

# Supportive Therapy for Schizophrenia: Possible Mechanisms and Implications for Adjunctive Psychosocial Treatments

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## Abstract

**This article posits that the positive findings for supportive therapy (ST) in recent trials may indicate an important but undervalued aspect of psychosocial interventions for schizophrenia. In developing this thesis, we consider the possible mechanisms underlying the beneficial effects of ST observed in recent trials of cognitive behavioral therapy for schizophrenia. We place this evidence in the context of a review of psychological models of mental health, the therapeutic alliance, and research on social cognition and social support in schizophrenia. We conclude this article by describing a new theoretically driven intervention for schizophrenia, functional cognitive-behavioral therapy (FCBT), which improves functional outcomes by integrating evidence-based advances in cognitive behavioral therapy with the strengths of ST approaches.**

**Keywords:** Schizophrenia, psychosocial treatment, supportive therapy, cognitive behavioral therapy.

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In this article, we suggest that considering the mechanisms underlying the beneficial effects of ST may result in more effective individual treatment for schizophrenia. Although evidence for the efficacy of ST for schizophrenia is not overwhelming (Mueser and Berenbaum 1990; Fenton 2000), many researchers believe that aspects of ST, such as the therapeutic alliance, the provision of support and advice, and efforts to minimize stress, may be beneficial in their own right (Coursey 1989; Weiden and Havens 1994; Buckley and Lys 1996; Fenton 2000). Although the potential merit of ST for schizophrenia has been previously discussed (Coursey 1989; Weiden and Havens, 1994; Buckley and Lys 1996; Fenton 2000), we suggest that incorporating lessons learned from ST may strengthen the effect of cognitive-behavioral therapy (CBT) on schizophrenia.

We begin with a review of recent research on ST, which indicates unexpected, positive ST effects for people with schizophrenia. We next consider the possible mechanisms underlying these effects. We conclude by introducing a new cognitive-behavioral approach to schizophrenia, functional cognitive-behavioral therapy (FCBT), which seeks to enhance adaptive functioning through cognitive-behavioral techniques as well as ST.

## Psychosocial Treatment for People With Schizophrenia

Individuals with schizophrenia have significantly impaired social, vocational, and self-care functioning. These impairments, which can militate against full recovery and reintegration into the community, demand optimal outpatient care. The front line of outpatient care is pharmacological treatment, which has been shown to reduce symptoms and relapse rates in people with schizophrenia (Ayuso-Guiterrez and del Rio 1997). Despite the beneficial effects of neuroleptics, however, pharmacological treatment alone presents a number of limitations (Hogarty and Ulrich 1998). First, suboptimal adherence to medication occurs in 45 to 60 percent of outpatients (Fenton et al. 1997). Second, persistent residual positive symptoms are apparent in 25 to 50 percent of those with schizophrenia, even with optimal medication (Kane and Marder 1993; Pantelis and Barnes 1996; Wiersma et al. 1998). Third, little evidence suggests that neuroleptic medication alone significantly improves social functioning, which is one of the strongest predictors of current functioning and long-term outcome in schizophrenia (Baum and Walker 1995; Halford and Hayes 1995; Macdonald et al. 1998; Amminger et al. 1999). Adjunctive psychosocial interven-

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tions have therefore emerged as important components in the comprehensive treatment of schizophrenia.

Because of schizophrenia's pervasive effects on daily functioning, an array of psychosocial approaches has been developed to improve adjustment. Some approaches provide services to clients in the community to increase monitoring of illness, adherence to medication, and address basic living needs (i.e., Assertive Community Treatment [ACT] and supported employment); others focus on improving specific skills (i.e., cognitive remediation and social skills training). In general, empirical support exists for ACT, family psychoeducation, social skills training, and supported employment (Mojatbai et al. 1998; Mueser et al. 1998; Birchwood 1999; Garety et al. 2000; Heinssen et al. 2000; Huxley et al. 2000; Mueser and Bond 2000; Bustillo et al. 2001). Therefore, a number of psychosocial interventions have shown positive effects on relapse rate, symptoms, employment, and social impairments.

