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# Psychotherapy for Schizophrenia in an ACT Team Context

**Stephen M. Smith[1] and Philip T. Yanos[1]**

**Abstract**

Cognitive-behavioral therapy (CBT) and assertive community treatment (ACT) are two evidence-based approaches to the treatment of schizophrenia; nevertheless, the two approaches are rarely combined. In the present case study, we discuss the treatment of a man diagnosed with schizophrenia with severe social anxiety. CBT approaches were used and treatment was conducted within the context of ACT services. CBT and ACT were found to be complementary, and the combination of approaches was found to be effective helping to reduce the client's social anxiety. Implications for the treatment of schizophrenia are discussed.

**Keywords**

schizophrenia, assertive community treatment, cognitive behavioral therapy

## 1 Theoretical and Research Basis

Despite the unquestionable success of antipsychotic medications in transforming the treatment of schizophrenia, there are also clear limitations to what psychopharmacologic approaches are able to accomplish with this population. Major limitations of antipsychotic treatment include the large number of persons who have poor or partial response (Meltzer, 1992) and the limited impact of medication on social functioning and quality of life (Corrigan, Reinke, Landsberber, Charate, & Toombs, 2003). Psychosocial treatments have demonstrated that, when combined with medications, they can help further reduce symptom severity, prevent relapses, improve social functioning, and overall quality of life (Kern, Glynn, Horan, & Marder, 2009). Two well-established models of psychosocial treatment for schizophrenia and other severe mental illnesses are cognitive-behavioral therapy (CBT) and assertive community treatment (ACT).

### *CBT for Schizophrenia*

CBT interventions for schizophrenia have been described by a number of authors (see Rathod & Turkington, 2005, for a review). Though there are some differences between the models that have been proposed, treatments tend to include some common features, including psychoeducation about symptoms and associated problems, a focus on enhancing coping skills to deal with hallucinations and negative symptoms, cognitive restructuring to address delusional ideas,

[1]City University of New York

**Corresponding Author:**
Philip T. Yanos, John Jay College of Criminal Justice, City University of New York, Psychology Department, 445 W. 59th St., New York, NY 10019
Email: pyanos@jjay.cuny.edu

problem-solving, and enhancing social skills. CBT is also used to address co-occurring disorders or clinical issues that diminish quality of life or functioning, such as social anxiety, post-traumatic stress disorder, or substance abuse issues. A recent meta-analysis of CBT for schizophrenia (Rector & Beck, 2001), showed that CBT has large clinical effects on both positive and negative symptom measures.

### *Assertive Community Treatment*

Assertive Community Treatment (ACT) is one of most extensively studied evidence-based practices for providing comprehensive community based treatment for individuals with severe mental illness, and particularly those who have histories of homelessness or long-term institutionalization (Bond, Drake, Mueser, & Latimer, 2001; Teague, Bond, & Drake, 1998). ACT has been the subject of more than 25 randomized controlled studies and has been shown to be effective in reducing hospitalization, homelessness, and improving mental health outcomes (see Coldwell & Bender, 2007, for a meta-analysis). ACT was originally designed to help recently discharged persons with severe mental illness to live in the community. It is broadly accepted as a successful treatment modality for people with severe mental illness, especially when two key fidelity ingredients are met: (1) the team is comprised of multidisciplinary staff, and (2) the team has 24-hour mobile access (Drake et al., 1998). Other key features of ACT include an emphasis on assertive outreach for difficult to engage clients, and an emphasis on providing services within clients' natural communities (e.g., their homes).

