Chapter 9
Cognitive Behavioural Therapy for Psychosis

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9.1 Introduction

Cognitive behavioural therapy for psychosis (CBTp) is an adaptation of CBT for anxiety and depression, tailored for the needs of people with psychotic symptoms. While the therapy approach and format is generally the same, particular aspects of CBT are emphasised within CBTp, such as a greater focus on building trust and ensuring engagement (Brabban et al., 2016). There are some aspects of CBTp that are unique to this client group, such as 'working within' a client's belief system rather than requiring major belief change (Johns et al., 2014). The emphasis of therapy is on reducing distress and disruption from symptoms and working towards recovery goals. This chapter will outline fundamental aspects of CBTp, together with key therapeutic change strategies. While evaluating beliefs about anomalous or other experiences is an important part of CBTp, there are other factors that contribute to and maintain psychotic symptoms, and which clients would like help with in therapy (Freeman et al., 2019). We will illustrate the approach using examples from our clinical work.

9.2 Overview of CBTp Approaches

Cognitive behavioural therapy for psychosis (CBTp) is an evidence-based and recommended treatment in several national guidelines for schizophrenia and psychosis (Kreyenbuhl et al., 2010; National Institute for Health and Care Excellence, 2009, 2014; Royal Australian and New Zealand College of Psychiatrists, 2005). UK NICE

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J. A. Díaz-Garrido et al. (eds.), *Psychological Interventions for Psychosis*,
https://doi.org/10.1007/978-3-031-27003-1_9

guidance (National Institute for Health and Care Excellence, 2009) recommends that CBTp follows a treatment manual (based on a clinical trial) and includes at least one of the following: monitoring thoughts, feelings or behaviours in relation to symptoms; finding ways of coping; reducing distress; and improving functioning. Generic or 'first generation' CBTp includes a variety of therapeutic approaches to help with the problems that patients with psychosis wish to work on. Morrison (Morrison, 2017) describes their approach, outlining the format and change strategies used successfully in their treatment trials of CBTp in different patient groups, including those at high risk of developing psychosis, those with first episode psychosis, and those seen as having treatment-resistant schizophrenia (Morrison et al., 2011, 2014, 2018a, b). Developments in CBTp have involved evaluating discrete intervention components for specific psychotic symptoms, focusing on the processes involved in triggering and maintaining these symptoms (Freeman, 2011, 2016). CBT emphasises appraisal and behaviour as key to the development and persistence of the problem. Making changes in appraisals and behaviours, through new learning, is the main tool of change in all CBTp approaches.

9.2.1 Appraisals of Experiences

Cognitive behavioural models of psychotic symptoms state that it is not unusual experiences per se that cause distress, but the appraisal of these experiences as external, personally significant, and threatening (Bentall et al., 2007; Birchwood & Chadwick, 1997; Freeman et al., 2002; Garety et al., 2001, 2007; Morrison, 2001). Unhelpful coping and safety seeking behaviours maintain distress and poor functioning by preventing disconfirmation of negative appraisals (Gaynor et al., 2013; Heriot-Maitland et al., 2012). CBTp aims to break these maintenance cycles by helping people to make sense of their psychotic experiences in a way that promotes effective coping and functioning and counters negative appraisals of self and illness. Key alternative appraisals for patients are that they are safe and they have some control.

If acceptable to the patient, CBTp will target specific appraisals directly in therapy, which is the approach taken in Cognitive Therapy for Command Hallucinations (CTCH). This cognitive model of voices has clarified that appraisals of voice malevolence and omnipotence influence the voice hearer's affect and behaviour (Chadwick & Birchwood, 1994; Tsang et al., 2021). Compliance or appeasement behaviours in response to commanding voices occur when the hearer believes the voice has malevolent intent and the power to deliver the threat. CTCH aims to weaken beliefs about the power of voices to inflict harm on the voice hearer or others if commands are not obeyed, thereby reducing the hearer's motivation to comply. The therapy tests out the perceived power of the voice by examining evidence for the voice hearer's perceived lack of control over voice activity, the perceived omniscience of the voice (e.g. the apparent ability of the voice to predict the future), and the perceived capacity of the voice to carry out its threats for non-compliance (Byrne et al.,

2006; Meaden et al., 2013). In a randomised controlled trial (RCT) comparing CTCH with treatment as usual (TAU) over 9 months, the rate of voice compliance in the CTCH was significantly lower than in the TAU group at 18-months' follow-up (odds ratio 0·45) (Birchwood et al., 2014). This effect was matched by a change in the key target of the intervention, the appraisal of voices' power. A subsequent analysis confirmed that change in power beliefs at 9 months mediated the effect of therapy on compliance at 18 months (Birchwood et al., 2018a).

Understanding the appraisals of other types of voices is important for formulating the experience and identifying therapy targets. Using qualitative interview data, Sheaves (Sheaves et al., 2020) identified 21 reasons why patients with psychosis listen to and believe derogatory and threatening voices. These reasons grouped into six categories: to understand the voices; to be alert to the threat; normal instinct to rely on sensory information; the voices can be of people the voice hearer knows; the voices use strategies to capture attention; and patients feel so worn down that it is hard to resist the voice experience. Awareness of these reasons can help clinicians understand the patient experience and guide the CBT intervention.

9.2.2 Triggering and Maintaining Factors

Recent work has highlighted the different factors that trigger and maintain psychotic symptoms, and which offer additional therapeutic targets in CBTp. In a survey of 1809 patients with non-affective psychosis and severe paranoia and/or frequent voices, Freeman and colleagues (Freeman et al., 2019) found that patients had high levels of treatable problems such as agoraphobic avoidance, worry, reasoning difficulties, low self-esteem, and insomnia. Furthermore, patients wanted these difficulties to be treated. The authors' theoretical model of paranoia (Freeman, 2016) highlights these factors as causal mechanisms, and successful treatment of these difficulties can decrease paranoia. Freeman and colleagues have shown that reducing anxious avoidance (Freeman et al., 2016a), worry (Freeman et al., 2015a), low self-confidence (Freeman et al., 2014), insomnia (Freeman et al., 2015b), and reasoning bias (Garety et al., 2015) all lead to reductions in paranoia/persecutory delusions.

Alternative change strategies in CBTp are important as less than half of patients given first generation CBTp engage fully with the direct cognitive-behavioural techniques (Dunn et al., 2012), and many patients in the RCT of CTCH described fear of doing some of the therapy tasks to test the power of the voices (Birchwood et al., 2018b). Therapists may not need to work on appraisals in CBTp or may find this work easier when they come to it in therapy having worked on maintenance factors first. The Feeling Safe Programme for persecutory delusions (Freeman et al., 2016b) has combined the individual interventions targeting each maintenance factor into a full CBTp treatment. In the therapy, safety is relearned by entering feared situations after the influence of the maintenance factors has been reduced.

9.2.3 Evaluation of CBTp

A limitation of evaluating first generation (generic) CBTp is that therapy uses composite approaches in heterogeneous patient samples/clients with heterogeneous presentations of psychosis., and the therapeutic targets are not easily captured by a single primary outcome measure. Meta-analyses of these CBTp treatment trials have reported effect sizes in the small to moderate range (Bighelli et al., 2018; Turner et al., 2014).

