# Implementing Cognitive Behaviour Therapy for Psychosis: Issues and Solutions

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Though services aim at offering psychotherapy for psychosis to those in need, multiple barriers exist to its implementation. Issues pertaining to organizational barriers, limited human resources, insufficiently trained mental health staff, and costs of extensive training are described.

## Introduction

Many countries, notably the UK, are offering Cognitive Behaviour Therapy (CBT) as an evidence-based therapy for symptoms of psychosis. The literature on CBT for psychosis is showing enough strong results, notably the diminution of distress and reduction of delusions and hallucination, to recommend it to be widely offered to persons living with psychosis (Tarrier & Wykes, 2004). But many reasons make it quite difficult to implement CBT in Canada, as well as in other countries. In Canada, these reasons are linked principally to the mental health system's organization and the universities' curriculum for mental health professionals. In the first part of this paper, we will discuss organizational barriers to implement CBT for psychosis and problems with the training of skilled CBT for psychosis therapists in Canada. We will also discuss the therapeutic training of health care professionals and the health reform taking place in part of the country (in the Province of Quebec). The second part will present two solutions to these barriers: The first solution is to suspend the implementation of CBT for psychosis until there are enough competent clinicians trained and there are enough funds to train them. The second solution is to modify and adapt current practices in CBT for psychosis in order to make them applicable by existing mental health clinicians with very little training. The second solution will be discussed extensively since it has been developed and empirically tested by our team in a randomised controlled trial.

## Organizational Barriers to Implementing CBT in Canada

In Canada, health and social services delivery stem from the provincial jurisdiction and offer service universality to all residents, as prescribed, by the Canadian Law on Health Services. Public resources finance most of the services (78 %) with important support from the private sector. Nine percent of the health budget of the Province of Quebec is allocated to mental health services (Fleury & Latimer, 2004). The mental health services continuum of care is organized according to a traditional model including a few psychiatric hospitals, psychiatric and mental health units in general hospitals, and outpatient clinics in hospitals settings or in different parts of the cities. Local mental health services are offered in smaller communities, mostly focusing on first line intervention. The system is linked to generalists and family doctors who can refer clients to the mental services or assume the care of persons living with different types of mental health problems, including psychosis. During the last ten years, case management was introduced to complement the service continuum, but not

everywhere. As far as we know, no case management services specifically offering CBT for psychosis are documented in Canada.

## Limited Human Resources and High Case-Loads

In some parts of Canada, the waiting list for mental health evaluations or treatment is very long. Some settings report months before one can obtain his or her initial appointment. In some cases, such as with individuals presenting a first episode of psychosis, a long wait is proscribed and goes against evidenced-based recommendations (Laporta, 2004). These delays could be explained by limited human resources or by the mental health system's organization.

When a citizen is introduced to the mental health system, outpatient services can be offered on a weekly basis, but more commonly on a monthly basis, and at times at a three months basis for persons with a stable condition. While some individuals might need more intensive levels of services, the demand currently exceeds the offer in the present health organizational system. When it is available, Case management is offered individually with often impressive "case-loads" (35 to 75 clients per case manager). Many clinicians working as case managers also have other duties, such as offering consultations to outpatient specialized clinics (mood disorders clinics, first episode clinics, anxiety disorders clinics, borderline personality disorders clinics, etc.). However, Case management can still be very helpful, especially for clients living in rural settings where clinics are few and located far away. The targets are sometimes clinical, and can include therapy, but generally Case management focuses on social functioning. Case management can be offered within a team-based program, for instance based on the ACT Model (Stein & Santos, 1998). Most of these teams were implemented in the last five years and are linked to mental health services of general hospitals or to psychiatric hospitals (Fleury & Latimer, 2004). ACT programs offer support therapy and skills training for daily activities associated with independent living for persons with severe mental illness (Bond & Drake, 2001). The case loads are different (10 to 20 clients per case manager), but the services are more intensive and offered 24 hours a day, seven days a week. The delivery of ACT program exists throughout the province of Quebec (as well as in other provinces), but only include a very specific clientele. Not intended for every person in need of mental health services, the ACT program is offered exclusively to persons living with severe mental illness who are considered "demanding" on the health system, i.e. they present persistent symptoms as well as other problems (such as homelessness, substance abuse, personality disorders) and count for less than 5 % of the population living with psychosis (Bond & Drake, 2001). Even if ACT case managers were to be trained in and deliver CBT for psychosis, very few clients would have access to it.