Recently, researchers have shown renewed interest in more "traditional" forms of psychotherapy for those with schizophrenia. Unlike earlier unsuccessful attempts at psychodynamic treatment for schizophrenia (Mueser and Berenbaum 1990; however, see Alanen et al. 2000), most current approaches are rooted in cognitive-behavioral models (Garety et al. 2000). These individual approaches can be divided into those that focus predominantly on affect regulation and personal/social adjustment, such as Personal Therapy (PT; Hogarty et al. 1995), and those that emphasize symptom remission as a primary goal, such as CBT for psychosis (Garety et al. 2000).

PT was developed to help stave off relapse in people with chronic schizophrenia, particularly during the second year of recovery following a relapse (Hogarty et al. 1995). PT seeks to enhance personal and social adjustment by improving patients' affect-regulation skills and their recognition of the sources and signs of stress. Results of a 3-year trial of PT for people with schizophrenia showed that, compared with family and supportive therapies, PT reduced relapse rates for those living with families but not for those living independently (Hogarty et al. 1997b) and had generally stronger effects on social adjustment by the second year of treatment (Hogarty et al. 1997a). These findings suggest that PT may be a promising approach for improving adjustment in people with schizophrenia.

Cognitive-behavioral approaches for addressing residual, distressing symptoms are varied, ranging from those that rely primarily on cognitive interventions (Chadwick et al. 1996) to those that are more behavioral in orientation (Tarrier 1992). Although these approaches differ in their place on the cognitive-behavioral continuum, most share a number of common goals (Fowler et al. 1995): reducing the distress and disability associated with residual symptoms, reducing emotional concerns, and promoting an understanding of the illness to reduce

relapse. CBT for residual symptoms places less emphasis on social adjustment and quality of life than does PT.

Reviews of the literature indicate that CBT can reduce residual positive symptoms in both inpatients and outpatients with schizophrenia (Bouchard, et al. 1996; Haddock et al. 1998; Norman and Townsend 1999; Dickerson 2000; Garety et al. 2000; Gould et al. 2001). However, this reduction is less pronounced when CBT is compared with alternative interventions, such as supportive counseling, rather than treatment as usual (Garety et al. 2000). A discussion of CBT studies that have included an active comparison intervention follows.

**CBT Versus Alternative Interventions.** Drury and colleagues (1996a, 1996b) compared CBT with recreational therapy for people in the acute phase of psychosis. The findings showed an advantage for CBT in positive symptoms, recovery from symptoms, and reduced hospital stays (Drury et al. 1996a, 1996b). However, no significant differences between groups were present at the 5-year followup. An advantage for CBT was observable only among a subgroup of patients who experienced a maximum of one relapse in the followup period (Drury et al. 2000). Unfortunately, a lack of adequate experimental blinding compromised this study's internal validity. In addition, the CBT comprised individual, family, and group formats, which obfuscates the active treatment ingredients.

Pinto et al. (1999) compared CBT plus social skills training with ST in people receiving clozapine for treatment-refractory schizophrenia. The ST included "psychoeducation, active listening, empathy, crisis management, reinforcement of the client's health seeking behaviors, and advocacy" (p. 902). The results showed that no subjects from either group relapsed and that no significant group differences in negative symptoms emerged. Although positive symptoms improved in both groups, the group receiving CBT showed greater symptom reduction than did the subjects receiving ST. These findings suggest a slight advantage of CBT over ST in positive symptoms only. However, like Drury et al. (1996a, 1996b, 2000), blind assessors were not used to evaluate clinical outcomes, compromising the study's methodology. Furthermore, the significant advantage of CBT over ST for positive symptoms may have been due to CBT, social skills training, or a combination of the two. Unfortunately, the design does not allow for a dismantling of these treatment effects.