Therapy approaches focused on specificity (targeting discrete factors causing or maintaining specific psychotic symptoms) have yielded higher effect sizes (Lincoln & Peters, 2018). Developments in CBTp have taken an 'interventionist-causal approach' (Freeman, 2011). In this approach, causation is ascertained by manipulation of the hypothesised causal mechanism and examination of the effect on the symptom of interest (Kendler & Campbell, 2009). In a systematic review of studies manipulating psychological processes potentially involved in psychotic experiences, Brown et al. (2019) identified the following mechanisms in patients with psychosis: worry and rumination, self-esteem, sleep, negative affect, reasoning biases, and beliefs about voices. Similarly, it has been argued that an interventionist-causal approach is necessary to untangle the relationship between trauma, PTSD, and psychosis (Brand et al., 2017).

In interventionist-treatment trials, there is a valuable combination of causal test and clinical test of specific treatment techniques (Brown et al., 2019). CTCH differed from generic CBTp as it was informed by a cognitive model of the psychological mechanisms involved in compliance with voices. This model proposed a single variable, which was the target of therapy and mediator of the outcome: the power differential between the voice and voice hearer. In addition, symptom-focused approaches are potentially more efficient than generic CBTp, and modular stand-alone interventions can be combined into a more comprehensive therapy (Freeman et al., 2016c). In the Feeling Safe Programme, patients chose treatment modules (e.g. worry, self-confidence, sleep) identified via assessment as being relevant to them. The Programme led to a significant end of treatment reduction in persistent persecutory delusions compared with befriending (Cohen's d –1·20) (Freeman et al., 2021).

9.3 Key Principles of the Therapeutic Approach

CBTp is formulation-driven, goal-directed, and uses cognitive behavioural interventions to disrupt key maintenance cycles. As with all CBT, the intervention occurs within the context of a warm, empathic, and collaborative therapeutic relationship, which is a prerequisite to effective therapy (Beck, 1979). However, there are differences from CBT for other conditions, not only in the theory-driven models that underlie formulations, but also in the emphasis of the work and therapeutic stance. When using CBT with people with psychosis, the therapist needs to have a greater

focus on engagement, show open mindedness and genuine curiosity towards clients' beliefs, and empathy with their difficulties, together with a normalising and culturally aware approach to psychotic experiences and processes.

Therapy sessions follow the same structure as CBT for other conditions, with agenda-setting, followed by the main content of the session, including learning from between-session tasks, and ending with feedback and setting further between-session tasks. Phone calls, text messages, or emails can help to maintain hope and momentum between sessions. While number of sessions depends on progress towards therapy goals, sessions are usually weekly and between 16 and 26 in total (although may be fewer in early intervention for psychosis services). Further details of the CBTp approach and style are summarised elsewhere (Johns et al., 2014, 2020; Morrison, 2017). Here, we illustrate the key elements of CBTp using two examples* from our clinical work. We outline the progression of therapy with each client through the stages of CBTp:

(i) Engagement and development of a therapeutic relationship.
(ii) Assessment.
(iii) Establishing a shared problem and goal list.
(iv) Formulation.
(v) Interventions derived from the formulation.
(vi) Planning for the future/relapse management.

*These are hybrids of anonymised cases.

9.4 Bryan

Bryan, 23, is a Black male living with his parents in the outskirts of a city in which he grew up. His parents had a strong focus on achievement and working hard in order to provide for family. Growing up he was stopped and searched by the police on several occasions while his White friends tended to be left alone by the police. When he was working as an apprentice engineer aged 19, he was subject to verbal and racist bullying by a colleague and manager. He was finding it increasingly stressful and left the workplace before his placement had ended, which then made it difficult for him to find work. Many of his friends were working or studying at university. He became increasingly isolated, and for a period of time, he started hearing voices and sounds of what he assumed were people trying to break into his room. Following an altercation with his neighbours, during which Bryan threatened them with a knife, believing they informed the police about him being "a waste of space and probably dangerous", Bryan was admitted to his local psychiatric hospital. Since his discharge almost a year ago, he spends most of his time in his room, has lost touch with friends, and has started to believe more strongly that there is a police-run group who are trying to control his life and stop him from succeeding. On the rare occasions he goes out, he notices helicopters and people walking in pairs and assumes they are part of this conspiracy, and may, once they have enough information to know he will not succeed in life, take him away and kill him.

9.4.1 Engagement and Development of a Therapeutic Relationship (i)

Given that clients often present with issues of trust, often explicitly in the form of persecutory beliefs that others want to harm them, it is unsurprising that engagement is a key focus in CBTp. Sometimes clients may not wish to disclose aspects of their presentation, especially hallucinations, for fear of being re-hospitalised, particularly as hospitalisations are often experienced as traumatic (Berry et al., 2015).

To facilitate engagement, it is important that therapists are explicitly warm, non-judgemental, and collaborative in their approach. This includes, but is not limited to, using the client's terminology and beginning the therapy within their framework of meaning and beliefs. While the therapist usually conceptualises the problematic appraisal as a belief rather than reality, the client's reality is respected and the therapist matches the client's language. So, if Bryan describes an incident of perceived harassment, for example hearing scratching on his walls, this is discussed using the same language so *"when you heard your neighbours…"* rather than *"when you thought you heard your neighbours…"* An assertive outreach approach is more common, with therapists encouraging attendance at appointments, for example with text message reminders and offering home visits.

It is important to empathise frequently and to use explicit empathic comments, for example: *"'I'm sorry to hear that … that sounds really difficult for you … it sounds like you've been through an incredibly tough time"*, since clients with psychosis may misinterpret or fail to notice subtle non-verbal cues. To try to overcome issues of mistrust of services, it can be important for therapists to be clear about their intentions and capabilities as a therapist; notably, that CBTp is focused on the client's goals for their life and wellbeing rather than stopping voice hearing or changing beliefs per se. Therapists are usually part of these same health services and therefore may represent a mistrusted institution. For Bryan, who had negative experiences at the hands of predominantly White institutions, engagement is likely to take additional effort for a White therapist who is part of a similar service. An acknowledgement of this, as well as of the inherent power imbalance in therapy and services more widely, is often helpful. Therapist's self-disclosure tends to be used to a greater degree in CBTp to help engagement and reduce the power differential between therapist and client. Additionally, openness is important, notably about the limits of confidentiality and trust, for example what the therapy notes say, where they will be stored, and which aspects will be shared with other team members. The collaborative nature of CBT lends itself well to this open and direct approach.

It is an advantage if clients can understand and relate to the broad tenants of a CBT approach, for example that different thoughts can lead to correspondingly different emotions and behaviours. However, this is not necessary. Nor is it necessary for the client to have or gain 'insight' and see their experiences and beliefs as symptoms rather than reality. The CBTp approach meets the client where they are and uses their language and belief framework.

9.4.2 Assessment (ii)

Assessment begins with general questions to get an overview, followed by specific questions to build up a maintenance formulation *("What happened?… How did you make sense of that? …How did you feel? …How did you respond/what did you do to cope? …What impact did that have?").* A key part of CBTp assessment is clarifying experience-appraisal links. The 'intrusion' or experience may be an internal feeling or emotion, a hallucinatory experience, an external event (that may also have anomalous perceptual qualities), or a combination of these. The key is understanding the appraisal of the stimuli rather than distinguishing the type of experience. The assessment also clarifies the processes that maintain the appraisal and distress, particularly how the client responds in the moment, and the impact of this in both the short and long term. Clients should feel heard and understood, with you as their therapist viewing their concerns and reactions as understandable.

