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Washington City Mission Position Paper

Exploration of Cognitive Enhancement Therapy (CET) as a potential component of the Christian based treatment and recovery model at the Washington City Mission

November 18, 2008

History of Mission Clients and Services:

The Washington City Mission was founded in 1941 when the Reverend Burt McCausland and his wife, Avis, answered God's call to help people whose lives were literally in the gutter. The Mission theme song was "Amazing Grace" and Burt's favorite saying was "Soup, soap and salvation." The new Mission began to demonstrate the Good News of the Gospel through spoken word and Samaritan Care (emergency shelter, meals, and clothing) to homeless and transient men, alcoholics and those left destitute by the Great Depression. In 1986, Avis Arbor was opened, a facility for the growing number of homeless women and women with children that sought help at the Mission. In the early 1990's, these established programs were augmented with two new program components. The Arbuckle Medical Clinic began providing critical healthcare for those in residence, and the Recovery in Christ Program offered classes and groups to address destructive habits, lifestyles and other root causes of homelessness and to provide additional knowledge, tools and support to help clients gain long-term recovery. Today, as the Mission continues to provide these Biblically based services, it is challenged to enhance its knowledge base and services for the people and variety of complex issues they bring to our doors.

Persons in residence today suffer from severe mental illness, chemical addictions, varied combinations of those problems, multiple relapses, time(s) spent incarcerated, histories of abuse, abandonment and isolation; and functional and vocational disabilities. It has become the mission of the Mission to competently address the needs of the whole person -- mental and emotional, medical, physical, spiritual, vocational, and career preparation.

Additional Competencies Needed:

Three years ago, prior to his departure as President of the Erie City Mission in Pennsylvania, Tom Schaffer was informed by Bill McCarthy, friend and President/CEO of Stairways Behavioral Health in Erie, about a new and cutting edge treatment developed at the University of Pittsburgh that he thought might benefit clients of the Erie Mission that were socially and emotionally disabled. This new treatment, known as Cognitive Enhancement Therapy, or CET, had demonstrated effectiveness with certain mentally ill patients through altering or creating new neurological pathways in the brain. However, before this information could be explored, Tom moved from the Erie Mission ministry to Florida.

Tom Schaffer, now President of the Washington City Mission, Washington Pennsylvania, directed Bob Scott, Ph.D., CCDP, and Clinical Director, to research and write this position paper on CET to determine if it is worth pursuing as an additional means to help clients of the Mission recover from their social and emotional disabilities that severely handicap their long-term success. Tom Nowak, MA, LPC, CCDP, and former Men's Program Coordinator and Counselor/Chaplain at the Washington City Mission was hired as a consultant to assist in researching CET. Tom's primary responsibilities have been to assist in finding relevant research articles and to make outside contacts with CET experts in Pittsburgh and elsewhere that could help facilitate the research process.

Cognitive Enhancement Therapy

CET was originally developed in the early to middle 1990s by Gerald Hogarty, MSW, Sam Flesher, Ph.D., Mary Carter, Ph.D. and Deborah Greenwald, Ph.D., at the University of Pittsburgh Medical Center, Western Psychiatric Institute and Clinic. Since 2000, CET has been conducted and refined at Mercy Behavioral Health in Pittsburgh, PA and by Planned Lifetime Assistance of Northeast Ohio (PLAN). In 2006, the Center for Cognitive Innovation (CCI) was established by PLAN to further the dissemination of CET and other cognitive innovations (Flesher et. al., 2007).

As initially designed, CET is a 15 month intervention that treats a narrow range of persons with severe mental illness, specifically those in the recovery phase of Schizophrenia or Schizoaffective Disorder, who are non-substance-abusing, symptomatically stable yet remain socially, cognitively and vocationally disabled (Hogarty et al., 2004). Cognitive disability is determined through a rigorous personal interview process that evaluates a person's cognitive style of impairment in three categories: impoverished/unmotivated, disorganized, or inflexible cognitive style (Hogarty & Greenwald, 2006). Each cognitive style reflects a corresponding social handicap, e.g., with *impoverished/unmotivated* style thinking, a person does not express needs, preferences, or opinions; lacks credible account of behavior; is withdrawn, disinterested, apathetic, and inactive and has low stamina. With this style, CET helps generate ideas, initiate motivation, enhance language, and activate thinking. *Disorganized* style impairment is demonstrated in inappropriate, not self-edited responses; difficulty using language coherently; hard to follow train of thought; and impulsivity and readily changing plans or goals. With this style, CET helps the person organize ideas, get the main point, and control the flood of strong emotions. *Rigid* cognitive style impairment is reflected in behavior restricted by preoccupation with details, tends toward stereotyped views, and has single-minded pursuit of inappropriate goals or career objectives. CET helps the person choose alternative solutions or explanations, become cognitively flexible, and tolerate uncertainty (Hogarty & Greenwald, 2006).

