom management. Incorporating selected CBTp strategies into psychoeducational groups for adult clients and their families has the potential to (a) help reduce family and client distress associated with psychotic symptoms and behaviors, and (b) enhance support for the family member who experiences psychotic symptoms.

CBTp: An Evidence-Based Practice

Nationalized medicine in the United Kingdom extensively explored CBTp through large randomized clinical trials (RCTs; e.g., Durham et al., 2003; Kuipers et al., 1998; Sensky et al., 2000; Tarrier et al., 1999; Turkington, Kingdon, & Turner, 2002) as an adjunctive approach to treating medication-resistant psychotic symptoms. RCT outcomes engendered optimism supported by meta-analyses of RCT data (Gould, Mueser, Bolton, Mays, & Goff, 2001; Pfammatter, Junghan, & Brenner, 2006; Zimmermann, Favrod, Trueu, & Pomini, 2005). Despite some

logistical challenges, community mental health (CMH) teams in the United Kingdom are integrating CBTp into their treatment repertoires (Jones, 2002), and the approach is starting to be explored in North America (e.g., Cather et al., 2005; Gaudiano, 2005).

CBTp approaches are based on Aaron Beck’s or Albert Ellis’ cognitive models and consist of CBT that incorporates intervention strategies specifically designed for delusions or hallucinations (i.e., positive psychotic symptoms). Davidson, Lambert, and McGlashan (1998) and Dickerson (2000) identified a variety of approaches or strategies uniquely associated with CBTp: focusing/reattribution; using a normalizing rationale; coping strategy enhancement; verbal challenge and planned reality testing targeting belief modification; and so-called “combination” CBTp approaches. Although mentioned in some CBTp literature, *personal therapy* as developed by Hogarty et al. (1995, 1997) is not CBTp (Garety, Fowler, & Kuipers, 2000; Turkington, Kingdon, & Weiden, 2006).

CBTp intervention strategies have increasingly been combined in treatment (Garety et al., 2000) and RCTs have noted clinically significant reductions in positive symptoms (i.e., hallucinations and delusions), using combination approaches that included specific interventions targeting psychotic symptoms (e.g., Kuipers et al., 1998; Tarrier et al., 1999). The outcomes of Durham et al.’s (2003) RCT suggest that CBT that does not incorporate psychosis-specific strategies may be less effective than CBTp with adults who experience psychotic symptoms. In other words, CBT alone is not enough—psychosis-specific CBT strategies must be included in the treatment package.

The following sections discuss two CBTp strategies: (a) using a normalizing rationale together with “decatastrophization” and (b) coping strategy enhancement. Subsequent sections outline ways these strategies could be used in practice settings for psychoeducational group work with families.

Using a Normalizing Rationale With Decatastrophization

Decatastrophization addresses fears associated with symptom exacerbation by assisting family members and the client in processing and demystifying the “what ifs” associated with the experience (Kingdon & Turkington, 1994). The process uses a normalizing ra-

tionale for psychosis that incorporates Zubin and Spring's (1977) seminal stress-vulnerability model while noting that psychotic symptoms can be induced in anyone (e.g., through sleep or sensory deprivation). The aim is to short-circuit the cycle wherein life events and vulnerability lead to stress that triggers: (a) psychotic symptom exacerbation; (b) telling someone about (or disturbing someone with) symptoms; (c) being consequently taken to a doctor or psychiatrist and fearing (or experiencing) involuntary hospitalization; and finally (d) increased distress and further exacerbated symptoms. Once people are aware of this cycle and the stress vulnerability model, interventions can be developed that may reduce the need to resort to hospitalization.

This material can be presented to and discussed with families during psychoeducational groups. Group content needs to include the stress-vulnerability model and life event/vulnerability cycle described previously, along with information on positive symptoms, specifically: (a) hallucinations are a normal response to sleep deprivation, something that often accompanies symptom flare-up, and (b) 1–3% of the nondiagnosable “normal” population experiences hearing voices (e.g., Honig et al., 1998; Romme & Escher, 1996; Tien, 1991). This material can help destigmatize psychotic experiences and associated diagnoses such as schizophrenia.