At CBT assessment, Bryan reports no longer hearing voices or other noises. This may be the case, but it is worth the therapist being aware that Bryan may not be reporting current voices due to fear of being readmitted to hospital. During the assessment, when trying to elucidate appraisals, the therapist asks gently about hallucinatory experiences:

Therapist: *So, from what you have told me, you know that this conspiracy against you is very active currently. I know from your notes that around the time you were in the ward you had been hearing noises of people trying to break in. I can only imagine how frightening that must have been. Is there anything like that happening at the moment which is giving you a clue about what these people are doing?*

Bryan: *No, I don't hear anything like that anymore.*

Therapist: *Fair enough, I just thought I would check. Let's look at what else is happening now.*

This is typical of the CBTp approach in that ideas are suggested tentatively and are withdrawn if the client is not receptive. Assessment is often a flexible and iterative process. At the time of assessment, Bryan said he did not hear any noises or voices, but later in therapy he said that when he was in his bedroom he heard almost constant tapping and scraping, which his parents had said they could not hear. This noise (auditory hallucination) was then incorporated into a re-formulation.

Questionnaire measures are used during the assessment process. These may be generic measures of distress and functioning for routine outcome monitoring (Fornells-Ambrojo et al., 2017), but can also be specific to the client's presenting issues and goals. Assessment of trauma and PTSD (Carr et al., 2018) is important because trauma is very common in this client group, pertinent to the formulation (Hardy, 2017; Morrison et al., 2003) and clients with psychosis are less likely to have been asked (Young et al., 2001).

9.4.3 Establish Shared Problem and Goal List (iii)

Collaboratively derived goals within CBTp will differ depending on the individual client and their presenting issues (Freeman et al., 2019). Goals may also differ depending on the timing of therapy. If a client is functioning well but has a fear of relapse, CBTp can focus on a relapse management plan to maintain their progress and help the client to plan how they might cope if difficulties were to re-occur (Gumley & Schwannauer, 2006).

The dialogue below shows the development of Bryan's goals and priorities in therapy:

Therapist: *So in terms of what we could look at together, you've said that you don't want things to carry on as they are at the moment, that you don't want these people who are following you to keep getting at you….*

Bryan: *Yeah, I mean if you could do that, but I don't think you'd have that level of influence over them.*

Therapist: *No, I know. It sounds like it's been a horrible time. If I could take that away from you or stop it happening, I would.*

Bryan: *It's been the worst time of my life. They won't stop harassing me.*

Therapist: *Absolutely, I can only imagine. So ultimately you want them to stop harassing you… Maybe we can think together about what we could do… If it were to stop, how would your life be different? What would you like to be doing that these events mean you're not able to do at the moment?*

Bryan: *I'd be back doing my apprenticeship, or maybe something better, but I'd be working for sure. But I can't even leave the house on my own. The level of surveillance is so intense.*

Therapist: *So would that be the first step towards that end goal of returning to your apprenticeship? Being able to leave the house?*

Bryan: *I mean it would be good if we could.*

Therapist: *We can see, can't we? There may not be but sometimes there are things we can do just to reduce stress, sometimes we are doing things that we don't realise are making us feel even more stressed than we need to be.*

Goals are then refined such that they are SMART and therefore progress (or lack thereof) can be measured and reviewed as therapy continues.

9.4.4 Formulation (iv)

Formulations can be complex with this client group and therefore formulation should be centred around the goals of the client rather than attempting an exhaustive understanding. Therapists may hold a separate formulation which encapsulates their broader understanding, but which they may not share with the client, for example

because it differs from the client's perspective or includes aspects such as suspected trauma which the client is not yet ready to discuss.

The shared formulation would include appraisals of anomalous or other experiences and specific maintenance processes. It is important to develop idiosyncratic formulations with clients that are simple but also detailed enough to explain the maintenance mechanisms (which are the targets for therapy). Certain CBTp models highlight particular appraisals (Chadwick & Birchwood, 1994) or maintenance factors (Freeman, 2016) to pay attention to while assessing and formulating. Cognitive models and formulation of specific psychotic symptoms is a developing area, for example, the role of defeatist performance beliefs in negative symptoms (Rector et al., 2005) and the importance of the compensatory function in delusions of exceptionality (Isham et al., 2021).

The therapist develops and holds in mind the longitudinal part of Bryan's formulation shown in Fig. 9.1.

Formulations are presented in as much detail as is useful for the client at that stage of therapy and should not contain aspects that the client would disagree with. The longitudinal part of the formulation is not shared with Bryan at this stage as he firmly believes the persecutory belief not to have any relationship with his background experiences and core beliefs. Directly targeting Bryan's persecutory belief by discussing the evidence for and against his persecutory belief and evaluating alternative appraisals of his experiences could have a detrimental effect on Bryan. While he believes he is being targeted and while this belief causes him distress, the formulation suggests that his persecutory beliefs might also protect him from a

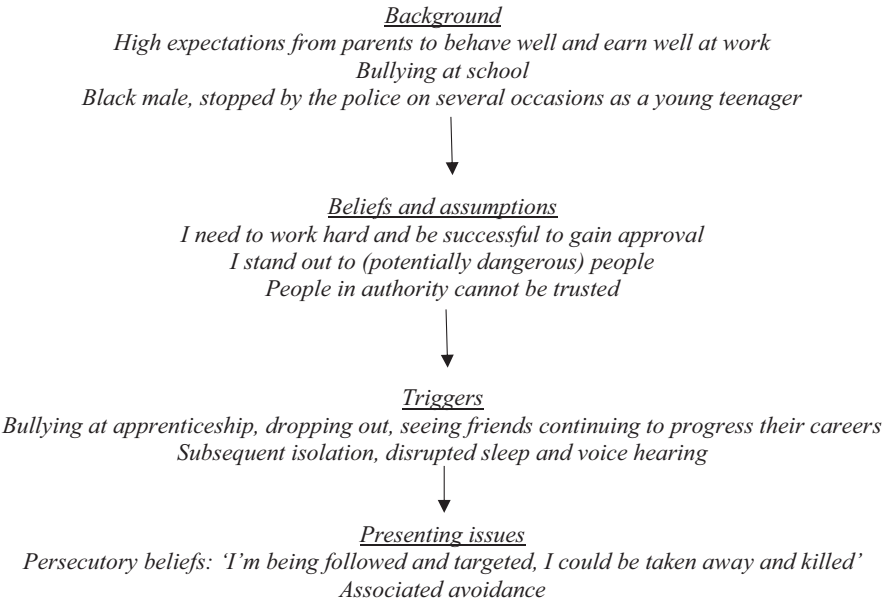

Fig. 9.1 Longitudinal part of Bryan's formulation

more psychologically damaging explanation for his lack of career: that he is not good enough and his parents are not proud of him. Instead, working towards the goal of returning to work by reducing maintenance factors should allow Bryan to hold more positive beliefs about himself. His persecutory belief would then lose its function and may well diminish as a result.