In addition to these cognitive *thinking* style impairments, the person's *social* cognitive deficits are evaluated (Hogarty & Greenwald, 2006). This disability in functionality is also referred to as *social cognition* or the awareness to act wisely with others. Specific deficits in social cognition include vocational ineffectiveness, interpersonal ineffectiveness, lack of foresight, impairment in gist extraction, and inability to adjust to

disability (Hogarty et al., 2004). *Vocational ineffectiveness* is recognized if the person is unemployed or working below potential; has reduced work stamina; is unable to establish or maintain a routine; is unable to use feedback from coworkers, supervisor or authority figures; and is unrealistic or absent career goals. *Interpersonal ineffectiveness* is displayed by lack of empathy, flexibility, or reciprocity; and inability to negotiate conflicts, express needs, act wisely, or take perspectives. *Lack of foresight* is demonstrated in the person's inability to assess long-term consequences of behavior (good or bad) and difficulty forming long-range plans. *Gist extraction* deficit reveals difficulty understanding formal or informal rules of conduct as social contexts change and the inability to assess the central point or norm of social situations. *Adjustment to disability* can be seen by the inability to temporarily revise expectations and the failure to understand or accept remaining limitations imposed by the illness.

CET views Schizophrenia as a neurodevelopmental disorder (Flesher et. al., 2007). It notes a strong correlation between delays in neurodevelopment and the impairments in cognition (attention, memory and problem solving), processing speed, and social cognition among people with Schizophrenia. Research also shows that brain development occurs in infancy through adolescence in the context of interpersonal, i.e., social relationships. Brain and personality development continue in adulthood and beyond as a lifelong process in the arena of adult relationships. Early research observations of patients with both cognitive and social cognitive deficits revealed that they seemed to never have negotiated the psychological and practical emancipation from their family of origin that happens during early adulthood, and many of the patients seemed to be dealing with issues of independence more typical of adolescence (Flesher, 2008). And it was noted that adults with Schizophrenia had the impaired neuropsychological function very similar to normal functioning in children.

Debilitating episodes of mental illness usually begin when a young person attempts to navigate from *primary socialization* (the more concrete and predictable structure of family and school) to *secondary socialization* (the more spontaneous, unstructured interactions of autonomous adult relationships) (Flesher et. al., 2007). The first time away from home, the challenge of getting and maintaining employment, negotiating friendships, romantic relationships and work environments, etc. can trigger the onset of the illness. As the mental illness persists, people often become socialized into limited roles in life such as an underemployed person or unemployed patient. CET challenges individuals and requires them to use social cognitive capacities.

CET is also based on research that shows that the brain has an innate capacity to repair developmental delays and trauma known as *neuroplasticity* (Hogarty & Flesher, 1999). Interventions are designed to help people exercise their brains, therefore increasing the likelihood that healing activity will occur by developing neurological pathways. CET interventions have been shown to facilitate neurodevelopment, cognitive development and social cognition. Numerous references featuring the neurodevelopmental theory of schizophrenia are noted (Hogarty & Flesher, 1999).

Positive Outcomes of CET:

With this seriously mentally ill population, CET has been shown to have remarkable and enduring effects as demonstrated in a large, long-term, randomized study funded by the National Institute of Mental Health (Hogarty et al., 2004). Over a two-year period, a total of 121 subjects were studied. Subjects participated randomly in two groups with 67 receiving the experimental CET and 54 receiving Enriched Supportive Therapy (EST) in a control group. EST is a type of personal therapy (PT) that is designed to foster illness management in part through education, adjustment to disability, and stress management (Arehart-Treichel, 2004). Subjects were between the ages 18 to 55, had an IQ equal to or greater than 80, were fluent in English, and had not abused *drugs or alcohol* in the previous three to six months. Additionally, 88% of subjects were more than one year removed from their last psychotic episode indicating symptomatic stability yet remaining cognitively disabled (Hogarty & Greenwald, 2006).