Coping Strategy Enhancement

Coping strategy enhancement (CSE) explores client perceptions of psychotic experiences, and the feelings and beliefs held about these experiences, in order to identify strategies clients use to cope with them. CSE can then be used to extend or expand on positive coping strategies clients already use. In addition, once positive strategies are identified, a client can begin to use them more purposefully. Successful use of positive coping strategies can reduce distress associated with symptoms; reducing distress may, in turn, reduce symptom severity. Coping strategy exploration can occur during group work with clients who have experienced psychotic symptoms, and supportive family members or supportive others. It is important for family members, supportive others, and the group facilitator to recognize that CSE aims to minimize distress associated with psychotic experiences, and not necessarily to increase insight or convince a client to agree with a medical model interpretation of symptoms.

With CSE, identifying existing coping strategies (e.g., walking, listening to music) can assist with generating additional coping strategies that may be practiced in role plays during group sessions. In some instances, beliefs associated with psychotic experiences (e.g., hearing voices) may change during the course of the group; this, too, may become part of the group process. The importance of linking psychotic experiences with personal narratives in order to facilitate therapeutic change is acknowledged throughout CSE (Yusopoff & Tarrier, 1996). Attitudes toward a potential change in, or loss of, symptoms are explicitly discussed, and these attitudes are addressed, if indicated, by relegitimization of the psychotic experiences (Tarrier et al., 1993), although this aspect of CSE is more suited to individual therapy than to psychoeducational group work.

In a group setting it is particularly important to avoid blaming the person who experiences symptoms, and CSE in psychoeducational groups should focus on identifying existing coping strategies and practicing new ones as group members share their experiences. It will be necessary to support and encourage family members to listen respectfully and nonjudgmentally to this open discussion of symptoms and coping, as they are likely to find it distressing. It is also critical

that no one feel pressured to share personal experiences with symptoms or coping strategies if he or she does not wish to do so.

Implications for Practice

The aspects of CBTp presented above lend themselves to incorporation into psychoeducational group work with clients and families. The implicit assumption in CBTp that reduced distress correlates with symptom reduction needs to be presented alongside psychoeducational material that normalizes the psychotic experience as an experience anyone could have under certain types of extreme stress. Describing the life event/vulnerability cycle (as discussed previously), and assisting families and clients to identify a potential intervention that might be tried at each stage of the cycle, takes place during subsequent groups. Clients and family members are encouraged to identify their own experiences with the life event/vulnerability cycle, with an emphasis on points for intervention for future use during crises.

CSE can then be addressed, and clients can be assisted in identifying and sharing coping strategies that help them manage and/or reduce symptoms and/or associated feelings and actions. Family members may need assistance in listening to these strategies without judgment, as some strategies may seem illogical or even nonsensical. Family members will likely find it difficult not to dispute client beliefs about psychotic experiences, particularly if symptoms manifest in ways that seem to relate to family issues or related material. Beliefs should not be disputed, and family and clients will need support and encouragement to “agree to disagree” at times during the group.

The group's purpose is to facilitate communication between and among family members and clients on topics often (or usually) avoided. Once communication is established within a nonjudgmental framework, clients can help to educate family members about (a) how to constructively offer support and (b) what their preferred crisis intervention strategies are, once options are identified. Having these conversations during a period when symptoms are not exacerbated may actually reduce anxiety and fear enough that symptom exacerbation may become less frequent. Intervention effectiveness for each client can be tracked using single-subject design (SSD) methodology. Processing SSD results in the group could both benefit group members and help evaluate the group itself.