Haddock et al. (1999) compared CBT with supportive counseling in 21 patients who had experienced a recent-onset acute psychotic episode. The supportive counseling was nondirective; unstructured; and designed to provide clients with emotional support, social interaction, and unconditional regard. The results showed no significant

treatment differences in symptoms, time-to-discharge, and relapse rate at the 2-year followup. Tarrier et al. (1998a, 1999, 2000) compared CBT plus routine care, supportive counseling plus routine care, and routine care alone in outpatients with chronic schizophrenia. The supportive counseling was the same as that used in Haddock et al. (1999). At treatment termination, the findings showed that both CBT and supportive counseling reduced symptom severity and frequency more than routine care alone, with CBT showing a statistical advantage over supportive counseling (Tarrier et al. 1998a). However, at 1- and 2-year followups, no significant differences between CBT and supportive counseling existed on any of the study measures, although they both remained superior to routine care alone (Tarrier et al. 1999, 2000). Finally, Sensky et al. (2000) compared CBT with "befriending therapy" in persons with schizophrenia with persistent positive symptoms. In befriending therapy, the therapist was encouraged to be "empathic and nondirective, with the sessions focusing on neutral topics" (p. 167). The findings showed no significant group differences in positive or negative symptoms at the termination of treatment, but at the 9-month followup assessment, CBT maintained positive effects on symptomatology and showed a significant advantage over befriending therapy in positive and negative symptoms.

It is unclear why in Tarrier et al. (1999, 2000), CBT was superior to ST at posttest but equivalent to ST at followup, whereas the opposite pattern emerged for Sensky et al. (2000). These studies differed in the types of CBT and supportive interventions conducted and in sample recruitment methods (a convenience sample in Sensky et al. [2000]) versus a geographic cohort in Tarrier et al. [1999, 2000]). Either of these factors could have accounted for the studies' pattern differences.

A number of themes emerge from recent individual psychotherapy trials that included ST in the design. First, the forms of ST conducted ranged from relatively unstructured "befriending" therapy (Sensky et al. 2000) to more intensive supportive conditions that included psychoeducation and case management (Hogarty et al. 1997a, 1997b). Similarly diverse definitions of ST have also been found in earlier clinical trials (e.g., reality-adaptive-supportive therapy; Gunderson et al. 1984). In most of these studies, ST was a placebo therapy designed to control for the effects of nonspecific therapist attention to the client. In these studies, ST often lacked specification and was usually not guided by a manual. As a result, no standard ST has been used in individual psychotherapy trials for people with schizophrenia. Second, the effects of ST on symptoms and relapses, particularly in the most methodologically sound trials, are similar to CBT in that both approaches improve clinical outcomes compared with treatment as usual (e.g., Tarrier et al. 1998, 1999, 2000; Sensky et al. 2000). On the other hand, there is no evi-

dence that ST outperformed CBT, and some data indicate that CBT may have an advantage in ameliorating specific symptoms such as hallucinations (Tarrier et al. 2001).

The positive effects of ST in recent trials suggest that further investigation may be informative. Does ST work simply because any additional care is of value for people with schizophrenia, or is ST especially suited for the problems encountered by people with schizophrenia?

## What Accounts for ST Effects?

Identifying potential treatment mechanisms for ST is an important step toward enhancing our current individual psychosocial treatments for schizophrenia. Potential mechanisms are suggested by empirical research in the areas of social support and health, psychological processes underlying mental health, the therapeutic alliance, and social cognition.

**Social Support and Health.** Research on the role of social support in physical and mental health has its roots in Durkheim's work showing higher rates of suicide among persons with fewer social ties (i.e., poor "social integration"; Cohen et al. 2000). Since then, the association between social support and mental health has been observed in more than 1,000 studies (Rhodes and Lakey 1999). Furthermore, the level of social support has not only a concurrent relationship with mental health but also a predictive one (Rhodes and Lakey 1999). Numerous studies have found that greater social support is associated with lower blood pressure, stronger immune responses, and lower mortality rates (Uchino et al. 1999). The links between social support and health and between social support and mortality are comparable in strength to the link between physical risk factors, such as smoking and physical inactivity, and health (Uchino et al. 1999).