On the other hand, outpatient mental health clinics have very large case loads. Though individual interventions are the common way of delivering services, few structured or evidenced-based therapies are being offered. Only specialized clinics, such as mood disorders clinics or first episode clinics, offer group interventions or specific therapies like CBT for psychosis. Medication is widely available and covered by government insurance. Therapy, however, is not always offered by community teams, and when it is offered, it mostly consists of supportive therapy.

## Insufficiently Trained Staff

In Canada none of the mental health disciplines (psychiatry, psychology, nursing, social work, occupational therapy) offering services and therapy to persons living with psychosis receive specific training in CBT for psychosis during their curriculum. Some psychologists can choose to be trained in CBT during their graduate studies (instead of humanistic or psychodynamic therapy for instance),

but the therapy is intended for people with anxiety or mood disorders, not with severe mental illness. Other disciplines are trained to work with individuals with psychosis, but they are trained in a conceptual framework inspired by humanistic therapy (Rogers) and mostly offer support therapy individually, or in a family context. In the late-80's, many mental health workers were trained in social skills training, and have therefore learned some principles of behaviour therapy, though few settings still offer these interventions. Contrary to the UK situation, in Canada there are very few psychologists hired within mental health teams working with individuals with psychosis. It is, however, possible to find some psychologists in front line intervention teams and in psychiatric departments. Still, their number is small and insufficient to offer CBT for psychosis to most of the clients who need it. The situation is quite similar in the US, with a recent compilation revealing CBT for psychosis being offered in a total of 12 settings in the country, many of those being private office settings[1]. The vast majority of psychologists in Canada can be found in private practice, and their services are only covered for clients with specific insurances. Individuals with severe mental illness rarely benefit from such employer-related insurances, and few can afford to seek therapy with a psychologist in private practice.

Furthermore, specific restrictions are now in place regarding who can deliver psychotherapy. In the Province of Quebec, for instance, a new definition of psychotherapy has been determined by the Office of Professions since 2006 and demands that psychotherapeutic training be introduced at graduate levels, not before, for all mental health disciplines in years to come. Actually, mental health clinicians receive very little continuing education following their degree. While some mental health professionals continue to graduate levels of training, most do not pursue any specialization or get any specific therapy training. The proximity of a university is however linked to staff specialization, with the three biggest cities in Canada (Montreal, Toronto and Vancouver) having the highest percentage of clinicians from nursing, social work and occupational therapy trained at graduate levels.

## Extensive Training and Resources

With few training opportunities offered by employers, extensive therapy training for clinicians is seen as almost impossible. High caseloads and minimal human resources have to be taken into account whenever a workshop or training is planned, since managers need to pay the clinicians attending the training, pay for their replacement in order to insure continuity of care, and pay the instructors or the institute offering the training. Every training day is costly, and managers are constantly dealing with cuts in their functioning budgets, limiting possibilities of offering expensive trainings to mental health workers. At times, even planned workshops get annulled because of the impossibility to cover for the missing clinicians, and the importance of their caseloads. Though managers wish to offer evidenced-based trainings to their staff, they are often restricted by the reasons mentioned above and can only offer very brief mandatory conferences on legal or professional issues.

Fleury and Latimer (2004) suggest certain organizational transformations needed at micro and macro levels in order to implement new interventions and treatments, and mention that working on only one level rarely suffices. Another reality factor is that though work is being done at the organizational level to improve services, human resources are currently suffering from the departure of experienced clinicians (from the baby boomers generation) eligible to for retirement. New clinicians fresh from universities are not yet trained to intervene therapeutically with persons living with psychosis. At this point in time, it is seen as almost impossible by various stakeholders to increase

[1]Id="fag-lecomte-59"> Compilation by Jennifer Gottlieb, Boston, MA

the intensity of mental health services offered, by offering CBT for psychosis for instance, because of limited human resources and the insufficient number of trained clinicians in CBT for psychosis. Given the current situation, how can Canada comply with the best practices guidelines and offer CBT for psychosis to all those needing it?

## Implementing CBT for Psychosis: Two Solutions

Given the situation described above in Canadian settings, which is very close to the one found in most North American settings, two potential solutions emerge. *The first solution* is to suspend the implementation of CBT for psychosis until there are enough competent clinicians trained and there are enough funds to train them. This implies putting pressure on government, particularly the health ministry, in order to assure the appropriate financing of clinicians able to deliver CBT for psychosis. If the clinicians targeted are psychologists, practicums and courses in psychology departments for psychology graduates need to be developed and offered. Such courses and training curriculums have been in place in the UK for many years, but only exist in a handful of places in North America. Of the places offering any type of training for psychologists interested in working with the severely mentally ill, few have specific CBT components or have only recently started to offer it. To date, in North America, most psychologists trained in CBT for psychosis are self-trained, i.e. they took the initiative themselves to seek training with experts in the field or had previous training in CBT with other types of pathologies and learned how to translate their knowledge to individuals with psychosis. The strategy of training future psychologists in CBT for psychosis is worthy, but implies many years before having enough trained individuals, particularly given the number of years necessary to become a certified psychologist and the limited number of students accepted in graduate clinical psychology programs.