Over a two-year period, the EST group demonstrated clinical meaningful improvements on the same measures as the CET group, but the CET group had improved even more. After 12 and 24 months, individuals in the CET group were shown to attain significant improvement in the following mental capacities: Neurocognition, processing speed, cognitive style, social cognition and social adjustment, with symptoms remaining stable (Hogarty et al., 2004; Hogarty & Eack et al, 2006). Similar positive outcomes of CET are reported at 12 through 36 months and continue over time. These improved mental capacities are listed as follows (Flesher et. al., 2007):

- *Processing speed*, a prerequisite for learning that is impaired or slow in people with schizophrenia and related mental illnesses;
- *Cognition/thinking* that includes motivation, initiative, energy, mental stamina, attention/concentration, working memory, verbal memory, problem solving and cognitive flexibility;
- *Social cognition* or perspective taking of self and others, gistful thinking, accounting for the actions of self and others, problem solving, role flexibility, fun/sense of humor, recognition and appreciation of social spontaneity of the joy of achieving personal goals of self and others;
- *Meaningful roles* as individuals become socialized into the adult roles they identify goals such as, employee, volunteer, friend, spouse, student, parent, etc;
- *Self management of mental and physical health* that recognizes and responds to cues of distress;
- *Adjustment to and acceptance of disability* by learning to work through the grief process and accept that they have a mental illness; that it does not define their entire person; that they also have strengths, talents, interests, and skills; and discover realistic hope about their recovery.

Structured CET Interventions:

Over 55 weeks, clients attend a 3-1/2 hour day session one day each week. This breaks down to one hour of computer-based cognitive exercises, 1-1/2 hour of psycho educational group (8–12 persons), and one hour individual coaching with each

participant. CET members have an attendance rate that averages 90% and a graduation rate 87% across all CET sites (Gonzalez, 2008).

CET therapists are called coaches and are licensed social workers, mental health, and vocational professionals that are trained to engage with participants in a process of secondary socialization to help them reflect upon, become aware of, and utilize their feelings, thoughts and perceptions to plan and execute wise actions that get effective results (Flesher et. al., 2007). There are two coaches in each CET group, and they provide group coaching as well as one-on-one coaching to each participant in separate individualized sessions.

In both the computer exercises and psychoeducational groups, each participant works with another participant. Partnerships provide participants with a sense of familiarity, safety, trust, and belonging as well as challenge each one to pay attention, listen, offer support, collaborate, negotiate and resolve conflict as it arises, and learn to process social cues (Flesher et. al., 2007). Partners begin the computer-based exercises prior to doing formal group work in order to assist new participants acclimate to the CET environment. Computer software is specifically designed to challenge individuals to exercise and rehabilitate attention, memory, processing speed, sorting, categorizing, predicting, and other mental capacities (Flesher et. al., 2007). The weekly computer exercises continue throughout the 55-week CET curriculum.

Group structure each week is by design similar and consistent (Flesher et. al., 2007). This framework of predictability provides a level of safety and trust for persons with Schizophrenia and related mental illnesses that tend to feel overwhelmed and threatened by spontaneous, unpredictable interactions. A typical group session includes the following (Hogarty & Greenwald, 2006; Flesher et. al., 2007):

- A welcome back introduction that provides an opportunity to briefly review and clarify the previous session's educational theme, correct misunderstandings, and review the agenda for the day's session;
- Selection of a chairperson who will read the homework assignment for the week, and then solicit and recognize volunteers who present their homework. This encourages leadership and peer collaboration.
- Homework presentation and discussion by each member based on the previous week's psychoeducational talk to help connect theory to real life;
- Questions from the coaches that encourage a deeper, big picture understanding of the task;
- Psychological talk and discussion on curriculum topics;
- Cognitive exercises of up to eight themes that require participants to interact with a partner in front of the whole group;
- Feedback provided by each member and coaches to the persons completing the cognitive exercise; and
- Homework assignment that connects the psychoeducational talk to real life.

Psychoeducational curriculum is utilized in each of the 55 weeks of CET. Examples includes the following topics: Rationale for CET, how the brain works, understanding schizophrenia, recovery plans, attention and memory, emotional temperature taking,

initiating conversation, methods for dealing with criticism, self-defeating thinking, how to take the perspective of others, how to accept and adjust to a disability impairment, how to cope with stigma, and how to measure meaningful life roles, and others (Hogarty & Greenwald, 2006; Flesher et. al., 2007).