Social support clearly has an important role in the functioning of people with schizophrenia. Specifically, individuals with chronic schizophrenia have smaller social networks and report having fewer friends than individuals without schizophrenia (Randolph 1998). These smaller networks are associated with greater illness chronicity (Lipton et al. 1981), severity (Sokolovsky et al. 1978), and more negative symptoms (Hamilton et al. 1989; Macdonald et al. 1998). Such networks tend to be composed mostly of other people with psychiatric disorders, mental health professionals, or family members (Sokolovsky et al. 1978; Isele et al. 1985). Finally, more restricted social networks are associated with poorer social functioning (Brugha et al. 1993; Estroff et al. 1994; Macdonald et al. 1998) and outcome (Erickson et al. 1989).

These findings, obtained from groups of people with schizophrenia, are consistent with individual subjective

reports. In studies examining first-person accounts and personal narratives about having schizophrenia, the most consistent themes were those of loneliness, social isolation, and the search for ways to belong or connect with others (Corin 1990; Corin and Lauzon 1992, 1994; Davidson et al. 1998). Davidson and colleagues (1998) argue that for those experiencing social isolation, individual psychotherapy may provide “a crucial bridge back into the social world” (p. 114). Through the therapeutic relationship, clients with schizophrenia may learn that positive social relationships are possible, largely because the therapist treats them not just as clients but as people. Therefore, because of their impoverished social networks and need for social contact, people with schizophrenia may be especially responsive to the nonspecific elements of a therapeutic relationship.

The mechanisms by which social support affects mental health are still unknown, although two models have been proposed: the stress-buffering model (Cohen and McKay 1984) and the main effects or social cognitive model (Cohen and Willis 1985; Rhodes and Lakey 1999). According to the stress-buffering hypothesis (Cohen et al. 2000), perceived social support (and a feeling of connection with others) may affect appraisal of a stressful situation by providing the individual with the belief that additional resources, in the form of other people, are available. Furthermore, social support may also reduce the person’s emotional reactions to the stressor. Some support for this hypothesis comes from studies investigating the electrodermal responses of people with schizophrenia in the presence of a key relative. In these studies (Tarrrier et al. 1979, 1988), the presence of a relative rated as low on Expressed Emotion (i.e., lacking strong negative affective qualities) appeared to have a calming effect compared with the presence of relatives rated as high on Expressed Emotion (i.e., characterized by high levels of criticism or emotional overinvolvement).

The main effects or social-cognitive model does not require the presence of stressful life events for the positive effects of social support to occur. The positive role of social support may occur because the recipient has access to others who possess information about engaging in appropriate mental health-related (or physical health-related) behaviors. In other words, others may provide either direct information (e.g., advice) or indirect information (e.g., via modeling) to help individuals negotiate their daily lives (Cohen et al. 2000). A more recent form of this model suggests that social support acts via increasing access to positive thoughts or conceptualizations about the self (Rhodes and Lakey 1999). This version of the model is consistent with early work from the symbolic interactionists, who posited that self-esteem and other self-concepts are based on individuals’ perceptions of how they are perceived by others (i.e., “reflected

appraisals”; Mead 1934). Therefore, according to the social-cognitive model, social support affects mental health by bolstering one’s sense of self.

**Models of Psychological Health.** The effect of social support on mental health appears to be part of a fundamental human need to form connections with others (Baumeister and Leary 1995; Andersen et al. 2000). In their seminal review of this field, Baumeister and Leary (1995) concluded that (1) people naturally seek and form relationships with others, (2) efforts to dissolve relationships are strongly resisted, (3) people process information about relationships and relationship partners more thoroughly than about other people (e.g., acquaintances or strangers), (4) Relationship quality and intensity have a direct relationship with mood, and (5) intermittent social bonds (e.g., a long distance relationship) or superficial bonds do not produce the same mental health benefits as closer, more stable bonds.

Taking a somewhat different stance, Ryff and Singer (1998) developed a model of “positive human health” in which social support and connection to others are given prominent roles. Specifically, they argue that positive human health involves leading a life of purpose (e.g., work and recreational activities) and of having quality connections with others. For example, the most important descriptor of well-being reported by middle-aged and older adults is having quality relationships (Ryff 1989). This finding is consistent with the general literature, which shows that social integration is a robust predictor of happiness (Baumeister 1991). A psychological intervention based on Ryff and Singer’s (1998) model in which individuals are asked to monitor and increase feelings of well-being has shown promise as a treatment for affective disorders (Fava et al. 1998; Fava 1999).