Another strategy involves training clinicians already working with individuals with psychosis, particularly psychiatric nurses, in delivering individual CBT for psychosis. This has been done in the UK with positive results (Durham et al., 2003) where selected nurses completed a one-year course of one-day a year (such as the Oxford course), with added supervision, part-time for two-years (Southampton's MSc program) or full-time one-year program (Institute of Psychiatry – King's College, London) in CBT for psychosis. The problem of funds arise here again, since sending nurses away for training for as many days is in most settings impossible. In the US, the Beck Institute offers a similar concept of intensive in person short-term CBT training with long-term supervision (by sending tapes) for people other than psychologists, but the workshop covers multiple pathologies, not just psychosis, and is again very costly both in terms of covering for the absentees and for sending the person to the workshop.

In terms of pushing the government to improve funds in order to pay for training more clinicians in evidenced-based practices, such as CBT, such initiatives have been ongoing for years with little or fluctuating success (Mueser, Torrey, Lynde, Singer, & Drake, 2003). Associations of parents and friends of schizophrenia can have some power, mostly on community mental health resources by pressuring them in spending part of their continuing education funds on talks pertaining to CBT for psychosis for instance, rather than only on new medication updates. However, successes at a larger level are few and disperse, and vary according to the elected party in place with new initiatives being shut down when a more conservative government takes power.

*The second solution* is to modify and adapt current practices in CBT for psychosis in order to make them applicable by existing mental health clinicians with very little training. The idea here is to ensure that as many people as possible needing to receive CBT for psychosis have access to it,

rather than simply treating the select few who can be seen by the experts or than waiting for more experts or more funds. This solution implies modifying the typical CBT for psychosis approach in order for it to be better adapted to the reality of the community mental health clinicians. Our team has developed several strategies in this regard, with the most important ones being: 1) offering a structured manual; 2) delivering CBT for psychosis in a group format; 3) training clinicians in an active and brief workshop; 4) encouraging colleague-to-colleague supervision.

## 1) Offering a Structured Manual

Many CBT therapists quickly oppose the use of a structured manual, stating that the best way of delivering CBT is with an individualized formulation of the client's problems (Fowler, Garety, & Kuipers, 1995; Morrison, 2002; Morrison, Renton, Dunn, Williams, & Bentall, 2004). The formulation is the working hypothesis explaining the person's difficulties. It typically considers the individual's history, the stress-vulnerability model, as well as the triggering events, the related beliefs and the emotional and behavioural consequences of the beliefs (Kingdon & Turkington, 2005). When possible it also attempts to include the core beliefs (which are not always apparent early in therapy and might not be acknowledged by the client). Though the relationship is a collaborative one, the formulation is often written up and presented by the therapist to the client who accepts it or not. The idea is to offer a workable model of the client's difficulties, instead of the original explanation the person had for his or her difficulties. Though a manual does not offer the same flexibility as an individual formulation-based CBT intervention, it does not necessarily mean that the treatment can not also be individualized and include most elements of the formulation. In fact, a manualized CBT intervention is nothing like the more traditional manuals for skills training where each sentence and each clinician intervention were dictated. In fact, the purpose of the manual is to serve as a guide to the clinician, making sure that a certain pace is respected (i.e. so that clinicians don't go too fast) and that specific themes, judged to be relevant for many individuals struggling with psychosis, are addressed.

For instance, most CBT for psychosis therapists agree that the first phase of the treatment involves assessments and non-threatening interactions in order to develop a therapeutic alliance, without which no treatment is possible (Kingdon & Turkington, 2005; T. Lecomte & Lecomte, 2002). During this phase the therapist inquires about the person's difficulties, gathers as much information as possible, and tries to understand the individual's explanation of these difficulties. Only after this phase is the formulation developed and presented to the client. With the manual we developed (T. Lecomte, Leclerc, & Wykes, 2001), the same phase is found but is broken down in specific sessions. For instance, the first session aims to simply introduce each other and ask where the clients are from, what they like to do, and what they are good at (therapists also actively participate and share their answers). The second session introduces the concept of stress, and clients are asked to rate their emotional, physical and behavioural reactions to stress. The third session addresses events, people, places and situations that might induce a stress-reaction, and clients need to determine what stressors they are particularly sensitive to. By the fourth session, the clients are asked to describe their first hospitalization or their first encounter with a psychiatrist, and explain what they had experienced and how they explain what happened. By the fifth session, the stress-vulnerability-competence model (see Figure 1) is introduced and personalized. This is considered the first part of the formulation since clients accept to consider another model than their own to explain their difficulties. By writing down their specific vulnerabilities, their stressors and their emotional and behavioural consequences of the interaction between the stressors and the vulnerability, the clients make the model their own. The model involves the "competence" part, which relates to the protective factors the person might have that can, for