Given Bryan's goal for therapy, and the evidence base for persecutory beliefs (Freeman et al., 2021), two key maintenance cycles that are contributing to his threat belief are mapped out with Bryan in session (see Fig. 9.2).

9.4.5 Interventions Derived from the Formulation (v)

Therapists draw upon a range of cognitive behavioural interventions to help the client reach their goal and disrupt the relevant maintenance cycle. While ultimately the aim of therapy is to change the appraisal to a less threatening and more empowered one (for example for Bryan this might be: *I am safe enough to return to work*), such a change in appraisal may not be addressed directly to begin with. Reviewing the maintenance formulation together in session, Bryan agreed to work on reducing worry, which felt a less daunting place to start making changes. Initial interventions are chosen by considering the client's preference and likelihood of achieving success quickly (which can enhance motivation, trust, and engagement in therapy).

Bryan introduced time-limited worry periods during the day and started lifting weights in his room as a way of directing his attention away from worry outside of these worry periods. This reduced his anxiety level and perception of serious threat and gave an early and easy win for therapy. Feeling calmer and having a sense of accomplishment through weight-lifting, Bryan felt ready to work on the next key maintenance process and consider reducing his avoidance of going out and safety seeking behaviours when out. Given that Bryan feared kidnapping and possible death, these behavioural experiments were negotiated and graded to make them feel

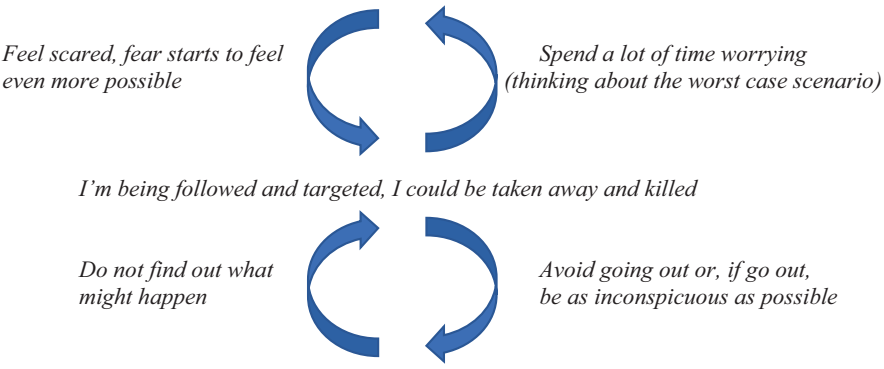

Fig. 9.2 Key maintenance cycles

as safe as possible. Once Bryan had completed a series of behavioural experiments to reduce anxious avoidance, both within and between sessions, an alternative safety belief was generated socratically as follows:

Therapist: *Bryan, we're reviewing our sessions and your progress today and I'm struck by how much more you are doing now. If we look at your maintenance diagram again, what do you notice?*

Bryan: *Because I've been going out I have seen what has happened. And it's been ok so far.*

Therapist: *Absolutely, you have done things that were feeling incredibly risky to do in terms of not just the likelihood of you being spotted but the likelihood that the harassment could worsen. Where would you say you are at with that now?*

Bryan: *I guess just that I can do a bit more than it seemed like I could do. They don't seem as focused on me, sometimes they are around but, even then, they usually leave me alone. They've had plenty of chances and they don't seem to be taking them.*

Therapist: *Absolutely. What do you take that to mean, both about them and about how safe you actually are, now that you have tested it out?*

Bryan: *That I am safer than I thought. They maybe aren't very effective or have other priorities. Maybe they are just keeping an eye on me but it seems like I can get out at least locally without too much harassment.*

Therapist: *That's brilliant, isn't it? So, you are safe to go out locally?*

Novice CBTp therapists might aim to change the client's delusional beliefs with good intention, but without considering whether such change is necessary for the client to reach their goals. Even when the formulation indicates that belief change would be helpful, minor changes may well be sufficient for the client to meet their goals (Johns et al., 2014) and be a more tractable therapy target. Offering an alternative belief too soon in therapy risks invalidating the client's past experiences and memories which the belief is based on (Janssen et al., 2003; Jun et al., 2018). It may also damage the therapeutic relationship and can result in the client defending their position more strongly.

9.4.6 Planning for the Future/Relapse Management (vi)

As with all CBT, final sessions focus on a therapeutic blueprint and plan for the future, which summarises progress in therapy and outlines CBT strategies to maintain, consolidate, or extend progress.

Positive CBT maintenance cycle formulations were drawn out for Bryan to record how he could continue to make helpful changes, as shown in Fig. 9.3.

We will consider how aspects of CBTp were tailored slightly differently with our second client example.

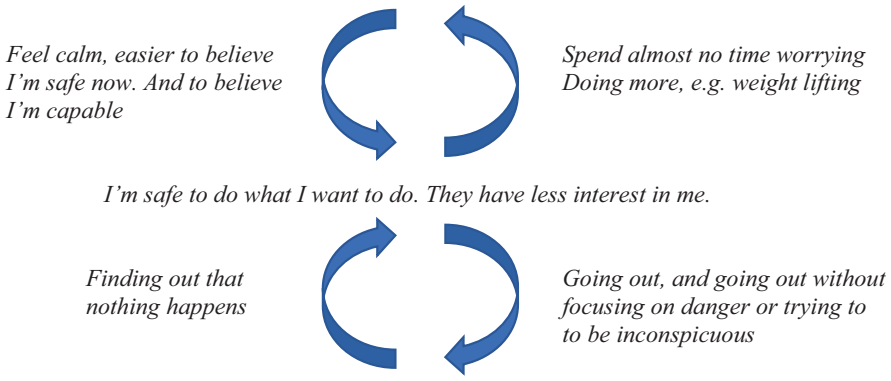

Fig. 9.3 Positive CBT maintenance cycles

9.5 Chrissy

Chrissy, 54, is a White female living in a small town with her longstanding partner. She was given a diagnosis of schizophrenia over 30 years ago and has had some ongoing contact with mental health services since that time. She has had a number of admissions to psychiatric units, but not for some years. Prior to her first contact with mental health services, she had ended her first romantic relationship, which had been one in which her partner was abusive. Having left this relationship, she experienced (undiagnosed) post-trauma reactions, hearing the voice of her ex-partner and starting to believe he still had control over her. Her mother took her to their family doctor and she was admitted to a psychiatric unit for 6 months and received a diagnosis of schizophrenia. She met her current partner around that time and they have been together since. Her partner has managed the household throughout their relationship and is protective of her. A referral for CBTp was prompted by her desire to become more active in her life, and also her partner becoming physically frailer and less able to provide care and support. Her fear of voices often prevented Chrissy from doing household chores and from leaving the house. She reported hearing one voice on a daily basis, usually threatening her ("If you go out, I'll kill you") or telling her not to do things ("Don't you dare make that cup of coffee").

9.5.1 Engagement and Development of a Therapeutic Relationship (i)

Voice hearing can make it more difficult for a client to concentrate on and remember session content, so reminders, prompts for the client to record the session on their phone to listen to it later, and more frequent in-session summaries can be helpful.