### *ACT and Psychotherapy*

ACT, as a comprehensive treatment model, is believed to be an effective vehicle for a number of evidence-based interventions, such as integrated treatment of dual disorders and supported employment (Salyers & Tsemberis, 2007). There is no reason why evidenced-based psychotherapy approaches, such as CBT, cannot also be incorporated into the ACT model. In fact, Rathod and Turkington (2005), in a review of CBT for schizophrenia, recommended that CBT for schizophrenia be integrated into ACT services in order to improve the effectiveness of both treatments. From another perspective, Davidson (2008) discussed how key elements of the ACT model such as the availability of team members to offer "in vivo" services, can be used to enhance the effectiveness of psychotherapy for persons with schizophrenia. Nevertheless, despite the fact that the two treatment models appear to be complementary, the application of CBT within the ACT context has been seldom discussed, and there is reason to believe that it is not typically applied. For example, when discussing the critical ingredients of ACT, the availability of psychotherapy is not discussed (McGrew, Pescosolido, & Wright, 2003), making it unlikely that most teams apply CBT in the absence of such recommendations.

## 2 Case Presentation

Joseph is a 30 year old Latino male[1] currently receiving services from an ACT and supported housing program in New York City. He was referred to the program due to his significant history of homelessness and a diagnosis of schizophrenia. Joseph has been with the program for approximately 4.5 years, receiving weekly support services related to housing, money management, and health, and monthly medication monitoring with the team psychiatrist. Before his enrollment in the ACT and supported housing program, he had various stays with relatives and a subsequent period of homelessness (including stays at a men's shelter and hospitalization). Joseph has no

substance use or criminal justice history. Joseph does not presently maintain contact with family members and resides alone in a one-bedroom apartment.

## 3 Presenting Complaints

An initial review of Joseph's records and consultation with treatment team revealed the following presenting difficulties: difficulty leaving his apartment, impaired interpersonal functioning (including poor engagement in treatment), and a lack of progress toward established goals, including getting a GED and working.

## 4 History

Joseph was raised primarily by his grandmother following the death of his parents during early childhood. Although unfamiliar with the exact details, Joseph was informed that his mother was murdered and that his father had died in prison. Joseph's childhood was marked mainly by difficulties interacting with others. He recalled problems paying attention in school and feelings of mild nervousness around other students. Records indicate that he began seeing school counselors at the age of 6. Counseling was terminated around age 9 as his family was unable to afford services. Joseph stated that he had few friends throughout his early childhood, but had decent relationships with his siblings and relatives. Joseph reports being extremely close to his grandmother.

Joseph's grandmother died when he was in his late teens. He and his siblings were sent to live with his aunt as a result. Joseph had problems coping with the death of his grandmother and developed various depressive and anxiety symptoms. He had frequent nightmares of her death, increased anxiety, and became suspicious in social settings. He stopped eating and reportedly made a suicide attempt. While at his aunt's house, Joseph was isolative and did not interact much with his siblings or relatives. His anxiety in school increased significantly as he developed a sensitivity to people talking in the classroom and had difficulty focusing on class lessons and lectures. He dropped out of school in the 11th grade and became more socially isolated. He stated that he did not have a good relationship with his aunt and believed that she did not like him. He then went to live with his brother in a different state. Records indicate that he was hospitalized twice while in the other state. It was reported that during his last hospital stay in the other state, Joseph was nonadherent with medications and demonstrated paranoid delusions revolving round the conviction that the nurses were trying to poison his food.

After spending 2 years in the other state, Joseph returned to live with his aunt in New York City. He had difficulty readjusting to the environment and began to evidence similar behaviors of isolation, unresponsiveness, and problems getting along with relatives. Joseph was eventually hospitalized for approximately 3 months during this period. Shortly after his discharge, Joseph was evicted from his aunt's home and was sent to live in a men's shelter. While residing at the shelter for a few months, Joseph was sent to the hospital following complaints that he refused to eat and was isolative. While in the hospital, he was frequently seen staring at the ceiling and appeared to respond to auditory hallucinations. Joseph stayed in the hospital for approximately 6 months before being discharged to the ACT and supported housing program.

## 5 Assessment

Aside from a review of previous records and consultation with treatment team, an initial assessment was not conducted. However, throughout the course of therapy Joseph was administered the Beck Depression Inventory–II (BDI-II) and the Beck Anxiety Inventory (BAI) weekly to monitor his symptoms and general functioning.