instance, act as a shield against fluctuations in stress levels. This is by far the preferred part of the model because the concept of protective factors involves a certain sense of power and control. The clients discover that they can actively work on building more and better protective factors, whereas they can not easily control their vulnerability or the stress in their lives. Many of the protective factors are in fact addressed in the CBT manual, and the clients are informed that they will be working on these during the following sessions.

**Figure 1.** *Stress–vulnerability–competence model (Ventura, Neuchterlein, Subotnik, & Hwang, 2002)*

The individual formulation can also be found at other moments in the manual, particularly at session seven when the A–B–Cs of CBT are explained (i.e. that a Belief is triggered by an Antecedent (situation) and will lead to a Consequence, both emotional and behavioural, which in turn can loop back to sustain the belief and impact the situation). By understanding these links, the clients then learn how they apply to their own beliefs and how changing their beliefs could change how they react to situations. Various exercises are used in order to reflect this link; some involving watching a movie excerpt, generating multiple possibilities of beliefs for situations not applying to oneself and determining what the Consequences would be, and applying it to their own lives. An example of one of the exercises is found in Figure 2. Throughout the sessions, clients are referred back to the vulnerability-stress-competence model as well as to the A-B-Cs for their distressing thoughts, when introducing concepts such as normalization, seeking alternatives for ones' beliefs, modifying negative attributions, investigating the facts, and developing a bigger and better repertoire of cognitive and behavioural coping skills. A detailed description of the 24 sessions covered in the manual has been published elsewhere (T. Lecomte, Leclerc, Wykes, & Lecomte, 2003).

**Figure 2.** *A–B–Cs of CBT exercise*

One of the biggest advantages of using a manual is to force a certain pace. Eager and briefly trained clinicians might be tempted to "jump right in" and try to modify dysfunctional beliefs from the start, without really taking the time to build the alliance and really understanding the issues at stake. By forcing a specific pace (one theme per session, with specific open-ended questions suggested to engage the clients), therapists see the effects of incremental learning while not addressing difficult issues too quickly. Even highly trained CBT therapists can at times make *faux pas* by challenging a belief without fully understanding its protective function and thus causing a break in the alliance, not to mention sometimes negatively impacting the client's self-esteem. An example of this would be trying to get a client to find alternatives for his having super powers' – most grandiose beliefs have a protective value (without the belief the person likely feels worthless), especially if the client does not express being distressed by these powers. Where it gets more complicated is when distress is being mentioned, but the belief still has a protective function, and without it the distress would be even greater. One such example is described as Mrs Y.

> Mrs Y was 65 years old. She had been hospitalized many times, and at times for many months. She was now living independently in an apartment. Her son had cut contact with her and she did not have any friends or family. Mrs Y was constantly calling the police, her landlord, even purchasing surveillance equipment because she was convinced doctors from the hospital nearby were entering her apartment by night and were stealing her internal

organs. Her therapist tried by every possible means to "prove" to her, by watching her surveillance tapes and showing her she had no scars, that this could not be true. Mrs Y was extremely worried and firmly believed she was robbed of her organs at night. Once she agreed to participate in a CBT group, she refused to consider seeking alternatives for her belief, but she mentioned, in the self-esteem activity, being good at bridge (card game). At that point, her therapist realized that her fear of being robbed could be linked to feeling lonely and that believing she was "worth something inside" – enough that people would go through major efforts to rob her was in fact protective. She was told by other group members that free Bridge evenings were being held at a nearby community center. She started attending, felt very proud of her game and eventually made friends. Her distress related to being robbed of her internal organs diminished at the same time, and she eventually stopped calling the police and mentioning anything to her caseworker about it.

