GROUP CBT FOR PSYCHOSIS

A GUIDEBOOK FOR CLINICIANS

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OXFORD

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Introduction

The purpose of this book is to make group cognitive behavioral therapy (CBT) for psychosis more accessible to clinicians everywhere. Cognitive behavioral therapy for psychosis is now recognized as an evidence-based intervention that should be offered to whoever demands it. The limited number of psychologists who are trained in CBT for psychosis, along with the limited number of psychologists in general working with people with psychosis, have led us to develop the first published group workbook for CBT for psychosis that can be administered by mental health staff, not solely by psychologists. Our workbook has been empirically validated in rigorous studies and has obtained very strong empirical support, with participants also recognizing significant clinical improvements. Although the workbook is straightforward, clinicians typically need to have prior experience in group therapy, as well as a good knowledge of CBT principles and techniques, in order to run our CBT group for psychosis. For more than a decade now we have been teaching clinicians the skills necessary to run group CBT for psychosis; this book is an addition to that training and provides clinicians access to more information and guidance on the techniques that work.

The current book is based on years of experience in running groups with people with psychosis, particularly CBT for psychosis groups. The workbook and the various clinical examples should enable more clinicians working with individuals with psychosis to successfully conduct group CBT for psychosis. Although some clinicians will need more extensive training, this book should help all clinicians understand how group CBT for psychosis works, what are the essential therapeutic elements involved, and how to apply this group in their setting. It is meant as both a reference and a guidebook.

Group CBT for Psychosis

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History of Group Therapies for People With Psychosis

Group interventions have been offered in institutionalized settings for many decades. This chapter reviews the changes in goals and purposes for group therapies over the years, describing psychoanalytical groups, encounter groups, milieu therapy, skills training, cognitive remediation groups, and peer support, to name a few.

Early Days: Psychoanalytical Group Therapy

Group interventions for people with psychotic disorders started many years ago, as early as 1921, when Edward W. Lazell began giving lectures to groups of patients in a psychiatric hospital in Washington, DC. Although these first groups mostly aimed at providing information, Lazell soon realized they also improved socialization of the participants. He later added discussions to his groups to further improve the participants' social skills. A few years later, as Sigmund Freud's ideas were becoming more popular worldwide, Lazell, along with psychoanalysts such as Wilfred Bion, Siegmund Heinz Foulkes, and Tom Main in England, applied the psychoanalytical principles to groups of inpatients and outpatients. The group in itself was viewed as a healing mechanism. In this model, psychosis was considered a personality structure that was ill-adapted as a result of inappropriate childhood interpersonal experiences (mostly interactions with parents were seen as the cause). The group would serve as a way to create positive relationships, repairing the harm caused by an inadequate family. The therapists believed that a healthy family-like setting, such as a therapeutic group, would allow participants to revisit their past in a safe way and address interpersonal problems through interactions with other participants and interpretations from the therapists (who were somewhat like the "parents" of the group).

Although these initial group therapies were developed with good intentions, and often resulted in increased socialization, critics (e.g., Gabrovsek, 2009) mention several limitations to their efficacy, particularly for individuals with psychotic disorders. For one, most psychoanalysts had been trained in individual analysis, primarily with individuals with neurosis, and simply tried to superimpose that model onto groups with psychosis. For instance, the analytical group was based on interpreting transference; it encouraged free association, with each member of the group being the "object" of the treatment, and every interaction in the group being subject to interpretation. Such groups when offered to people who had paranoid thoughts, who were socially anxious and withdrawn, or to people who presented with concrete thinking could quickly create even more confusion and anxiety, given the paucity of structure within the sessions. Lack of clear structure and goals in an inpatient group setting with people with psychosis quickly led to chaos, with participants accusing each other of being someone in their delusion (the Devil, for example). Another issue was related to the transference interpretations themselves: An individual with psychosis could experience them as intrusive and potentially dangerous, seeing the therapist as attempting to "steal his or her thoughts," for instance. Similarly, the focus on emotional expression often backfired, with participants not always being able to identify their emotions or easily becoming overwhelmed by others' emotional expression, therefore creating even more anxiety in attending the group (Gabrovsek, 2009).

Furthermore, given that there was little training available in group therapy at the time, many therapists "improvised," offering group sessions based on what they had read about or thought could be useful. Psychoanalytical group therapy for people with psychosis as described here is rarely seen anymore. Structured brief psychodynamic group approaches, involving interactive and dynamic therapists and with clearly defined goals for the group, can be found in some settings. Few studies, however, have been published to date that do or do not support these groups with individuals with psychosis.