The following are examples how of CET group sessions in weeks 2 and 26 would be structured and include psychoeducational information (Hogarty & Greenwald, 2006):

Session 2: Agenda and Educational Handouts: Understanding Schizophrenia

1. Welcome back –
2. Education Topic – Speaker
“Understanding Schizophrenia”
3. Recovery Plans –
4. Homework Assignment -
Come prepared to talk next week about a time when it was difficult for you to take your medication.
How were you able to resolve this issue?
Is there anything about taking medication that you are still struggling with?

Understanding Schizophrenia

- I. Schizophrenia is a brain disorder:
 - Problems in early and late brain *development*
 - Problems with the structure of certain brain *areas*
 - Problems with *neurotransmission* or how messages travel through the brain electrically or biochemically
- II. Schizophrenia is a Disorder of vulnerability (Neurochemical sensitivity to stress)
 - High stress tends toward higher vulnerability
 - Low stress tends toward lower vulnerability
 - Medication lowers vulnerability (think of a thermostat)
 - CET (and other psychosocial treatments) lowers stress and its effects
- III. Schizophrenia is a Disorder of Cognition and Emotions...Problems with:
 - Concentration (attention)/mental stamina, memory, decision making, getting motivated, maintaining interesting things, too little or too much emotion
- IV. The Value of Treatment
 - If you take your medication and use psychosocial treatment strategies to live a safe and rewarding life, relapse will be less than 10% per year.
 - If you take your medication, but do not use psychosocial treatment, your relapse will be between 20% and 30% in the first year following hospitalization.
 - If you stop your medication, (with or without psychosocial treatment) and you have had only *one* prior episode, your relapse rate will be between 60% and 70% in the next year.
 - If you stop your medication, and you have had *more than one* prior episode, your relapse rate will be between 70% and 95% in the next year.

- Treatment lowers relapse
 - As relapses accumulate, behavior and adjustment deteriorate. Life goals are less likely to be reached.
- V. The Need to Avoid Drugs and Alcohol
- Alcohol and drugs are used to cope with life stressors...BUT
 - Drugs stimulate the release of neurochemicals that can cause schizophrenia symptoms.
 - Alcohol is a sedative, impairs performance, disrupts relationships and work, interacts with medication, and can lead to serious brain changes in patients with schizophrenia.
 - CET will give you a healthy, more effective and rewarding way to cope.

Next group meeting, Date and Time

Session 26: Agenda and Educational Handouts: Emotional Consequences of Self Defeating Thinking

1. Welcome back
2. Homework Presentation – Chairperson
 1. Think of a recent time when self defeating thinking led you to behave in a way that had bad consequences for you. What were these consequences? What changes in thinking might have led to a good consequence?
3. Exercise – Condensed Messages #4 Baseball story – Look for self defeating thinking in this father and son story and how it might have unknown but dire financial and career consequences.
4. Education Topic – Speaker
“Emotional Consequences of Self Defeating Thinking”
5. Homework Assignment –
 1. Try to describe how you *feel* when you engage in self defeating thinking. Give an example. How do these negative feelings lead to more types of self defeating thinking? How can you challenge these feelings?
 2. Take home question
You begin a new competitive or volunteer job. The job is challenging and you feel overwhelmed and are falling behind in accomplishing the assigned tasks. You feel frustrated with yourself and angry with the boss because there is little direction or feedback. You begin engaging in self defeating thinking (“I’ll never get finished with this.” “My boss does not like me.”). Your confidence decreases and you feel like quitting even though you have only been working there for two weeks. How might you apply what you have learned in CET?
What might be your self defeating thinking and the associated feelings?
What would be your strategy in dealing with these thoughts and feelings?
What are some alternatives to quitting? (Use “if...then” statements to help generate alternatives.)
What is the boss’s perspective? What could you say to your boss?

Some Emotional Consequences of Self Defeating thinking –

- Feel anxious, angry, depressed (cues of distress) and become discouraged > “I’ve failed again, so it’s hopeless.”
- Feel inadequate and ignore progress > “I’m powerless over this illness.”
- Surrender to the illness > “I’m too disabled to make a better life or career.”
- Sell oneself short > “I’ll never be independent.”
- Become hard on self or others > “Success is risky and demanding. Let others do it.”

Next group meeting, Date and Time

In addition to the 1-1/2 hour group, participants will have one hour of computer-based exercises and one hour of individual coaching.