Pace is not only related to speed but to content. Some issues, such as distressing beliefs, suicidal thoughts, substance use or abuse, can be difficult to address and might deter clients from continuing the therapy if they feel that the sessions are emotionally too difficult. One way to avoid such an outcome is to alternate more difficult sessions with positive uplifting sessions on self-esteem. These self-esteem sessions are not perceived as "out-of-the-blue" since self-esteem is considered an important protective factor (see figure 1) and clients truly enjoy those sessions. Apart from their hedonistic properties, working on improving self-esteem is essential for individuals with psychosis for many reasons. Not only is poor self-esteem often linked to the core beliefs (as with Mrs Y), studies have linked low or unstable self-esteem to psychotic symptoms (Garety, Kuipers, Fowler, Freeman, & Bebbington, 2001), namely to paranoia (Bentall, Corcoran, Howard, Blackwood, & Kinderman, 2001) as well as to poor social functioning (Brekke, Levin, Wolkon, Sobel, & Slade, 1993). Furthermore, studies have shown that CBT-type interventions addressing self-esteem can have positive impacts with this clientele (Hall & Tarrier, 2003; C. Lecomte & Lecomte, 1999). In the CBT manual, self-esteem is tackled in various ways: by setting weekly personal goals, determining positive qualities and values, modifying attributions to become more optimistic in life, and by discovering one's competence in coping with various thoughts, voices or stressors. The manual also allows the clinician to introduce various CBT techniques at the appropriate time.

A lot has been written on the CBT techniques, how to use them, their efficacy, etc. (McMullin, 2000), with the negative consequence that many clinicians might see them as the effective ingredients that can be used at random, or at any given moment of the therapy (T. Lecomte & Lecomte, 2002). Yet, as experienced CBT for psychosis therapists know, the techniques are carefully selected and are only appropriate in specific contexts and only once the therapeutic relationship has been consolidated. A manual-based intervention can in fact help the less-knowledgeable clinician in using appropriate techniques at appropriate moments. For instance, normalization is introduced earlier on whereas seeking alternatives or checking the facts come later, and exploring coping strategies and developing a staying well-plan (i.e. relapse prevention) are discussed toward the end of the therapy. Even though earlier CBT techniques can be used at later sessions, the clinician is informed not to use a technique that has not yet been introduced in the manual.

An undeniable clinical advantage of using a manual, especially with clients presenting with paranoia, is the safety it procures. Our manual is meant to be used by the clinician as well as the clients. The theme of each session being predetermined, the clients can see what is coming and they can feel reassured that they won't be tricked into discussing issues they would rather not

address. Along with the stable structure of the sessions (fixed day, time, etc), the manual becomes something clients can rely on, and is theirs to keep and bring home either to complete their homework assignments or to refer back to once the therapy is over. In the study that we recently completed with individuals with a first episode of psychosis, the use of the manual was mentioned by many as one of the preferred aspects of the intervention, along with learning from the other group members (Spidel, Lecomte, & Leclerc, 2006).

## 2) Delivering CBT for Psychosis in a Group Format

More and more researchers and clinicians see the value of a group format for delivering CBT for psychosis. Though to date no large-scale study has compared the results of individual CBT and group CBT, the studied CBT for psychosis group interventions all mention positive effects. In San Diego, Granholm and colleagues developed a skills training/CBT approach for older individuals with psychosis and obtained decreases in negative symptoms and increase in functioning (Granholm et al., 2005). In the UK, Wykes obtained improvements in coping with voices as well as increased self-esteem (Wykes, Parr, & Landau, 1999), whereas Landa's study in New York (not yet published) demonstrated specific impact on paranoid delusions for those attending her group. Our group has recently terminated a randomized controlled trial comparing a CBT group to group Skills Training for first episodes and have found positive results in terms of symptom reduction, self-esteem and social support (manuscript in preparation).Though the group CBT for psychosis intervention was initially designed for individuals with a first episode of psychosis (T. Lecomte et al., 2003), clinicians in the community believed that individuals with a longer course of the illness could also benefit. Indeed, many CBT groups, using the proposed manual, have been conducted outside of our study with older clients and have also obtained positive results. To implement CBT for psychosis in a group format is also more feasible in a Canadian setting than the one-to-one model found in most UK CBT studies. One of the main reasons is that fewer therapists are needed to offer CBT to more individuals. Typically, a group includes between four and eight participants for two clinicians for a period of five to twelve weeks. Individual therapy length varies from case to case, but often aims at lasting close to nine months and, in order to treat many clients, necessitates much more clinician time. Group therapy, on the other hand, can have beneficial effects from as little as three months, when for instance offered twice a week (T. Lecomte et al., 2003).