## 6 Case Conceptualization

Joseph has a significant history of childhood and adolescent social anxiety that was magnified by the death of his grandmother (his primary caretaker). Joseph developed subsequent depressive symptoms including depressed mood, social withdrawal, and a reported suicide attempt and psychotic symptoms of auditory hallucinations and paranoid delusions. Since then, Joseph has been hospitalized four times relating to similar complaints. He has been given past diagnoses of Paranoid and Undifferentiated type Schizophrenia and Psychosis NOS.

Joseph's concerns were conceptualized according to a cognitive-behavioral model in which his social anxiety developed in parallel to (and was made worse by) his primary psychotic disorder, and was being maintained by fears of negative judgment by others and victimization (the belief that one day someone will take their anger out on him), negative cognitive distortions (relating to extreme and unfavorable social outcomes), and avoidant behavior. Although there is no direct evidence of it, it is possible that Joseph's anxiety symptoms were initially triggered by the adverse life event of the death of his grandmother and subsequent psychological abuse by his aunt.

## 7 Course of Treatment and Assessment of Progress

### *Early Phase (Sessions 1-11)*

Prior to the current treatment, Joseph's treatment history was characterized by an overall lack of engagement. According to his records, Joseph's pattern of behavior consists of a negative symptoms, symptom minimization, discomfort and avoidance of social interactions, and a significant history of medication nonadherence. As such, the bulk of the engagement process was dedicated to developing a nonthreatening and accommodating therapeutic relationship.

Initial sessions were conducted intermittently at his home and at the office. During these sessions, Joseph presented with an anxious and indifferent mood, constricted affect, and guarded posture. He frequently displayed poor hygiene, wearing unclean clothing and a skullcap that partially covered his eyes, and was poorly groomed. He had avoidant eye contact, and responded only when prompted, usually with one-line responses. He was routinely questioned about his status to which he would always respond, "I'm okay," denying any symptoms aside from mild anxiety. However, when questioned about his daily activities, Joseph would admit to experiencing various difficulties including insomnia (sleeping 3-4 hours a night), continuous rumination about his past, difficulty concentrating, and an avoidance of others. He explained that he would rarely leave his apartment (approximately 3-4 times a month) and did so only out of necessity (i.e., to buy food, do laundry, etc). Attempts to engage Joseph in discussions about his symptoms were often ineffective. As such, much of the focus remained on his daily activities, personal goals, and case management services as these were easier discussion topics. Joseph appeared uneasy during these initial meetings and, after the fourth session, expressed that he no longer wished to continue with psychotherapy treatment.

Although it was apparent that Joseph was uncomfortable with meeting with the therapist, working within the ACT model helped to ensure that a therapeutic relationship, though less direct, was maintained. Joseph had weekly contact with the ACT team members, receiving regular case management services both at the office and his home. On the recommendation of the team, the therapist accompanied team members on these regular case management visits. For Joseph, this service provided him with a valuable source of social contact, despite his preference for avoidance and isolation. For the therapeutic relationship, the at-home contact was more suitable (less threatening) and helped to maintain a basic dialogue. After a few home visits with other team members, Joseph was approached for re-engagement in therapy, to which he agreed.

It was unclear whether Joseph intentionally under-reported his symptoms or if he simply lacked insight. As such, sessions quickly steered toward psychoeducation and exploring his goals for therapy. Joseph was given psychoeducational material on mood, anxiety, and psychotic symptoms. He endorsed a host of symptoms including problems concentrating and paying attention, sleep difficulties, sadness, anhedonia, nervousness, and social withdrawal. Joseph also reviewed material on common coping skills such as engaging in distracting and pleasurable activities, and relaxation exercises. Although he now endorsed a wide range of symptoms, it was evident that his social anxiety was a predominant factor in his life. Joseph's social anxiety was characterized by a consistent worry that others were talking about him and judging him negatively and an underlying fear that on any given day someone would take their anger out on him. These feelings of public judgment and victimization had crippled his social skills and in one particular session Joseph admitted that he had not had a real conversation with anyone else in years. As a result, sessions during this phase incorporated the teaching of appropriate communication techniques such as maintaining eye contact, meaningful disclosure, and reciprocity in dialogue.