**The Therapeutic Alliance.** Another mechanism underlying ST effects may be the role of the therapeutic alliance on clinical outcomes. The therapeutic alliance, which refers to the quality of the working relationship between client and therapist, has its roots in both psychodynamic theory (in relation to the concept of transference) and Rogers’ work on client-centered therapy (Horvath and Luborsky 1993). Since then, it has evolved into a pantheoretical construct based largely on the work of Bordin (1976), whose model describes the working alliance as being composed of three elements: tasks (the within-therapy behaviors that form the basis of the intervention), bonds (mutual trust and personal attachment within the therapeutic relationship), and goals (mutually agreed-on targets for treatment). From this model, a widely used measure of the therapeutic alliance, the Working Alliance Inventory (Horvath and Greenberg 1989), emerged.

In comprehensive reviews of the literature, Horvath and colleagues (Horvath and Symonds 1991; Horvath and Luborsky 1993; Horvath 1994) concluded that the therapeutic alliance has a moderate but consistent association with treatment outcome. The results of meta-analyses indicate effect sizes that range between 0.22 and 0.26 (Horvath and Symonds 1991; Martin et al. 2000), which, according to Horvath (1994), is similar to the gains associated with different types of therapy. The magnitude of this relationship did not differ as a function of therapy type or frequency of sessions, although some evidence suggests that CBT is associated with a stronger alliance than psychodynamic approaches (Raue et al. 1997). Finally, some studies suggest that the client's perception of the therapeutic alliance has a stronger relationship with outcome than observer or therapist ratings (Horvath and Luborsky 1993; Horvath 1994). Note, however, that in some cases a strong therapeutic alliance may be a consequence rather than a cause of beneficial treatment outcome. For example, Tang and DeRubeis (1999) found that strong increases in the therapeutic alliance followed rather than preceded symptom change in clients with major depression who received CBT. Other research, however, has found that the interaction of the therapeutic alliance with cognitive change contributes to clinical outcomes (Rector et al. 1999). Therefore, the relationship between the therapeutic alliance and outcome may be complex, with each having the potential to affect and interact with the other.

Growing evidence suggests a role for the therapeutic alliance in the outcome of schizophrenia. A stronger therapeutic alliance is associated with higher client functioning (Allen et al. 1985; Neale and Rosenheck 1995; Svensson and Hansson 1999), lower symptom severity and higher levels of community functioning (Neale and Rosenheck 1995), increased goal attainment (Gerhs and Goering 1994), and greater medication and treatment adherence (Frank and Gunderson 1990; Corriss et al. 1999; Olfson et al. 2000). Furthermore, the absence of a positive relationship with a case manager has been found to predict worse client outcomes; that is, more severe symptoms and a lower quality of life (Tattan and Tarrier 2000).

Social needs are important topics for the treatment of persons with schizophrenia. Coursey and colleagues (1991, 1995) examined the mental health needs and preferences of persons with a severe mental illness, including schizophrenia. These studies revealed that people with severe mental illness ranked issues such as friendship and self-confidence higher on their list of needs than addressing specific symptoms (Coursey et al. 1991). Furthermore, the highest ranked therapist quality valued by clients with severe mental illness was "friendliness," followed by being an "expert on their illness" (Coursey et al. 1995). These findings underscore the need to focus on more per-

sonal aspects of the illness (e.g., self-esteem and friendships) rather than on medical or symptom-related aspects alone. In their discussion, Coursey et al. (1995) note that in the individual treatment of people with schizophrenia, little attention has been given to addressing these very fundamental human needs. This oversight may be one critical reason why individuals drop out of CBT (Tarrier et al. 1998b; Curtis 1999; Tarrier 1999).

**Social Cognition.** Social cognition is a domain of cognition that involves the perception, interpretation, and processing of social information (Ostrom 1984). Compared with nonsocial cognition, the targets of social cognition tend to be interactive, dynamic, and personally relevant (Fiske and Taylor 1991). Furthermore, unobservable attributes (e.g., the intentions of others) tend to be of critical importance for social cognitive stimuli and less important for nonsocial cognitive stimuli (Fiske and Taylor 1991).