Another big advantage of group interventions is the normalization aspect. One of the important steps in conducting CBT for psychosis is to help clients feel less alienated by normalizing their experience, i.e. making them realize that other people have had similar experiences (Kingdon & Turkington, 2005). Though examples of grief, lack of sleep, and sensory deprivation can be used in CBT to illustrate this concept, the sharing of other's experience in group therapy is a much stronger tool to increase normalization. The group format also allows us to work on one of the most prevalent consequences of psychosis: social isolation. Social isolation, either being linked to social anxiety (Lysaker & Hammersley, 2006), paranoia (Huppert & Smith, 2005), feelings of social incompetence (Couture, Penn, & Roberts, 2006), or to stigma linked to having a mental illness (Birchwood et al., 2006), has severe consequences on the individual's integration in society. A group intervention offers the opportunity to interact with others in a safe and non-judgemental setting, and therefore to practice social skills and even create friendships. Group cohesion typically takes around six to eight sessions to build, and translates into feelings of belonging, sympathy and empathy for each other, as well as between-client invitations for recreational activities outside of group times (Spidel et al., 2006). In a CBT context, the group participants can also help each other by suggesting alternatives

to others' beliefs, or by trying each other's coping strategies. In fact, the group approach is much less demanding on therapists because the participants are active therapeutic agents, somewhat like co-therapists, who suggest, use and propose CBT techniques for the other participants to use during the sessions. Therefore the training involved for clinicians wishing to conduct group CBT, in comparison to individual CBT for psychosis, can be much briefer, especially when the group intervention follows a manual.

## 3) Training Clinicians in an Active and Brief Workshop

The format a workshop takes can greatly influence the retention and actual practice of the information. According to studies in education, most people have an attention span of a maximum of 15–20 minutes and typically retain only 30 % of information given in a traditional classroom format. This is mostly true when the material presented is mostly didactic, rather than interactive, and when the teaching does not involve any actual "in vivo" practice. Our team has developed an active, brief and intensive training program in group CBT for psychosis that has demonstrated positive results in terms of actual application of the skills learned. The training was developed with two goals in mind: being brief enough that most mental health workers could attend, and offering a canvas that closely resembles what running a group looks like.

The first goal was in response to demands from psychiatric hospital clinical directors and regional health authorities asking for CBT for psychosis workshops lasting no more than three days. This constraint was financial and managerial, since freeing up clinician time to attend workshops involved rescheduling clients, work accumulating during the person's absence, and hiring temporary staff to fill in for the absentees. Three days, and at times even two days, was the most that settings could manage. The three-day format involves one day of theoretical information, made interactive with small group discussions, case examples, and questions to the group throughout the day, and two days of role-plays with direct supervision. The content covers principles of recovery, principles and rules of group therapy, the basics of CBT for psychosis, and concrete applications of the most common CBT for psychosis techniques in a group setting. Some research results as well as guidelines for supervision (explained later) are also covered. The two-day format is more challenging since we ask the attendees to familiarize themselves with the CBT for psychosis model by reading selected book chapters, and to have previously read the group manual before coming to the workshop. Without this preparation phase, the attendees would not be able to actively participate in a two-day version of the workshop. Though we also recommend the same readings for the three-day version, more time is reserved to review concepts and answer conceptual, theoretical, clinical, and empirical questions.

The second goal stems from the first one, in that for a brief workshop to be effective learning on multiple levels is targeted, and more than one teaching method needs to be used. Three levels of knowledge need to be targeted in order to promote real change: Know (i.e. the actual content or conceptual information given), Know-How (specific skills learned and applied), and Know-How-To-Be (implies adopting the values and philosophy of the approach) (C. Lecomte, 2006). The Know is the focus of most traditional workshops and is easily offered through visual presentations (such as Powerpoint) and recommended readings. The main strategy that we have developed for the Know-How is to offer the workshop in a manner that resembles an actual CBT group. The workshop itself is somewhat the canvas that participants can model themselves on. The co-trainers work together in the same way that the co-therapists would interact within the group; and the attendees are asked to participate throughout the workshop in a manner similar to what they would do in a CBT group. The group format was developed to be delivered by two co-therapists working together, alternating