## *Middle Phase (Sessions 12-31)*

Joseph's level of engagement became a significant marker of his progress. He became slightly more forthcoming with his experiences and would often give spontaneous and elaborate comments during discussions. Whereas initial sessions lasted only 20-25 minutes, sessions during the middle phase consistently reached the 45-50 minute mark. Once it was established that Joseph was more comfortable with the therapy setting, a push was then made to help him understand the mechanisms underlying his social anxiety. The following three objectives were used to accomplish this goal: identification of negative cognitive schemas, the completion of behavioral assignments, and addressing his thoughts about treatment.

Several sessions were dedicated to educating Joseph on the basic tenets of cognitive behavioral therapy. Joseph was informed of the link between his negative thinking style, avoidance behaviors, and his feelings of intense anxiety and subsequent depression. An extensive account of his psychosocial history was obtained in order to identify the antecedents of his symptoms. He recalled episodes of social withdrawal, fears of being judged by classmates and teachers, and victimization by others. Joseph was given homework assignments to practice identifying the relationship in his daily activities. After completing two exercises using encounters with neighbors as examples, Joseph expressed that he did not wish to continue doing the homework assignments. When questioned about his unwillingness, Joseph stated that he "did not want to do work." The CBT exercises were continued through open discussions rather than through written assignments.

It is believed that Joseph's reluctance to complete homework reflected not only a lack of motivation, but also a possible difficulty with the abstract notions inherent in cognitive restructuring. As such, behavioral activation became the focus. Past attempts by the treatment team such as encouraging Joseph to engage in conversations with strangers were unsuccessful. Instead of creating new social relationships, Joseph was now encouraged to build upon his existing relationships. Joseph was given the task of reciprocating greetings with ACT team members that visited him. Specifically, he was encouraged to ask, "How are you?" whenever any team member greeted him, an act which he had never done before. Team members were asked to acknowledge Joseph's efforts and provide him with consistent positive feedback. This behavioral assignment proved more manageable and he successfully completed the task on several visits with staff members. Taking advantage of the momentum of his efforts, an effort was then made to use other social skills that were presented during the engagement phase such as asking questions, appropriate self-disclosure, and maintaining eye-contact. Joseph resisted these attempts and as time passed only intermittently reciprocated greetings with team members, despite encouragement.

Although Joseph had put forth effort in certain tasks, he was rather resistant to the majority of the intervention up to this point. He dismissed many of the recommended assignments and his anxiety toward social relationships appeared to be hindering his willingness to fully enter into a therapeutic relationship. In an attempt to address his resistance, Joseph was periodically questioned about his views regarding his progress, prognosis, and treatment goals. He often wavered back and forth between a belief that he will not change and a conviction that he must change. He admitted that the sessions had helped him to "talk more to others," but was conflicted as to whether he wished to take a more active (and effortful) role in the treatment process. Although it did not appear that he was unmotivated to work on his treatment, it was uncertain whether he believed at this time that he could do so through psychotherapy.

In addition to his apprehension toward engaging in therapeutic relationship, it was suspected that Joseph's ambivalence was also being maintained by a lack of insight as to the full extent of his condition. Joseph soon began to admit to psychotic experiences including paranoia and ritualistic behavior, symptoms which were never previously disclosed to treatment staff. Joseph stated that even when alone in his apartment he believes that people are watching and speaking about him. Brief reality testing revealed that these experiences were more likely misperceptions than actual delusions. Although he believed that his neighbors were actively talking about him, he denied the possibility that it was actually happening. Joseph also admitted to engaging in daily ritualistic behaviors whereby he would repeatedly walk up and down the length of his apartment, open his refrigerator without taking out any food, check the lock on the front door, and place clothes on his bed only to put them back in his drawer. To Joseph, this behavior reflected a heightened state of anxiety when he felt "energized." Joseph denied any lapses in memory or having any specific thoughts or obsessions during these daily episodes.