Artistic Groups and Psychodrama

As psychoanalytical theory became the essential framework in most psychiatric hospitals, mental health clinicians explored various forms of treatments that could unleash the unconscious and help individuals with psychosis build better defense mechanisms through interpretation of their transcending unconscious thoughts. Art was considered by many as an efficient way to access the unconscious, particularly among patients with psychotic disorders who did not communicate much and were not good candidates for verbal therapy. Art therapy groups were created in which inpatients were asked to draw whatever came to mind and were then asked to describe the picture, ideally trying to think of what it reminded them of. Although this was often done in a group, the interventions were mostly individual, with the group used simply as the format for offering this therapy. Some art therapy groups allowed participants to expose their art, helping some

of them to develop a sense of pride and of belonging to the group of "artists." Benefits to expressing oneself through art and improvements in self-esteem from exposing one's artistic creations have been reported; the usefulness of interpretation of such artworks for improving the person's well-being or alleviating symptoms has not been empirically demonstrated to date.

Another psychoanalytically inspired artistic group intervention is psychodrama. Developed by Jacob Moreno in 1925, it involved using theater, especially improvisation and multiple characters, to act out one's personal difficulties onstage. Various techniques were used, at times having multiple actors playing different facets of the same person, or having many actors playing the same person in the same situation, or having the person play different characters in his or her scenario. These variants aimed at helping the person understand the interpersonal issues at play and find ways to modify them. Psychodrama was always done in groups, often on a real stage with real prompts, but Moreno did not consider it group therapy because the focus was on one individual at a time. Sociodrama, a modified version of psychodrama, in contrast, is considered one of the early forms of group psychotherapy given that group issues and relationships that affected everyone in the group were played out (Bour, 1983). Moreno did not specifically target people in psychiatric institutions for his psychodrama, but several clinicians after him have done so. According to a fairly recent review (Ruddy & Dent-Brown, 2007), none of the studies using psychodrama or sociodrama with people with psychosis demonstrated evidence of benefits, not even in increased attendance compared with treatment as usual. Still, no studies have clearly demonstrated harm either.

Milieu Therapy

As new forms of treatments for people with mental illness emerged, groups often played an important part. For instance, the 1950s saw the development of the idea of a therapeutic community, where people with severe mental illness and mental health workers lived together as a small community, voting for rules and changes, and where everything in the environment was perceived as therapeutic (PsychiatricNursing, 2011). In such settings, groups were used for support and encouragement, for decision-making, and also for the influence of peer pressure on changing inappropriate behaviors—bringing (through feedback) the person to fit the group's social norm. Milieu therapy encouraged autonomy and aimed at improving adaptive coping skills through positive interactions. These groups offered the first opportunity for people with mental illness to have a voice in their treatment. Milieu therapy offered a context in which problematic behaviors could be addressed directly, and often successfully (Townsend et al., 2010). Unfortunately, such environments implied the quasi absence of hierarchy, a difficult concept to implement in a psychiatric setting. It was also difficult to adapt the environment to fit each person's needs, both at the inpatient level and in the

community. In fact, milieu therapy is scarcely offered today, but the essence of its ideas can be found in the current recovery movement. Indeed, milieu therapy brought forth the idea of personal choice, of the person's own expertise regarding his or her mental health, of the beneficial role of having a job and of being an important member of one's community (PsychiatricNursing, 2011).