Due to current voices and often high levels of anxiety, therapists may need to ask more frequently how the client is tolerating the session. As Chrissy was open with the therapist that she was hearing a voice, this allowed the therapist to agree questions to ask her and her voice, for example *"Are you hearing anything now?… Can I ask what?…Would you like to wait a few minutes or ask him if it is ok for us to continue?"*

Chrissy had, over the years, formed an identity as a long-term patient, someone with 'chronic schizophrenia' and her expectation of achieving change in therapy was low. The therapist was explicit that she believed Chrissy had significant resilience, resources and skill, and held hope that therapy would result in positive change.

9.5.2 Assessment (ii)

While Chrissy had a trauma history, she did not meet criteria for current PTSD. Chrissy's therapy goal was to improve daily functioning, so assessment was tailored around her activity and hearing voices. Measures were given to understand Chrissy's experience of voices, relationship with her voice, and relevant beliefs about her voices and associated behaviours (Birchwood & Chadwick, 1997; Chadwick et al., 2000). An activity diary was completed between sessions to see Chrissy's current level of day-to-day activity and then generate a realistic goal to extend this.

9.5.3 Establish Shared Problem and Goal List (iii)

Chrissy had a clear aim to become more independent. The therapist asked questions to understand the current barriers to achieving this goal, illustrated in the dialogue below:

Therapist: *So you would like to be doing more, especially in the house. Can you tell me a bit more about what is stopping you at the moment?*
Chrissy: *This voice is, he just won't let me do more.*
Therapist: *Can you tell me more about him?*
Chrissy: *He sounds awful, really controlling and frightening.*
Therapist: *Gosh, that sounds awful for you. Do you know who he is?*
Chrissy: *To be honest, I've never really thought but he sounds like the first guy I was ever with, that was a grim relationship. He always said "Don't you dare!" and I knew that something would happen to me if he said that.*

Sometimes the client's goals are to stop their experiences happening, for example, to stop hearing voices or to stop (perceived) persecution. This was the case for Chrissy and was the only way she envisioned being able to do more. While as

therapists we are ultimately aiming to change an appraisal about anomalous experiences, we are not aiming to stop the anomalous experience itself. This is similar to CBT in other areas, for example, for obsessive compulsive disorder or panic, we are not aiming to stop intrusive thoughts or physical sensations, respectively, but to change how they are appraised and responded to. These changes in appraisals and responses may lead to a reduction in the client noticing anomalous experiences (or intrusive thoughts or bodily sensations), but this is not the primary aim. The negotiated shared goal for Chrissy was as follows: *To be able to do daily chores (using dishwasher, cooking meals, washing clothes) and to meet my friend in the cafe once a week. To be 8/10 confident I can do this safely without my voice hurting me.*

9.5.4 Formulation (iv)

The shared maintenance formulation highlighted her appraisals about the power of the voice, leading to fear plus appeasement and compliance behaviours (see Fig. 9.4).

As Chrissy had disclosed and made a link between her voice and her experience of trauma, in a later session, the therapist added this information into the formulation and tentatively shared it with her (see Fig. 9.5).

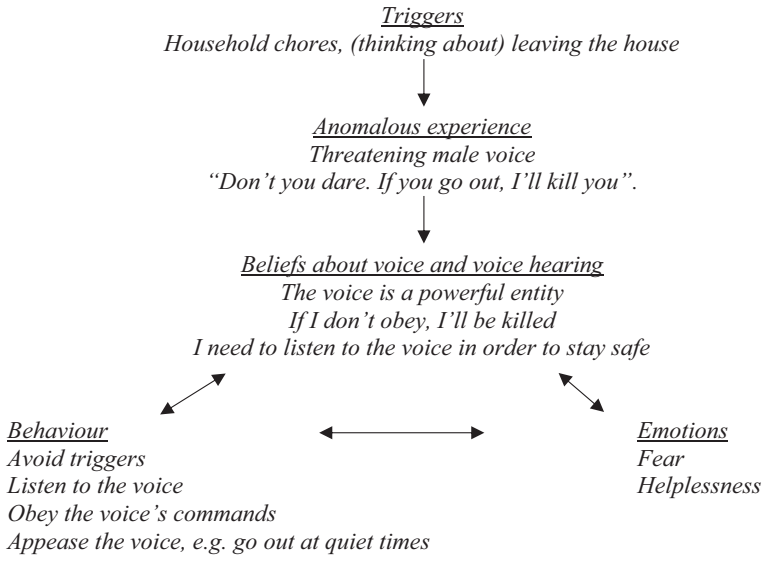

Fig. 9.4 Maintenance formulation. (Adapted from Morrison 2001)

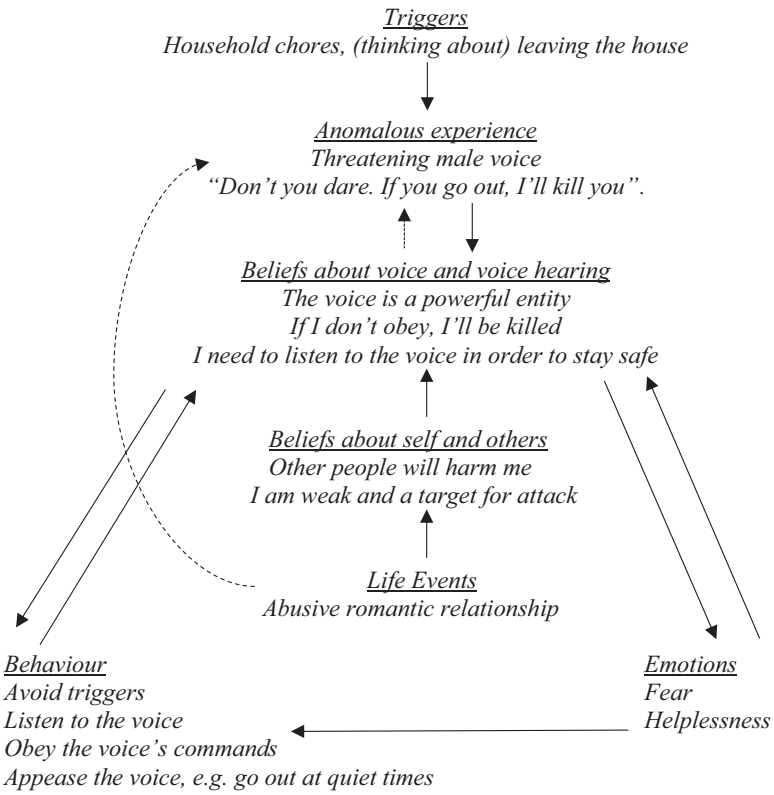

Fig. 9.5 Longitudinal formulation. (Adapted from Morrison 2017)

9.5.5 Interventions Derived from the Formulation (v)

Sessions started using the CTCH protocol (Meaden et al., 2013), enhancing coping strategies to build up Chrissy's sense of control and evaluating the power of the voice. The therapist and Chrissy spent some time discussing complex PTSD and some of the common sequalae of being a survivor of domestic abuse, leading to a new understanding that the voice was linked to her past trauma (Longden et al., 2012). This updated formulation offered an alternative (trauma-informed) appraisal of the voice. Chrissy accepted this possible alternative appraisal: *"Maybe my voice is related to my first relationship rather than being a powerful being"*. This shift in belief also meant she was more willing to test the power of the voice as therapy went on. Behavioural experiments allowed her to collect evidence that the voice gave empty threats, and nothing happened to her whether or not she obeyed. Her self-belief that she was weak and vulnerable also reduced, and she felt safe and empowered to do the things in life she wanted to.