It was clear at this point that neither Joseph nor the treatment team were fully aware of the extent of his symptoms. Joseph suffered from severe social anxiety that limited his ability to take active steps toward his goals. His anxiety was further complicated by paranoia and daily ritualistic behavior. To address these complications and to get a better understanding of his functioning, Joseph was given the Beck Depression Inventory- II (BDI-II) self report measure and was asked to rate his level of sadness on a scale of 1-10. He obtained a score of 24 indicating a mild to moderate level of depressive symptoms. However, when verbally questioned about his overall sadness he said it was significant, rating it as an 8 out of 10. Again, it appeared as though he was minimizing his symptoms.

Open discussions about the negative schemata associated with his weekly activities and small behavioral assignments became a routine practice during sessions. Joseph soon reported that he had taken steps to socialize with neighbors. During one session, he recalled an interpersonal experience in which he received both a favorable outcome whereby a neighbor reciprocated a greeting and an unfavorable outcome in which he was ignored. Although he correctly recognized the first outcome as being positive, Joseph was more moved by the unfavorable outcome and claimed that he would never make any future attempts. This experience served as a gauge for his abilities to take active behavioral steps. It was apparent that Joseph had difficulties socializing in situations that did not involve specific needs (e.g., buy food, do laundry). As a result, behavioral assignments focused on processing and mastering only those experiences in which he is forced to socialize in order to fulfill a basic need.

### *Later Phase (Sessions 32-44)*

Based on Joseph's progress, an effort was made to engage him in a more intense and active treatment phase focused on symptom monitoring, guided exposure, and continual cognitive restructuring assignments. To facilitate symptom monitoring, Joseph was now given the BDI-II

and BAI (Beck Anxiety Index) measures weekly and was routinely questioned about his overall level of sadness. Although his sadness-rating remained consistent over this period (8 on 10-point scale), his scores on the two symptom measures decreased significantly (mean scores of 16 on BDI-II and 3 on BAI).

Behavioral exposure techniques were also incorporated into the agenda in order to assist Joseph with navigating through his interpersonal experiences. He was given breathing and relaxation exercises and performed hypothetical role-playing scenarios and on one occasion he applied these techniques during a doctor's visit. Joseph (accompanied by the therapist) used the exposure techniques to reduce his anxiety levels prior to the meeting, and during the meeting was able to successfully ask his doctor specific questions about his health, a task which he believed he would not be able to do. Although this marked a major step in his treatment, Joseph downplayed its significance and stated that he would probably never do it again. Attempts at encouraging further exposure exercises such as holding a conversation with the therapist outside of his apartment door or going outside for 5 minutes every day were repeatedly declined. However, a few weeks later, Joseph surprisingly was able to go to a local barbershop to get his hair cut for the first time in several years.

It was again made apparent that Joseph had developed increased skills for engaging in small interpersonal interactions, but did so when he felt it was necessary. Once he was able to successfully grasp the concrete points of the behavioral assignments, treatment then returned to a focus on the cognitive components of CBT. Several sessions extended upon the previous focus on negative schemas by incorporating discussions regarding various cognitive distortions. During each session, Joseph completed a Dysfunctional Thought Record (DTR) exercise in which he had to identify his automatic thoughts, cognitive distortions, challenging thoughts, and anxiety levels associated with real and hypothetical social interactions (i.e., speaking to cashier at grocery store). He was also asked to rate the probability of receiving a negative and/or unfavorable outcome. Over time, Joseph was able to identify his most frequently used cognitive distortions such as mind-reading (believing that people do not like him and think he is an outsider), all-or-nothing thinking, and catastrophizing (anticipating the most extreme and undesirable outcomes in every situation). While reflecting on these situations, he was able to recognize that the probability was very low that he would actually have an unfavorable or even damaging experience. Joseph was able to develop a basic understanding of these abstract concepts and successfully completed the DTR homework assignments on his own.