between being the leading therapist and the assisting therapist. In fact, we strongly recommend that therapists chose co-therapists with complementary strengths and qualities and of different gender, in order to build an alliance with as many participants as possible. The group is also designed to be pleasurable, even if the topics addressed can at times be difficult, and therefore the workshop is also an enjoyable learning experience. Each attendee is asked to participate in multiple role-plays, either as a co-therapist or a group participant, in order to learn how to concretely apply the skills being learned. Attendees working in pairs are asked to prepare a session, by reading through the manual and using the information presented to them, and to perform part of the session in front of the entire group of attendees, with a small group of them role-playing clients. Attendees are supervised during their preparation for the session, during their session (when needed if they seem to be diverging from the content or goal) and after their role-play. Positive and constructive feed-back is offered immediately and, at times, the practicing co-therapists are asked to start over if an element was missed or off-target. All of the attendees get to role-play being a co-therapist at least once. The sessions chosen to be role-played are the ones judged to be the most challenging or difficult, in order to ensure that things go as well as possible in real-world settings. As much as this might appear stress-inducing for the workshop attendees before doing their first role-play, they actually really appreciate this learning strategy in part because it allows them to apply the skills, but also because it is done in a respectful and competence-inducing manner.

Throughout the workshop, a strong emphasis is attributed to the Know-How-To-Be aspect of knowledge. The role of the therapist as a collaborator and facilitator rather than as an expert, and the importance of trying to understand the clients rather than trying to change them, reflects the importance of a certain set of values and philosophy underlying CBT for psychosis. This philosophy shift is discussed, often with much energy from nursing personnel (as well as others) who were initially trained to avoid addressing psychotic symptoms directly, or were taught to help by doing for them' or finding solutions for the clients as quickly as possible instead of respecting the clients' pace and helping them find their own answers. Know-How-To-Be is also developed by encouraging workshop attendees to practice what they preach, i.e. to learn to identify stress in their lives and their own vulnerabilities, to use coping strategies, to be authentic (i.e. act the same "in and out" of the therapy), to recognize their strengths as therapists in order to build on them, and to realize the areas they need to further develop. All of these aspects, along with the feed-back given following the role-plays, help the therapists develop a sense of competence that will enable them to conduct CBT groups following the workshop. Specific strategies to help further develop competence, such as supervision, are also discussed.

## 4) Colleague-to-Colleague Supervision

In order to maintain and further develop competence as a CBT group therapist for psychosis, practice as well as supervision is necessary. Issues pertaining to qualified therapists able to deliver supervision are similar to those mentioned earlier, namely that there are not enough competent, available and affordable therapists able to offer CBT for psychosis supervision to all who would need it. The solution we recommend is to encourage colleague-to-colleague supervision. Given that most mental health workers in a given setting will have received the workshop, and that each one will have retained specific information from that workshop, will have practiced conducting a specific session, and will have specific strengths; each mental health worker should therefore be able to bring constructive feed-back to those running the CBT groups. We recommend that sessions be videotaped and that these tapes be shown (at least in part) for instance at a weekly lunch-meeting. The level of stress involved

in being exposed as a therapist in front of colleagues is diminished by the fact that everyone has already had to role-play a session in front of colleagues during the workshop, and therefore everyone understands the stress involved and the importance of giving positive as well as constructive feed-back. We have found that this formula works in fact very well, particularly paired with occasional refresher workshops or sporadic external supervision. For instance, some clinical settings asked for a one-day workshop on specific questions that arouse during the groups, one year after the initial workshop, whereas others have asked for a two-hour consultation to be reassured in their supervision and group process, though everything was going great. We realized that people are more accustomed to being supervised by "experts" and to supervise each other is unsettling, partly because we suggest that they have the necessary competence. With the group therapy, mental health workers are taught to jump in' with a clear structure, basic knowledge, and previous preparation, but also learn that true competence only develops with experience, self-reflection, integrating feed-back and learning from successes and mistakes. The same guidelines apply for supervision, with the added importance of accepting that running CBT groups for psychosis might not be for everyone. Following the workshop, mental health clinicians are typically able to recognize if they have the necessary Know, Know-How, and Know-How-To-Be in order to run CBT for psychosis groups. In some cases, clinical directors have asked us to give them the names of those most likely to succeed immediately in running a group, i.e. to become team champions' and get the ball rolling. Once the first groups are done, the "champion" therapists with one group under their belt often start groups with other therapists, who will then go one to run groups with others, and so on.

## Preliminary Results

We haven't yet specifically studied the long-term impact of the group CBT for psychosis workshop, but we have managed to obtain certain information from the various clinicians that we have trained. For one, we have found that the clinicians trained in the context of the randomized controlled trial that we conducted in order to verify the efficacy of the group CBT intervention were able to follow the structure and guidelines provided and essentially delivered the intervention as planned. Since all of the sessions were videotaped, it was possible to determine the therapists' fidelity to the treatment protocol by having two independent raters watch 50 % of all the sessions and code the therapists according to a revised version (i.e. applicable to group CBT) of the *Cognitive Therapy Scale* (Young & Beck, 1980). In fact, therapists' fidelity to CBT averaged 80 %, with the most typical omission being forgetting to reinstate the goal of each session at the beginning.