9.5.6 Planning for the Future/Relapse Management (vi)

Given Chrissy's self-identity as a chronic and disabled patient, both within the home and the wider service, meetings were held jointly with her primary worker and her partner, in which Chrissy was empowered to outline her progress and how they could support her to continue with this.

9.6 Conclusion

CBTp is a client-centred and evidence-based therapy that aims to reduce distress and meet the goals of the client so they are able to live more fulfilling lives. Cognitive models identify a central role for appraisals of anomalous and other experiences, which therapy often focuses on, but in a way in which the current reality of the client is respected. Although not always specified in the cognitive models, formulation and intervention in CBTp will take into account the person's context and the function of delusional beliefs. This is reflected in the therapeutic approach, for example, considering the pros and cons of particular interventions and obtaining consent from the person to proceed, working within delusional beliefs to help the person to feel more in control, protecting the person's self-esteem, and linking change strategies to the person's goals. An interventionist-causal approach to the development of cognitive models of specific symptoms offers further promise to increase the precision and effect of therapy, with interventions targeting maintenance factors, including worry, negative affect, and cognitive biases. As with all therapies, CBTp must be done within the context of a good therapeutic relationship, in which the therapist is warm, open, and genuine. The therapist is curious, receives what the person communicates, validates the experience and distress, and works together with the client to make positive changes. It is a privilege to walk alongside our clients towards their recovery goals.

Disclaimer Clinical cases presented in this chapter do not include real names or personal information of real persons.

References

Beck, A. T. (1979). *Cognitive therapy and the emotional disorders*. Meridian Book.

Bentall, R. P., Fernyhough, C., Morrison, A. P., Lewis, S., & Corcoran, R. (2007). Prospects for a cognitive-developmental account of psychotic experiences. *The British Journal of Clinical Psychology/The British Psychological Society, 46*(Pt 2), 155–173. https://doi.org/10.1348/014466506X123011

Berry, K., Ford, S., Jellicoe-Jones, L., & Haddock, G. (2015). Trauma in relation to psychosis and hospital experiences: The role of past trauma and attachment. *Psychology and Psychotherapy, 88*(3), 227–239. https://doi.org/10.1111/PAPT.12035

Bighelli, I., Salanti, G., Huhn, M., Schneider-Thoma, J., Krause, M., Reitmeir, C., Wallis, S., Schwermann, F., Pitschel-Walz, G., Barbui, C., Furukawa, T. A., & Leucht, S. (2018). Psychological interventions to reduce positive symptoms in schizophrenia: Systematic review and network meta-analysis. *World Psychiatry, 17*(3), 316–329. https://doi.org/10.1002/WPS.20577

Birchwood, M., & Chadwick, P. (1997). The omnipotence of voices: Testing the validity of a cognitive model. *Psychological Medicine, 27*(6), 1345–1353. https://doi.org/10.1017/s0033291797005552

Birchwood, M., Michail, M., Meaden, A., Tarrier, N., Lewis, S., Wykes, T., Davies, L., Dunn, G., & Peters, E. (2014). Cognitive behaviour therapy to prevent harmful compliance with COMMAND hallucinations (COMMAND): A randomised controlled trial. *The Lancet Psychiatry, 1*(1), 23–33. https://doi.org/10.1016/S2215-0366(14)70247-0/ATTACHMENT/1B6515DE-0B69-4120-8252-1B68C1262280/MMC1.PDF

Birchwood, M., Dunn, G., Meaden, A., Tarrier, N., Lewis, S., Wykes, T., Davies, L., Michail, M., & Peters, E. (2018a). The COMMAND trial of cognitive therapy to prevent harmful compliance with command hallucinations: Predictors of outcome and mediators of change. *Psychological Medicine, 48*(12), 1966–1974. https://doi.org/10.1017/S0033291717003488

Birchwood, M., Mohan, L., Meaden, A., Tarrier, N., Lewis, S., Wykes, T., Davies, L. M., Dunn, G., Peters, E., & Michail, M. (2018b). The COMMAND trial of cognitive therapy for harmful compliance with command hallucinations (CTCH): A qualitative study of acceptability and tolerability in the UK. *BMJ Open, 8*(6), e021657. https://doi.org/10.1136/BMJOPEN-2018-021657

Brabban, A., Byrne, R., Longden, E., & Morrison, A. P. (2016). The importance of human relationships, ethics and recovery-orientated values in the delivery of CBT for people with psychosis. *Psychosis, 9*(2), 157–166. https://doi.org/10.1080/17522439.2016.1259648

Brand, R. M., Rossell, S. L., Bendall, S., & Thomas, N. (2017). Can we use an interventionist-causal paradigm to untangle the relationship between trauma, PTSD and psychosis? *Frontiers in Psychology, 8*(MAR), 306. https://doi.org/10.3389/FPSYG.2017.00306/BIBTEX

Brown, P., Waite, F., & Freeman, D. (2019). "Twisting the lion's tail": Manipulationist tests of causation for psychological mechanisms in the occurrence of delusions and hallucinations. *Clinical Psychology Review, 68*, 25–37. https://doi.org/10.1016/J.CPR.2018.12.003

Byrne, S., Birchwood, M., Trower, P., & Meaden, A. (2006). *A casebook of cognitive behaviour therapy for command hallucinations: A social rank theory approach*. Routledge.

Carr, S., Hardy, A., & Fornells-Ambrojo, M. (2018). The Trauma and Life Events (TALE) checklist: Development of a tool for improving routine screening in people with psychosis. *European Journal of Psychotraumatology, 9*(1), 1512265. https://doi.org/10.1080/20008198.2018.1512265

Chadwick, P., & Birchwood, M. (1994). The omnipotence of voices. A cognitive approach to auditory hallucinations. *The British Journal of Psychiatry, 164*(2), 190–201. http://www.ncbi.nlm.nih.gov/pubmed/8173822

Chadwick, P., Lees, S., & Birchwood, M. A. X. (2000). The revised Beliefs About Voices Questionnaire (BAVQ-R). *The British Journal of Psychiatry, 177*, 229–232.