Recently, Dr. Sam Flesher and staff of Mercy Behavioral Health in Pittsburgh invited Bob Scott and Tom Nowak, as representing the Washington City Mission, to attend a CET group and computer based intervention with a new class of participants in their third week of treatment. We were asked to observe and provide feedback at the appropriate time in the group as well as work with clients in the interactive computer class. Perhaps the most impressive feature of the group session was the effectiveness of the structure with participants. In the center of the group room was a large, rectangular table where CET participants, coaches and visitors sat. On the walls around the room were the individualized treatment plans serving as a constant reminder of each person’s specific goals. Coaches referred to individual plans as necessary to help each person maintain focus. The chairperson, volunteer or appointee for the session, respectfully made sure each person, participant or coach, that wanted to speak, first raised his or her hand before proceeding. The social microcosm of the group and process worked well and all CET participants appeared to buy in to, appreciate, and benefit from the structure at this early stage of the 15-month process. The group exercise that day was called “Categorization.” Two participants partnered together in front of the group to sort 25 words into five categories and then again into five more categories. It was a very challenging exercise that revealed some reluctance, distress, and low mental effort in the participants at first; but then they gained momentum and worked diligently as a team to solve the problem successfully and were accorded with very positive and rewarding feedback regarding their effort and competency.

The following hour was spent with CET participants and coaches in the computer lab. As guests, we observed and worked separately with two individuals. Both persons had severe and disabling mental disorders. One participant worked on a computer exercise known as “The Attention Reaction Conditioner,” an exercise in attention training designed to help the person when reading, watching TV or a movie, or paying attention to what others are saying (Hogarty & Greenwald, 2006). Over about twenty or so minutes, this person dramatically overcame significant difficulty with his attention and finished with consistent, best possible scores. The other participant we partnered with worked on a very challenging computer exercise known as “Paired Associates Recall” designed to improve working memory and abstract thinking. After facing several initial failures and with practice, this individual began to show significant improvement in both memory and

abstract thinking scores. She expressed that she was mentally tired and fatigued when the exercise was completed.

CET and the Treatment of Other Mental Health Disorders:

Initial CET research clearly targeted severely mentally ill individuals with the Axis I diagnoses of Schizophrenia and Schizoaffective Disorder (American Psychiatric Association: DSM-IV-TR, 2000). Review of the two-year random trial study noted that clients had the specific diagnoses of Schizophrenia: Paranoid Type; Schizoaffective Disorder and other schizophrenia (Hogarty et al., 2004). However, recent contacts and discussions with professionals that currently practice CET in both Pittsburgh, Pennsylvania and Cleveland, Ohio have made it clear that practitioners of CET are now utilizing it to treat persons with other severe mental disorders who are cognitively, socially and vocationally disabled as a result of their impairment. Currently this fact is only generally referred to in available literature (Flesher et. al., 2007), although there is one trial study in the use of CET with a broader range of persons with various severe mental illnesses that is due to be completed soon.

Practitioners at both Mercy Behavioral Health in Pittsburgh and Planned Lifetime Assistance Network (PLAN) of Northeast Ohio informed me that participants in their respective CET practices have Axis I disorders in addition to those mentioned above, e.g., Bipolar Disorder, Depressive Disorders, Post-traumatic Stress Disorder (PTSD), Attention-deficit Hyperactivity Disorder, Autistic Disorder, Obsessive Compulsive Personality Disorder (OCD) and brain injury (American Psychiatric Association: DSM-IV-TR, 2000). Depending on which coach I spoke with recently at the CET Coaches Conference in Beechwood, Ohio, some CET groups are comprised primarily of persons with schizophrenia but other groups with a cross section of persons with the variety of the above severe mental health disorders just noted. The constant factors in these persons qualifying them for CET, in addition to the mental impairment, is that they are symptomatically stable in the recovery phase of the illness, non-substance-abusing, and yet remain socially, cognitively and vocationally disabled. Dr. Gilho Cho, Psy.D., practicing licensed psychologist at PLAN of Northeast Ohio, noted in the recent CET Coaches Conference that he believed even clients in the acute (not stable) stage of their mental illness might benefit from the rigorous computer exercises utilized in CET, though those persons would not be ready for the complete CET program. Nevertheless, CET participants with a range of severe mental illness are consistently attending the program at a rate that averages 90% and a graduating at a rate 87% across all CET sites (Gonzalez, 2008; Flesher et. al., 2007).

Implications:

As noted above, persons in residence at the Washington City Mission today suffer from severe mental illness, chemical addictions, varied combinations of those problems, multiple relapses, time(s) spent incarcerated, histories of abuse, abandonment and isolation; and functional and vocational disabilities. It appears that these persons could benefit from CET if it would be introduced as an additional treatment competency.