Encounter Groups

The encounter group grew exponentially more popular during the 1960s and 1970s, both in the general population and in clinical settings. In fact, most psychology or psychiatry students in those decades were required to attend such groups as part of their curriculum. The encounter group was a form of experiential group where participants' interactions were openly discussed in the here and now and where the goal was personal growth. Initially coming from social psychology and educational backgrounds, therapists were typically trained briefly, over a weekend, mostly in observing interactions and offering feedback. Very much influenced by Carl Rogers's humanistic movement, encounter groups aimed at inducing changes in self-actualization by addressing behaviors, attitudes, and values in the present moment. The encounter group was based on honesty but also on exploration, emotional expression, self-disclosure, and interpersonal confrontation. The effects of such groups were often linked to the leader's therapeutic style, with personnal attacks and overintrusive leaders having more dropouts or "casualties," that is, negative effects from the group (Yalom & Lieberman, 1971). Some leaders followed what Yalom and Leszcz (2005) describe as the "more is better" paradigm whereby participants were asked to interact in extreme ways. For instance, emotional expression could be pushed to the point of screaming and punching pillows; feedback could become incessant verbal attacks from group members until the person broke down crying; revealing personal secrets could be asked but naked, to truly show oneself. Many versions of encounter groups appeared during those years, with a subsample of participants experiencing "decompensation" or psychotic episodes as a result. Although leaders of encounter groups in the community rejected references to illness or symptoms, contrasting their "mind-opening" techniques to "head shrinking" by psychiatrists or trained clinicians, the essence of such experiential groups did translate into clinical settings, namely, in psychiatric institutions and outpatient services offered to people with psychosis. Well-trained Rogerian encounter group leaders in psychiatric settings mostly offered empathy and understanding and tried to help people grow by focusing on positive here-and-now interactions, limiting harsh confrontations, and they typically did not report important casualties. However, no studies have reported any benefits from encounter groups with people with psychosis. In fact, although they might be considered as predecessors of Irvin Yalom's interpersonal group approach or Nick Kanas's integrated approach, encounter groups are rare and are no longer offered to people with psychosis.

Yalom's Inpatient Interpersonal Group Approach

Irvin Yalom's book *The Theory and Practice of Group Psychotherapy*, initially published in 1970 and now in its fifth edition, is still in many ways considered the bible of group therapy. The book covers in detail years of research on the essential elements of group therapy, many of them being described in the current book in cognitive or behavioral terms in Chapter 4. Yalom's own theoretical model or theoretical influences are never thoroughly or clearly described, though psychodynamic, existential, and social learning theories are evident in his work. His interpersonal approach aims at providing a corrective experience to heal early traumatic experiences, linking past experiences with the here and now and using the positive group interactions as social learning. As in Rogerian encounter groups, empathy, expression of emotions happening in the present, and therapist transparency (e.g., the therapist disclosing his or her own feelings during interactions) are encouraged. Yalom's approach also focuses on early childhood experiences, with the group being perceived as a corrective family and transference at times being interpreted, as in the psychoanalytic approach. Yalom's interest in research lay mostly with process variables, focusing on facilitators of change. Through his empirical work and clinical experience, he describes therapeutic factors that are essential in order for a group therapy to induce change. These are instillation of hope, universality, imparting information, altruism (a desire to help others), interpersonal learning, group cohesiveness, development of socializing techniques, corrective family re-enactment, and imitative behavior. Many of these elements are present in evidence-based group interventions and have been demonstrated in empirical studies, such as group cohesion (Norcross & Wampold, 2011) and universality (or normalization), whereas others have yet to be demonstrated as essential (e.g., the corrective family re-enactment).

Yalom has worked for many years with people with psychiatric disorders in inpatient settings and has described important factors to consider when working with this population, ranging from organizational barriers to the importance of providing structure and formulating clear goals for the therapy (Yalom, 1983). However, unlike behavioral or cognitive behavioral group therapists, he does not believe that important changes can occur with this clientele over a short period of time and proposes instead that the therapy should simply aim at getting people to talk, become less isolated, and attempt to be helpful to others.

Kanas's Integrated Model

Like Yalom, Nick Kanas (1996) has devoted much time to studying process issues in group psychotherapy but focusing almost exclusively on people with psychosis. His approach is influenced by Yalom's work, incorporating psychodynamic, interpersonal, and existential components but also adding psychoeducation and advice giving into the model.

The group's aim, in Kanas's approach, is to help people develop coping strategies for their symptoms and find solutions to interpersonal difficulties they might share. Based on his studies, he has proposed certain guidelines when working with people with psychosis in group psychotherapy, particularly in inpatient settings: Groups should be homogeneous in terms of diagnosis (this point will be addressed in more detail in Chapter 6, with a slightly different twist), groups that focus on interpersonal aspects work better than groups that aim at improving insight in the psychoanalytical sense, emotional expression is encouraged but excludes the expression of anger, and reality testing is encouraged. Unlike other therapists of the time, Kanas encouraged the expression and description of delusional thoughts, as well as exploring ways to determine if the patient's experience was based in reality or not. Some of the principles and techniques used by Kanas are also found in cognitive behavioral therapy (CBT) for psychosis, namely, openly discussing symptoms and checking the facts (see Chapter 8). Kanas also used the group as a platform to improve social interactions and practice social skills—something behaviorists greatly developed—even encouraging participants to interact outside the group.