Dunn, G., Fowler, D., Rollinson, R., Freeman, D., Kuipers, E., Smith, B., Steel, C., Onwumere, J., Jolley, S., Garety, P. A., & Bebbington, P. E. (2012). Effective elements of cognitive behaviour therapy for psychosis: Results of a novel type of subgroup analysis based on principal stratification. *Psychological Medicine, 42*(5), 1057–1068. https://doi.org/10.1017/S0033291711001954

Fornells-Ambrojo, M., Johns, L., Onwumere, J., Garety, P., Milosh, C., Iredale, C., Peters, E., Webster, A., & Jolley, S. (2017). Experiences of outcome monitoring in service users with psychosis: Findings from an Improving Access to Psychological Therapies for people with Severe Mental Illness (IAPT-SMI) demonstration site. *British Journal of Clinical Psychology, 56*(3), 253–272. https://doi.org/10.1111/bjc.12136

Freeman, D. (2011). Improving cognitive treatments for delusions. *Schizophrenia Research, 132*(2–3), 135–139. https://doi.org/10.1016/J.SCHRES.2011.08.012

Freeman, D. (2016). Persecutory delusions: A cognitive perspective on understanding and treatment. *The Lancet Psychiatry, 3*(7), 685–692. https://doi.org/10.1016/S2215-0366(16)00066-3

Freeman, D., Garety, P. A., Kuipers, E., Fowler, D., & Bebbington, P. E. (2002). A cognitive model of persecutory delusions. *The British Journal of Clinical Psychology/The British Psychological Society, 41*(Pt 4), 331–347. https://doi.org/10.1348/014466502760387461

Freeman, D., Pugh, K., Dunn, G., Evans, N., Sheaves, B., Waite, F., Černis, E., Lister, R., & Fowler, D. (2014). An early Phase II randomised controlled trial testing the effect on persecutory delusions of using CBT to reduce negative cognitions about the self: The potential benefits of enhancing self confidence. *Schizophrenia Research, 160*(1–3), 186–192. https://doi.org/10.1016/J.SCHRES.2014.10.038

Freeman, D., Dunn, G., Startup, H., Pugh, K., Cordwell, J., Mander, H., Černis, E., Wingham, G., Shirvell, K., & Kingdon, D. (2015a). Effects of cognitive behaviour therapy for worry on persecutory delusions in patients with psychosis (WIT): A parallel, single-blind, randomised controlled trial with a mediation analysis. *The Lancet Psychiatry, 2*(4), 305–313. https://doi.org/10.1016/S2215-0366(15)00039-5

Freeman, D., Waite, F., Startup, H., Myers, E., Lister, R., McInerney, J., Harvey, A. G., Geddes, J., Zaiwalla, Z., Luengo-Fernandez, R., Foster, R., Clifton, L., & Yu, L. M. (2015b). Efficacy of cognitive behavioural therapy for sleep improvement in patients with persistent delusions and hallucinations (BEST): A prospective, assessor-blind, randomised controlled pilot trial. *The Lancet. Psychiatry, 2*(11), 975–983. https://doi.org/10.1016/S2215-0366(15)00314-4

Freeman, D., Bradley, J., Antley, A., Bourke, E., DeWeever, N., Evans, N., Černis, E., Sheaves, B., Waite, F., Dunn, G., Slater, M., & Clark, D. M. (2016a). Virtual reality in the treatment of persecutory delusions: Randomised controlled experimental study testing how to reduce delusional conviction. *The British Journal of Psychiatry: the Journal of Mental Science, 209*(1), 62–67. https://doi.org/10.1192/BJP.BP.115.176438

Freeman, D., Bradley, J., Waite, F., Sheaves, B., DeWeever, N., Bourke, E., McInerney, J., Evans, N., Černis, E., Lister, R., Garety, P., & Dunn, G. (2016b). Targeting recovery in persistent persecutory delusions: A proof of principle study of a new translational psychological treatment (The feeling safe programme). *Behavioural and Cognitive Psychotherapy, 44*(5), 539–552. https://doi.org/10.1017/S1352465816000060

Freeman, D., Waite, F., Emsley, R., Kingdon, D., Davies, L., Fitzpatrick, R., & Dunn, G. (2016c). The efficacy of a new translational treatment for persecutory delusions: Study protocol for a randomised controlled trial (The Feeling Safe Study). *Trials, 17*(1). https://doi.org/10.1186/s13063-016-1245-0

Freeman, D., Taylor, K. M., Molodynski, A., & Waite, F. (2019). Treatable clinical intervention targets for patients with schizophrenia. *Schizophrenia Research, 211*, 44–50. https://doi.org/10.1016/J.SCHRES.2019.07.016

Freeman, D., Emsley, R., Diamond, R., Collett, N., Bold, E., Chadwick, E., Isham, L., Bird, J. C., Edwards, D., Kingdon, D., Fitzpatrick, R., Kabir, T., Waite, F., Carr, L., Causier, C., Černis, E., Kirkham, M., Lambe, S., Lister, R., et al. (2021). Comparison of a theoretically driven cognitive therapy (the Feeling Safe Programme) with befriending for the treatment of persistent persecutory delusions: A parallel, single-blind, randomised controlled trial. *The Lancet Psychiatry, 8*(8), 696–707. https://doi.org/10.1016/S2215-0366(21)00158-9

Garety, P. A., Kuipers, E., Fowler, D. G., Freeman, D., & Bebbington, P. (2001). A cognitive model of the positive symptoms of psychosis. *Psychological Medicine, 31*(2), 189–195. https://doi.org/10.1017/S0033291701003312

Garety, P. A., Bebbington, P. E., Fowler, D., Freeman, D., & Kuipers, E. (2007). Implications for neurobiological research of cognitive models of psychosis: A theoretical paper. *Psychological Medicine, 37*(10), 1377–1391. https://doi.org/10.1017/S003329170700013X

Garety, P., Waller, H., Emsley, R., Jolley, S., Kuipers, E., Bebbington, P., Dunn, G., Fowler, D., Hardy, A., & Freeman, D. (2015). Cognitive mechanisms of change in delusions: An experimental investigation targeting reasoning to effect change in paranoia. *Schizophrenia Bulletin, 41*(2), 400–410. https://doi.org/10.1093/SCHBUL/SBU103

Gaynor, K., Ward, T., Garety, P. A., & Peters, E. (2013). The role of safety-seeking behaviours in maintaining threat appraisals in psychosis. *Behaviour Research and Therapy, 51*(2), 75–81. https://doi.org/10.1016/j.brat.2012.10.008

Gumley, A., & Schwannauer, M. (2006). *Staying well after psychosis*. Wiley. https://doi.org/10.1002/9780470713303

Hardy, A. (2017). Pathways from trauma to psychotic experiences: A theoretically informed model of posttraumatic stress in psychosis. *Frontiers in Psychology, 8*(MAY), 697. https://doi.org/10.3389/FPSYG.2017.00697/BIBTEX

Heriot-Maitland, C., Knight, M., & Peters, E. (2012). A qualitative comparison of psychotic-like phenomena in clinical and non-clinical populations. *British Journal of Clinical Psychology, 51*(1), 37–53. https://doi.org/10.1111/j.2044-8260.2011.02011.x

Isham, L., Griffith, L., Boylan, A. M., Hicks, A., Wilson, N., Byrne, R., Sheaves, B., Bentall, R. P., & Freeman, D. (2021). Understanding, treating, and renaming grandiose delusions: A qualitative study. *Psychology and Psychotherapy, 94*(1), 119–140. https://doi.org/10.1111/PAPT.12260

Janssen, I., Hanssen, M., Bak, M., Bijl, R. V., de Graaf, R., Vollebergh, W., McKenzie, K., & van Os, J. (2003). Discrimination and delusional ideation. *The British Journal of Psychiatry, 182*(1), 71–76. https://doi.org/10.1192/BJP.182.1.71

Johns, L., Jolley, S., Keen, N., & Peters, E. (2014). CBT for people with psychosis. In *How to become a more effective CBT therapist: Mastering Metacompetence in clinical practice* (pp. 191–207). Wiley.