Persons entering Mission programs have an intake interview at which time they report their mental health history if there is one. Following the intake interview, these individuals have an intake assessment with the nurse practitioner in the Mission's medical clinic, and they visit the clinic as often as necessary to meet with doctors, have follow up appointments, etc. As ongoing mental health information is gathered over time through the clinic and in collaboration with staff counselors or outside agencies, a clearer picture of the client's needs emerges. Based on initial intake interview information during the last quarter from July 2008 through September 2008, 78 persons (42%) of residents had a mental health diagnosis, and 122 persons (65%) reported drug and alcohol problems. Seventy-one persons (38%) of those individuals reported having a dual diagnosis of MH and D/A problems.

Over a 12 month span from September, 2007 to September, 2008, clients reported at intake that they had a been formally diagnosed at some point in their lives with the following mental health disorders: Schizophrenia (12), Depressive Disorders (138), Bipolar Disorder (95), PTSD (14), ADHD (4), OCD (4), and Anxiety Disorders (34). These numbers do not take into account those persons that have never had a mental health diagnosis but, based on self-reports or staff observation of symptoms, demonstrate a need for such a diagnosis. In addition, the medical clinic at the Mission periodically does point in time surveys of residents based on updated client information. In the most recent one day survey, the following mental health disorders were noted as current: Schizophrenia (4), Schizoaffective Disorder (1), Depressive Disorders (28), Bipolar Disorder (23), PTSD (2), ADHD (4), OCD (1), Anxiety Disorders (15), Personality disorders (3), and probable but undiagnosed persons (4). Treatment staff at the Mission suspect that the number of mentally ill persons in our program is higher than statistics indicate.

These persons demonstrate varying but significant levels of functional disability based on poor work histories, observed mental and physical impairments, drug and alcohol histories, and by the fact that they have to reside in a facility that houses homeless persons and those unable to sustain a viable, normal lifestyle in the community. Given the significance of the issues faced by our clients while in residence and the fact that many of them cycle through the Mission treatment program as well as other treatment programs again and again, indicates that they need help they are not yet receiving. A successful mode of treatment as evidenced with CET, that enhances neurocognition and social cognition in persons with mental illness and limited functionality, has shown that, given the information and treatment, mentally ill clients are capable of compensating for many of their disabilities and regaining some of their social and vocational functioning.

CET Client Pool:

Current research and practice of CET indicates that clients entering a CET program may need to be referred or drawn from a large base of potential individuals. Clients for the two-year trial study came from referrals from the University of Pittsburgh Medical Center's Comprehensive Care Center (a local outpatient mental health center) and a University of Pittsburgh Medical Center satellite clinic (Hogarty et al., 2004). And recent

discussions with treatment staff at Mercy Behavioral Health in Pittsburgh indicate CET clients in treatment are referred through the MBH's own extensive client base. Therefore a CET program offered by the Washington City Mission in all likelihood would have to draw clients from mental health treatment programs throughout Washington County in addition to the Mission.

Research Opportunities:

The fact that CET is now recognized as an established evidence based practice (EBP) does not preclude the need for further research; rather CET is still cutting edge and the need for ongoing research is quite apparent especially with persons having serious mental illnesses apart from schizophrenia as listed above. The fact that CET participants have an attendance rate that averages 90% over 55 weeks and a graduation rate 87% across all CET sites (Gonzalez, 2008) is impressive. Coaches describe the effectiveness of CET they are witnessing with their clients. One coach noted that one of her CET participants told her she has made more progress with CET in one year than with all the supportive therapy she had combined over 20 years for her bipolar disorder (Martz, 2008). Video of persons screened prior to entering CET and again after graduation is remarkable and clearly demonstrates the benefit and effectiveness of the treatment on participant's neurocognition and social cognition. The American Psychiatric Association notes that it would be interesting to see how CET could be replicated for a larger, more diverse group of mentally and functionally impaired persons because it has the potential to revolutionize patient care (Arehart-Treichel, 2004). The Washington City Mission is interested in research to determine if CET might be adapted to the Christian based curriculum of the Mission program. In this regard, the Mission plans to explore potential relationships with university graduate programs in Southwestern Pennsylvania that would be interested in such a relationship. We envision that this mutual relationship would entail internships for graduate students that would be highly beneficial for both organizations.

Sources

This position paper was written with references to the sources listed below.

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