Outside of the trial, more than one hundred mental health workers with diplomas in occupational therapy, nursing, psychology, psychiatry, and social work, from two Canadian provinces (Quebec and British Columbia) and another thirty from the UK have so far participated in our workshop. Feedback provided by the clinical directors who hired us suggest that around one third of the trained mental health workers will go on to run groups in a near future, with the others either integrating some of the elements of the philosophy or techniques in their clinical practice, or not really applying any of it but feeling they gained a greater understanding of how CBT for psychosis works. Our team is in the process of developing a study to determine the short-term and long-term effects of the CBT workshop on clinical competence, and actual application of the intervention.

Many settings have chosen to purchase the manual alone, without the workshop, often because at least one clinician had previous CBT and group experiences. The group CBT for psychosis manual is therefore available in multiple countries (as well as in various cities within certain countries), such as Finland, Germany, Australia, New Zealand, Canada, the USA, and the UK. The group manual's

popularity stems from the fact that it is not only user-friendly but has demonstrated its efficacy within a randomized-controlled trial, with positive results above and beyond the control conditions (manuscript in preparation). As such, the American Psychological Association's Task Force on Severe Mental Illness has developed a *Training Grid Outlining Best Practices for Recovery and Improved Outcomes for People with Serious Mental Illness*, and has listed our group CBT for psychosis manual among the suggested best practices' (APA, 2004).

## Conclusion

CBT for psychosis has demonstrated its effects in multiple studies and needs to be made accessible to the clients wishing for this intervention. However, the political reality in North American settings is that few funds are reserved for health, and even fewer are geared toward mental health, with direct consequences on the delivery of new interventions needing specific training, such as CBT. Two solutions emerged: to wait for more funds and for more people trained within academic settings before implementing CBT for psychosis in the community, or to modify the approach, while still respecting its philosophy, in order for CBT to be made accessible quickly to those needing it. In this paper we have tried to describe the importance of working on the first solution, i.e. to encourage training in academic settings and to push for more governmental funds, while applying the second solution and offering a CBT for psychosis structure, format, and workshop applicable to the current clinical reality in North America. The proposed group CBT for psychosis approach does not replace individual CBT given by an expert therapist, but could be considered a good compromise considering the present context, or even an adjunct to individual therapy. It also has many advantages, including increased socialization, a structured manual that clients can keep, and brief training for therapists, that the individual format does not offer. Furthermore, we anticipate the eventual training and inclusion of former group CBT "graduates" as co-therapists. A peer-co-therapist could help clients in their recovery by being somewhat of a role-model, as well as by having shared similar experiences and by having a thorough understanding of many issues raised by clients. The group CBT approach could very well include such peer-co-therapists, who could be hired specifically for that position.

The proposed group CBT for psychosis can also be used as a platform for other interventions. For instance, after having completed the 24 sessions proposed, some participants wished to work on specific issues linked to intimacy and received eight sessions, using the CBT techniques they were already familiar with (Leclerc, Gauvin, & Lecomte, 2006). Other issues that might need more attention than what is offered in the manual could include dealing with substance abuse problems, low self-esteem, or difficulties in stress management; all of which could be offered as extra sessions using similar CBT techniques and concepts. The group CBT for psychosis format has also been modified to be offered in a brief inpatient setting and will be adapted for forensic settings shortly. Another project is to modify it to be offered within supported employment services. Though more studies are warranted in order to determine the effectiveness and efficacy of the group CBT in various settings, we believe that the proposed CBT intervention can easily and successfully be implemented in existing mental health services in North America, and perhaps in other countries as well.

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## Key publications

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Multiple studies support the use of Cognitive Behaviour Therapy (CBT) for psychosis and reommend its implementation. Though services in the UK aim at offering CBT for psychosis to those in need, multiple barriers exist to its implementation in Canada, and likely in other countries as well. Issues pertaining to organizational barriers, limited human resources, insufficiently trained men-tal health staff, and costs of extensive training are described. Two potential solutions are offered: 1) to suspend

the implementation of CBT for psychosis until more people are trained through academic settings while demanding more funds from the government, or 2) modify the CBT approach for it to be adapted to the current mental health system's reality. A thorough description of the second solution, including the use of a structured manual, delivering CBT for psychosis in a group format, training clinicians in an active and brief workshop, and encouraging colleague-to-colleague supervision are discussed.

Keywords**:** psychosis, cognitive behaviour therapy, implementation, training, mental health systems