Skills Training

As the golden age of psychiatric institutions passed, individuals needed to be prepared to return to the community, often after having spent many years incarcerated in psychiatric asylums. Clinicians quickly realized that psychoeducation training, often resembling classes, giving verbal instructions and information regarding the effects of medication and the importance of adherence, for instance, did not suffice. In fact, psychoeducation training rarely enabled behavioral changes and often addressed only topics pertaining to the illness or to medication, whereas many other behaviors needed to be mastered in order to lead fulfilling community lives. Behavioral group interventions became essential. Based on Albert Bandura's theory of self-efficacy, interventions were tailored to optimize learning through the demonstration of appropriate social behaviors, repetition, and social encouragement. Skills training, namely, independent living skills and social skills, was offered in groups using Bandura's self-efficacy model. Individuals learned most of the skills in groups, including how to cook simple meals, how to start a friendly conversation with a neighbor, and how to be happy and satisfied at work. Two pioneers in social skills training were Robert Liberman and Charles Wallace, from the University of California, Los Angeles. In the 1980s and early 1990s they developed and studied (often in randomized controlled trials) a large array of modules and videos for skills training (see www.psychiatricrehab.com). Some skills were more medically oriented, such as learning to independently manage one's medication or to recognize and cope with one's symptoms, whereas others were more social (e.g., skills for developing friendship and intimacy). A number of books have been written on social skills training (e.g., Bellack, Mueser, Gingerich, & Agresta, 2004; Liberman, 1992), but they essentially include the same recipe: (a) Introduce the skill to be learned (why is it important to learn

this skill?); (b) demonstrate how to apply the skill (model it or show a video); (c) practice the skill (role plays with feedback); (d) plan the needed resources to use the skill; (e) do it! (in vivo); (f) if things do not work as planned, use problem-solving; and (g) try again (independently).

It is important to mention that each large skill is broken down into smaller skills that are easier to learn. For instance, learning how to take medication autonomously can be divided into several skills: (a) how to verify your prescription and dosage; (b) how to count your pills and remember to take them daily; (c) how to record side effects and discuss them with your doctor at your next appointment.

In a group setting, social skills training would involve everyone reading and learning together about a new skill. For example, for the skill "how to record side effects and discuss them with your doctor," after learning about the skill, the participants would see an example (such as a video recording) of someone having tracked on a sheet daily side effects and showing it to his or her doctor while saying that he or she is really bothered by one specific side effect. This would be followed by a group discussion regarding what the group members saw and understood in the video. Then participants would be asked to recognize their own side effects, using the same tracking sheet as was seen in the video. This could also be done as a take-home assignment. The following group session would involve participants role-playing either the client or the doctor, with the client trying to explain to the doctor his or her preoccupation with a specific side effect. Everyone else in the group would be instructed to notice verbal and nonverbal signs such as tone, eye contact, posture, and the coherence of the message conveyed. Following a role play, positive and constructive feedback is always offered before comments on aspects that need improvement. Everyone would get a turn at trying the new skill in a role play, with participants at times doing the role play many times in a row to get it right. The following sessions would explain the seven steps in problem-solving, which are as follows:

- Is there a problem?
- What is the problem?
- What are potential solutions?
- What are pros and cons for each solution?
- Which solution seems the best at this point?
- Verify resources.
- Do it!

The participants would be instructed to come up with examples of what might go wrong when trying to apply, for instance, the skill "how to record side effects and discuss them with your doctor." Each potential problem would be a target for the seven-step problem-solving technique. Discussions pertaining to the resources needed to apply the skill and how to practice the skill outside of the group before meeting the doctor would also take place. Finally, actual applications of the skill in real life would take place, with participants

coming back to the group for feedback. Such behavioral groups are time-limited, with an average of 24 sessions for skills such as the medication management skills illustrated here. These groups usually end with a graduation party, where a diploma is given to each graduating participant and a friendly meal is served. Studies have demonstrated that social skills training in groups does improve the actual learning of the skill and, when offered in conjunction with community support, can lead to sustained learning (Kopelowicz, Liberman, & Zarate, 2006). Social skills training was essential during the deinstitutionalization era but is still used today, especially with individuals who have poor social skills and cognitive deficits. In fact, many group cognitive remediation programs for people with cognitive deficits include social skills training.