Compared with clinical and nonclinical control subjects, people with schizophrenia have various impairments and biases in social cognition (Penn et al. 1997). These difficulties are evident on tests of emotion perception (Penn et al. 1997; Hellewell and Whittaker 1998; Mandal et al. 1998; Edwards et al. 2002), theory of mind tasks (i.e., the ability to make inferences about others' intentions and states of minds; Corcoran 2001), and attributional style (Garety and Freeman 1999; Bentall 2001). In general, people with schizophrenia have particular difficulty perceiving and interpreting negative emotions (Mandal et al. 1998; Edwards et al. 2002), and individuals with persecutory delusions tend to blame others, rather than situations, for negative events (Garety and Freeman 1999).

Social cognition is important for understanding the potential benefits of ST for two reasons. First, evidence suggests that social cognition is related to social functioning in schizophrenia and that this relationship is not redundant with nonsocial cognition (Penn et al. 2001). Second, social cognitive impairments, particularly those associated with positive symptoms, are not random but instead reflect well-organized, subjective experiences that revolve around consistent interpersonal themes (discussed in Strauss 1994; Penn et al. 1997). These themes, such as those involving persecution, social comparison, and grandiosity, arguably reflect concerns people with schizophrenia have about their place in the social world (Roberts 1991). Therefore, ST may indirectly exert positive effects by addressing the client's concerns regarding her or his place in the social world and her or his interactions with others. ST may provide one such positive relationship that could bolster people's confidence in themselves or help them think differently about others in their environment.

## Implications for Individual Therapy for Schizophrenia

In sum, models of psychological health posit a central role for meaningful social contact with others, and there is consistent support for a link between a paucity of social support and various physical and emotional disorders. Because schizophrenia is a disorder in which the disruption of social bonds and meaningful relationships tends to be the rule, ST's apparent benefits may derive from its provision of needed social support, informal, nonconfrontational, and time-limited social interactions.

These hypothesized mechanisms, although speculative and needing evaluation, may help to better inform current CBT approaches for people with schizophrenia in several ways. First, CBT may be able to further extend treatment effects by better targeting the social needs and goals of patients, which is important because CBT, although effective on the symptoms of schizophrenia, appears to have little effect on social functioning or quality of life (Garety et al. 2000). Approaches to CBT for schizophrenia may be more effective if they place greater emphasis on the interpersonal context and social consequences of symptoms (Tarrier and Calam 2002). This approach is consistent with recent models of cognitive therapy, which emphasize interpersonal aspects of psychological disorders (Safran and Segal 1990; Keller et al. 2000) as an important target for treatment.

Second, attending to social and recreational goals may provide better "traction" for current CBT interventions; that is, rehearsing symptom-management skills in the context of social and recreational goals and other functional activities may aid the transfer of these skills to the areas of functioning where they are most needed and where there may be greater motivation to use difficult interventions. For example, in the context of negative symptoms such as amotivation and anhedonia, therapists should try to link all interventions to specific client goals and activities. Accordingly, the control of positive symptoms need not be a goal in its own right but may be targeted in the context of strategies to enhance coping and well-being during activities frequently avoided (or disrupted) because of positive symptoms.

To address some of these issues, we have developed a new approach, functional CBT (FCBT), that uses empirically supported strategies but focuses on enhancing functionality and well-being among persons with schizophrenia. We introduce elements of this philosophy below.<sup>1</sup> Functional cognitive-behavioral therapy (FCBT) is a brief

individual treatment for schizophrenia-spectrum disorders that targets residual symptoms that interfere with functional goal attainment, including interpersonal goals. Rather than discussing hallucinations or delusions as real or unreal, or rational or distorted, FCBT focuses on whether psychotic symptoms and responses to these symptoms interfere with the client's ability to function in the community. Although it bears some resemblance to PT (Hogarty et al. 1995), it differs from PT in that it is time-limited, places more emphasis on increasing functionality and well-being and less on affect regulation and relapse prevention, and appears more rooted in cognitive-behavioral theory and models of mental health than PT.