Other topics and concerns were also revisited during this final stage of treatment. Joseph was again questioned about his views regarding his progress and his desire for treatment. He remained ambivalent, expressing both an interest in working on improving his condition and a desire to be left alone. Although he had made significant progress throughout the course of the year, it was uncertain how long he would stay engaged given his persistent anxiety toward forming a therapeutic relationship. What was certain was that both Joseph and the treatment team were now becoming fully aware of the extent of his condition and that treatment goals should focus on assisting him with smaller, but more essential socialization skills.

## 10 Follow-Up

Treatment termination was initiated due to the therapist's completion of his training rotation with the ACT team. Prior to the termination of this treatment period, Joseph was approached with the suggestion that he continue with psychotherapy with a new trainee. Although he had made considerable progress with his anxiety and accompanying symptoms, the team felt that he could still benefit from the more focused emphasis that psychotherapy can provide. Joseph acknowledged his progress, but stated that he no longer wished to participate in psychotherapy.

## 11 Treatment Implications of Case

The present case study has significant implications for the use of the psychotherapy within an ACT model. First, this case study highlights the benefits that a comprehensive and assertive treatment approach provides to individuals with histories of poor engagement in treatment. As typified in the case of Joseph, clients with social avoidance may be at greater risk of having deteriorated self-care and developing increased symptoms. These individuals may not only have difficulty attending to personal needs, but may also be more passive, resistant, or avoidant of mental health services. The ACT model addresses the avoidance of these individuals by counteracting their hesitance with assertive outreach services. Joseph, for example, was initially hesitant to engage in psychotherapy. He self-terminated the psychotherapy treatment and returned to his isolative behaviors. Through the ACT model, team members, including the therapist, were able to maintain contact with Joseph by providing him with home visits. This made it easier to both continue case management services and to provide him with a more accommodating method of psychotherapy. Given his history of social withdrawal and avoidance, it is unlikely that Joseph would have sought psychotherapy on his own if it was not made available to him in his home, and after a period of initial engagement.

Another key implication is that psychotherapy provides the treatment team with a valuable and enhanced perspective that differs significantly from that obtained through routine case management visits, which tend to be shorter and more focused on specific concrete issues. In the case of Joseph, neither the team members nor the team psychiatrist were fully aware of the extent of his symptoms. Prior to therapy, it was apparent that he simply had difficulties with engagement and demonstrated isolative behavior. Only through extensive therapy was it discovered that Joseph experienced persistent symptoms that significantly hindered his ability to not only interact with others, but more important, to attend to his basic needs. Furthermore, he was generally uncomfortable addressing any goals which involved significant social interaction. Based on information from psychotherapy sessions, a new approach was undertaken which aimed at both accommodating his underlying anxiety and motivating him to change. Rather than urging him to go to get his GED (something which the client had consistently avoided), the treatment team now worked on helping him to develop basic conversational skills and to leave his apartment for extended periods of time. Guided by the increased understanding of his symptoms, a new treatment plan was established which was tailored to his current functioning.

A third and more fundamental issue raised is that the inclusion of psychotherapy is in alignment with the principles of the ACT model. If the purpose of the ACT model is to provide comprehensive assertive treatment to clients, then it is fully appropriate for a therapeutic component to be included in the approach. As evidenced by the research, psychotherapy perfectly complements the already established psychiatric service and is especially beneficial to individuals who are either unresponsive to psychotropic medications or have additional clinical needs.

## 12 Recommendations to Clinicians

It is recommended that clinicians working within ACT teams attempt to incorporate CBT approaches to better address the needs of their clients. Furthermore, it is recommended that other clinicians working with individuals with schizophrenia adopt aspects of the ACT, such as the provision of services within the community, when possible, to more effectively engage clients who are likely to initially avoid services.

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1. Names and identifying information have been changed to protect identity.

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## Bios

**Stephen M. Smith**, MA, is a doctoral student in forensic psychology at the John Jay College of Criminal Justice, City University of New York. His research focuses on examining cultural bias in treatment and risk assessment practices.

**Philip T. Yanos**, PhD, is an associate professor in psychology at the John Jay College of Criminal Justice, City University of New York. He received his doctorate in clinical psychology from St. John's University. His research focuses on ways to maximize opportunities for recovery among people with severe mental illness.