Johns, L., Isham, L., & Manser, R. (2020). Cognitive behavioural therapies for psychosis. In J. Badcock & G. Paulik (Eds.), *A clinical introduction to psychosis* (pp. 343–377). Elsevier. https://doi.org/10.1016/B978-0-12-815012-2.00015-8

Jun, H. J., Nam, B., Fedina, L., Smith, M. E., Schiffman, J., Link, B., & DeVylder, J. E. (2018). Paranoid beliefs and realistic expectations of victimization: Data from the survey of police-public encounters. *Schizophrenia Research, 199*, 326–332. https://doi.org/10.1016/J.SCHRES.2018.02.046

Kendler, K. S., & Campbell, J. (2009). Interventionist causal models in psychiatry: Repositioning the mind–body problem. *Psychological Medicine, 39*(6), 881–887. https://doi.org/10.1017/S0033291708004467

Kreyenbuhl, J., Buchanan, R. W., Dickerson, F. B., & Dixon, L. B. (2010). The schizophrenia Patient Outcomes Research Team (PORT): Updated treatment recommendations 2009. *Schizophrenia Bulletin, 36*, 94–103. https://doi.org/10.1093/schbul/sbp130

Lincoln, T. M., & Peters, E. (2018). A systematic review and discussion of symptom specific cognitive behavioural approaches to delusions and hallucinations. *Schizophrenia Research*. https://doi.org/10.1016/J.SCHRES.2017.12.014

Longden, E., Corstens, D., Escher, S., & Romme, M. (2012). Voice hearing in a biographical context: A model for formulating the relationship between voices and life history. *Psychosis, 4*(3), 224–234. https://doi.org/10.1080/17522439.2011.596566

Meaden, A., Keen, N., Aston, R., Barton, K., & Bucci, S. (2013). *Cognitive therapy for command hallucinations: An advanced practical companion*. Routledge.

Morrison, A. P. (2001). The interpretation of intrusions in psychosis: An integrative cognitive approach to hallucinations and delusions. *Behavioural and Cognitive Psychotherapy, 29*(3), 257–276. https://doi.org/10.1017/S1352465801003010

Morrison, A. P. (2017). A manualised treatment protocol to guide delivery of evidence-based cognitive therapy for people with distressing psychosis: Learning from clinical trials. *Psychosis, 9*(3), 271–281. https://doi.org/10.1080/17522439.2017.1295098

Morrison, A. P., Frame, L., & Larkin, W. (2003). Relationships between trauma and psychosis: A review and integration. *The British Journal of Clinical Psychology, 42*(Pt 4), 331–353. https://doi.org/10.1348/014466503322528892

Morrison, A. P., Stewart, S. L. K., French, P., Bentall, R. P., Birchwood, M., Byrne, R., Davies, L. M., Fowler, D., Gumley, A. I., Jones, P. B., Lewis, S. W., Murray, G. K., Patterson, P., &

Dunn, G. (2011). Early detection and intervention evaluation for people at high-risk of psychosis-2 (EDIE-2): Trial rationale, design and baseline characteristics. *Early Intervention in Psychiatry, 5*(1), 24–32. https://doi.org/10.1111/J.1751-7893.2010.00254.X

Morrison, A. P., Turkington, D., Pyle, M., Spencer, H., Brabban, A., Dunn, G., Christodoulides, T., Dudley, R., Chapman, N., Callcott, P., Grace, T., Lumley, V., Drage, L., Tully, S., Irving, K., Cummings, A., Byrne, R., Davies, L. M., & Hutton, P. (2014). Cognitive therapy for people with schizophrenia spectrum disorders not taking antipsychotic drugs: A single-blind randomised controlled trial. *The Lancet, 383*(9926), 1395–1403. https://doi.org/10.1016/S0140-6736(13)62246-1

Morrison, A. P., Law, H., Carter, L., Sellers, R., Emsley, R., Pyle, M., French, P., Shiers, D., Yung, A. R., Murphy, E. K., Holden, N., Steele, A., Bowe, S. E., Palmier-Claus, J., Brooks, V., Byrne, R., Davies, L., & Haddad, P. M. (2018a). Antipsychotic drugs versus cognitive behavioural therapy versus a combination of both in people with psychosis: A randomised controlled pilot and feasibility study. *The Lancet Psychiatry, 5*(5), 411–423. https://doi.org/10.1016/S2215-0366(18)30096-8

Morrison, A. P., Pyle, M., Gumley, A., Schwannauer, M., Turkington, D., MacLennan, G., Norrie, J., Hudson, J., Bowe, S. E., French, P., Byrne, R., Syrett, S., Dudley, R., McLeod, H. J., Griffiths, H., Barnes, T. R. E., Davies, L., Kingdon, D., & FOCUS trial group, S., … Tully, S. (2018b). Cognitive behavioural therapy in clozapine-resistant schizophrenia (FOCUS): An assessor-blinded, randomised controlled trial. *The Lancet Psychiatry, 5*(8), 633–643. https://doi.org/10.1016/S2215-0366(18)30184-6

National Institute for Health and Care Excellence. (2009). *Schizophrenia: Core interventions in the treatment and management of schizophrenia in primary and secondary care (update)*. Gaskell.

National Institute for Health and Care Excellence. (2014). *Psychosis and schizophrenia in adults: Treatment and management (CG178)*. National Institute for Health and Care Excellence.

Rector, N. A., Beck, A. T., & Stolar, N. (2005). The negative symptoms of schizophrenia: A cognitive perspective. *Canadian Journal of Psychiatry., 50*(5), 247–257. https://doi.org/10.1016/j.ahj.2005.01.046

Royal Australian and New Zealand College of Psychiatrists. (2005). Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of schizophrenia and related disorders. *Australian and New Zealand Journal of Psychiatry, 39*(1–2), 1–30. https://doi.org/10.1111/j.1440-1614.2005.01516.x

Sheaves, B., Johns, L., Griffith, L., Isham, L., Kabir, T., & Freeman, D. (2020). Why do patients with psychosis listen to and believe derogatory and threatening voices? 21 reasons given by patients. *Behavioural and Cognitive Psychotherapy, 48*(6), 631–645. https://doi.org/10.1017/S1352465820000429

Tsang, A., Bucci, S., Branitsky, A., Kaptan, S., Rafiq, S., Wong, S., Berry, K., & Varese, F. (2021). The relationship between appraisals of voices (auditory verbal hallucinations) and distress in voice-hearers with schizophrenia-spectrum diagnoses: A meta-analytic review. *Schizophrenia Research, 230*, 38–47. https://doi.org/10.1016/J.SCHRES.2021.02.013

Turner, D. T., van der Gaag, M., Karyotaki, E., & Cuijpers, P. (2014). Psychological interventions for psychosis: A meta-analysis of comparative outcome studies. *American Journal of Psychiatry, 171*, 523–538. https://doi.org/10.1176/appi.ajp.2013.13081159

Young, M., Read, J., Barker-Collo, S., & Harrison, R. (2001). Evaluating and overcoming barriers to taking abuse histories. *Professional Psychology: Research and Practice, 32*(4), 407–414. https://doi.org/10.1037/0735-7028.32.4.407