FCBT is delivered in 16 weekly outpatient sessions followed by 4 biweekly booster sessions. The first five sessions are delivered similarly across clients. The first session is devoted to an instructional videotape developed by the authors (M.W.O., C.C., and D.L.P.) to orient clients to the FCBT model. The clients are also encouraged to tell their story: what brought them to therapy and what they want to get out of it. In the second through fifth sessions, clients engage in two primary activities: (1) developing a list of functional goals and the symptoms that interfere with goal attainment and (2) enhancing their well-being by pursuing pleasant activities. The functional goals serve the primary purpose of increasing quality of life and daily productivity and the secondary purpose of increasing the clients' motivation to work on residual symptoms that compromise day-to-day life. Typical functional goals selected by our clients include making more friends; developing a new hobby; and finding activities to fill one's day such as part-time work or volunteering. By the end of the fifth session, the client and therapist have developed a functional goal list linked to specific symptoms.

Enhancement of well-being is based on the work of Fava and colleagues (Fava et al. 1998; Fava 1999) and is composed of the following steps: (1) monitoring periods of well-being, (2) identifying thoughts or activities associated with periods of well-being, and (3) helping the client choose potential pleasurable activities (if the client doesn't report any during the self-monitoring phase) using a pleasant events list in the manual. Again, the well-being approach is based on the philosophy of FCBT to enhance quality of life rather than merely eliminating or modifying maladaptive behaviors or thoughts.

The content of sessions 6 through 16 is determined by decision rules for the selection of particular treatment modules. Each module involves targeting a symptom or behavior that may be interfering with functionality. The four treatment modules address negative symptoms, dysfunctional reaction to voices, delusions, and social inte-

<sup>1</sup>A more extensive description of this model is reported elsewhere (Cather et al., in press), and a treatment manual is available from the first author of this article.

gration difficulties (because of skills deficits, low self-esteem, or concerns about stigmatization). The specific interventions (e.g., behavioral experiments, reality testing, increasing activity level, and skills training) include those typically used in current CBT interventions, although symptom alleviation is a means to an end (i.e., increasing functionality), rather than an end in itself. For example, negative symptoms are addressed by activity scheduling, by focusing on “doing” rather than on the client’s anhedonia or amotivation.

Interventions to address positive symptoms (i.e., modules 2 and 3) do so by placing these symptoms into a specific functional context and addressing them as just another obstacle to goal attainment, in the same way that lack of money would be an obstacle to purchasing new clothes. For example, an individual may bemoan his social isolation and identify the goal of broadening his social network. However, he avoids others because of residual paranoia. In module 2, his paranoia would be identified as an obstacle to achieving his goal. In collaboration with the therapist, weekly homework assignments would increase the client’s contact with others, while the therapy session would either address the paranoid beliefs (i.e., via the “verbal challenge” or “behavioral experiments”; Chadwick et al. 1996) or explore strategies to cope with paranoia when in those situations (e.g., using coping self-statements or distraction). Thus, the client and therapist work collaboratively on alleviating obstacles, symptoms or otherwise, that interfere with the client’s goal of increasing social contacts. A similar approach is taken in module 3 (i.e., addressing residual auditory hallucinations and maladaptive coping strategies). Module 4 is appropriate for clients whose social skill deficits or concerns (e.g., about being stigmatized by others) prevent adequate social integration.

We are currently conducting a pilot study of FCBT in which we compare FCBT to psychoeducation in people with either schizophrenia or schizoaffective disorder. Fidelity to treatment is monitored via recording of therapy sessions and weekly supervision, although a fidelity manual is currently being developed. Anecdotally, clients have been receptive to FCBT’s goal of improving functioning and overall quality of life rather than focusing only on symptom reduction. We hope that FCBT, with its emphasis on enhancing well-being and functionality, will help therapists better capitalize on some of the apparent positive effects of ST while coemphasize the core CBT interventions that have been supported by research. To do so, we must strive to collaboratively develop a shared formulation of how a client’s symptoms impede important personal struggles and concerns. This understanding will only enhance our ability to help our clients manage, and perhaps recover from, schizophrenia.

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