Cognitive Skills Groups

Along with social skills training, the 1980s were marked by the arrival of more comprehensive assessments of neurocognitive impairments in individuals with schizophrenia. Specific deficits in subtypes of memory or attention were documented, along with deficits in other aspects of executive functioning. A group of clinicians and researchers from Germany developed a stepwise group program, known as *integrated psychological therapy* (IPT), keeping in mind these deficits in order to teach participants how to improve their cognitive skills (Roder, Mueller, Mueser, & Brenner, 2006). Given the perceived importance of these skills for social functioning, the program also included social skills training at the end, as the ultimate skills to master. Initially available in inpatient settings, IPT was offered in groups from two to five times a week for up to 12 months. The program covered basic cognitive skills (e.g., remembering elements on a card), more complex language skills (synonyms and antonyms, or synthesizing information), and more complex social problem-solving. Eventually, it also included more social cognitive elements of emotional recognition and regulation (Roder et al., 2006). The groups focused on learning new skills, not on group processes, and therapists were instructed to offer the information in the most neutral way possible (until they reached the social skills training part). A meta-analysis describes this group intervention as being effective in improving cognitive skills, especially when offered together with skills training, but does not offer evidence that it actually improves functioning (Roder et al., 2006). Although IPT is still offered in various community or outpatient settings today, the authors themselves do not recommend it for people with early psychosis given the length of the treatment.

Since this first cognitive skills group, other groups aiming at improving cognitive skills along with social skills have been developed and studied, with most being offered as an adjunct to individual cognitive remediation, such as computer training (McGurk, Mueser, & Pascaris, 2005) or even attempting to modify cognitive biases that underlie specific psychotic symptoms, using metacognitive training (MCT; Moritz et al., 2011). *Metacognition* here refers to abilities linked to social cognitive skills such as theory of mind, as well as judgment skills such as not jumping to conclusions, or appropriately

determining timelines or attributing causal links in cartoon storyboards, for instance. Such groups offer validated training that in several pilot studies has demonstrated preliminary evidence for its potential for improving metacognitive skills (Moritz et al., 2011). Both MCT and IPT are considered more "training" than "therapy" given that personal problems and goals are not brought up, and group processes are not acknowledged.

Peer-Support Groups

Peer support comes in many formats and has changed greatly over the years (Davidson, Chinman, Sells, & Rowe, 2006). Already in the 1970s, individuals with mental illness living in the community wished to benefit from sharing and meeting with people with similar difficulties. Various groups that aimed at offering support in a nonstigmatizing environment, free of medical staff, were developed and led by people with mental illness, for people with mental illness. Clubhouses, such as Fountain House in New York City, offered groups that met weekly over coffee and snacks. The discussions were often informal, but at times they could address a specific theme, depending on what participants wanted. Today these support groups are usually open, with newcomers always welcome, and time-unlimited. The therapeutic elements in these groups are mostly social support and belonging, given the absence of clear goals or tools. Attendees mention developing friendships, feeling similar to others in the group, and being able to share their experiences without being judged. Peer-support groups are considered useful mostly for social reasons, given that many who attend are otherwise socially isolated. However, the therapeutic value of these groups is limited by the absence of therapists, of goals, and of tools to help with any of the issues that are brought up. For instance, groups for individuals who hear voices exist in a few countries and enable people to share their experience, providing self-help but without offering evidence-based strategies to alleviate the voices or help individuals feel more in control of the voices (although such strategies have been demonstrated in CBT for psychosis, for instance; Wykes, Parr, & Landau, 1999). Similarly, groups based on the Alcoholics Anonymous framework, such as Schizophrenia Anonymous or Dual Diagnosis Anonymous, offer steps to follow and gatherings that help instill hope and help participants feel more connected with others and less lonely, but they do not offer a group therapy context per se and do not really help people deal with their personal issues. As such, peer-support groups that operate in the traditional way (reciprocal relationships, no therapist) are not considered group therapy and have not yielded any specific benefits in studies other than the ones mentioned here. They do, however, offer a setting where participants can meet people with similar issues and potentially make friends.

There is today another form of peer-run therapeutic groups that stems from the recovery movement whereby peers with training and sufficient expertise can become mental health therapists and offer various services, from case management to psychotherapy, including group psychotherapy (Davidson et al., 2006). The peer worker is not