Incorporating CBTp Into CMH Settings

In the United Kingdom, psychologists and psychiatric nurses were trained to deliver CBTp in outpatient settings with mental health service users (i.e., clients) who had been given schizophrenia diagnoses or who were experiencing psychotic symptoms. In the United States, however, psychologists work infrequently with clients diagnosed with SPMI in CMH settings, and psychiatric nurses work primarily in hospital or other inpatient settings. Social workers are the professionals who “provide a majority of the professional mental health treatment to people with schizophrenia” (Brekke & Slade, 1998, p. 175) in community settings in the United States. These social workers may have graduate or undergraduate degrees; at a postgraduate level, they may be licensed for clinical social work. Professionals with two-year graduate backgrounds in mental health counseling, marriage and family therapy, or psychology also provide mental health treatment to clients in CMH settings. Discipline credentialing and licensure vary from state to state across the United States, and line staff in mental health agencies may simply have a high school diploma or an undergraduate

degree along with state mandated certification. Among these professionals and paraprofessionals, social workers are particularly suited to implement the suggested family group work intervention because of their discipline's professional emphasis on group work.

British community psychiatric nurses trained in the CBT approach used a manual based on Kingdon and Turkington's (1994) handbook to deliver CBTp (Turkington et al., 2002), showing that expert cognitive therapists are not necessarily required for effective CBTp implementation. With this in mind, one viable approach to implementation in the United States is to introduce mental health line staff who are not necessarily therapists to some of the specific strategies for working with clients experiencing medication-resistant psychotic symptoms, and to the "spirit of CBT" (Tarrier & Wykes, 2004). Although focusing/reattribution and delusional belief modification involve gradual, relatively structured approaches that would be difficult to implement and monitor outside of individual therapy, using a normalizing rationale and aspects of CSE are both strategies that line staff could be trained to implement relatively easily in group formats. Either or both of these strategies could be developed as interventions in a variety of CMH venues.

Psychosocial Rehabilitation Programs

Psychosocial rehabilitation (PSR) programs for mental health could employ group formats or life skill modules to present a normalizing rationale or CSE. For example, trained and supervised staff could develop a series of CSE group modules based on material from available CBTp manuals and workbooks (e.g., Chadwick, Birchwood, & Trower, 1996; Coleman & Smith, 1997; Fowler, Garety, & Kuipers, 1995; Kingdon & Turkington, 1994, 2005). Similarly, a psychoeducational group sequence for clients and family members could include exploring a normalizing rationale allied with decatastrophization and the associated life event/vulnerability cycle.

Psychiatric Clubhouse Model Programs

Psychiatric Clubhouse model programs, such as the International Center for Clubhouse Development (ICCD; <http://www.iccd.org>) are psychosocial rehabilitation programs that focus on the benefits of paid or unpaid work, and what ICCD terms a "work-ordered day." Within this venue, in cases where clients have a supportive family, family members could be invited to attend psychoeducational modules that include a review of normalizing rationale or CSE content. Trained staff could present these as job readiness training modules (e.g., to help develop coping strategies for job-related stress and symptom management). With clients who obtain volunteer positions, or community employment, a trained job coach could then reinforce these strategies.

Mentored Workbook Approach

Another way to accomplish the goal of exposing clients and families to cognitive strategies for symptom management is to introduce a mentored workbook intervention that has commonalities with CBTp (Casstevens, 2007; Coleman & Smith, 1997). Such an approach has been piloted with clients on an individual basis (Casstevens, Cohen, Newman, & Dumaine, 2006) and could be adapted for group work in program and agency settings. Using a workbook approach could reduce training and supervision requirements while maintaining a treatment focus on psychosis-specific strategies. Coleman and Smith's (1997) workbook is intended for sharing with a trusted other or family member, and would lend itself to group work with adult clients and family members.

Conclusion

Issues of treatment fidelity, training, and supervision arise when implementing any new intervention (Jones, 2002). In the fragmented and variably resourced CMH arena, systematic integration and implementation of reliable and effective CBTp presents a particular challenge (Tarrier, 2005; Turkington et al., 2006). There is now substantial evidence that supports the use of psychosis-specific strategies and combination CBTp with clients experiencing medication-resistant positive psychotic symptoms. Echoing Mueser and Noordsy's (2005) call to action, it becomes relevant to ask (a) where these strategies might be introduced most constructively and (b) who might deliver them. Given the toll that severe mental disorder diagnoses takes on families, emphasizing the use of CBTp in a family context appears to be a reasonable next step. This article explored an approach to psychoeducational group work that includes family members in a CBTp process with the goal of reducing family distress and enhancing available support for clients.

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