



Cognitive Behavioral Therapy for Psychosis (CBTp)

An Introductory Manual for Clinicians

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Contents

I. Introduction	Page 3
II. Modules	Page 4
A. Overview of CBTp and Therapeutic Techniques	Page 4
B. Working with Delusions	Page 15
C. Working with Hallucinations	Page 19
D. Group Intervention for Delusions and Voices	Page 21
E. Working with Thought Disorder and Negative Symptoms	Page 22
III. Summary and Applications	Page 24
IV. Further Readings	Page 25
V. References	Page 26

INTRODUCTION

This manual provides clinicians with an introductory knowledge of Cognitive Behavioral Therapy for Psychosis (CBTp). Developed as a companion to training workshops, it has been created as a reference for mental health professionals as they learn foundational theories and techniques of CBTp, an evidence-based psychological treatment for individuals suffering from psychotic disorders and symptoms. This manual provides information about the history and development of CBTp, clinical research and evidence base for the treatment, and techniques for applying CBTp in individual and group formats to core psychotic symptoms, including delusions, hallucinations, negative symptoms, and thought disorder. At the end of the manual, users will find selected readings and references to deepen their knowledge of CBTp.

This manual is intended as a guide for clinicians who are interested in learning about CBTp as a treatment modality for their patients with psychotic symptoms and disorders. The goal of the manual is to provide VA clinicians with a secure knowledge base in CBTp so that they can feel confident in their ability to identify patients who may benefit from CBTp, provide information about the treatment to patients and other clinicians, and make appropriate referrals to existing CBTp services. This manual can also serve as an entrée into CBTp for clinicians who may wish to pursue further training in the CBTp and eventually provide CBTp services. It is important to note that CBTp is a more than just a collection of strategies or techniques, and is rather a comprehensive psychological treatment approach comprised of (1) a comprehensive theory of psychopathology and (2) a detailed description of and guide to therapeutic techniques related to this model (Beck, 1976, 2009). Clinicians who wish to practice CBTp must therefore undergo further training than this manual can provide, so that they can become proficient in CBTp case formulation and treatment approach. That said, the hope is that this manual will provide valuable information to clinicians working with patients with psychotic disorders, as well as new insights and perspectives on the nature and treatment of psychotic symptoms. Clinicians who have been intensively trained in CBTp and those who are currently providing CBTp services may also find this manual useful as a reference point, guide, and refresher to their previous training. Those who are interested in learning more about CBTp, training opportunities for CBTp clinicians, and CBTp services in the VA System should contact: Yulia Landa, PsyD, MS, CBTp Program Director, or Rachel Jespersen, LMSW, CBTp Program Coordinator.

TRAINING MODULES

This manual is organized into five topic-areas, or modules of study, which align with introductory training workshops for clinicians in CBTp. In the first module, information about the development, research base, underlying theories, and therapeutic techniques is presented. The second module provides information about CBTp theory and techniques for working with delusions and the third provides information about working with hallucinations. The fourth module expands on these topics by providing information about CBTp group protocols to treat delusions and hallucinations. The fifth module covers treating negative symptoms and thought disorder with CBTp.

A. Overview of CBTp and Therapeutic Techniques

A1. History of CBTp and Current State

Cognitive Behavioral Therapy for Psychosis (CBTp) is an evidence-based treatment approach shown to improve symptoms and functioning in patients with psychotic disorders. CBTp aims to enhance function despite difficult symptoms and experiences such as hallucinations, negative symptoms, thought disturbances, and delusions. CBTp forms a collaborative treatment alliance in which patient and therapist can explore distressing psychotic experiences and the beliefs the patient has formed about these experiences, with the goal of reducing distress and disability caused by these experiences. CBTp is a structured, time-limited, and goal-based treatment modality. CBTp can be delivered in individual and group modalities, has long-lasting benefits after the termination of therapy, and is cost effective.

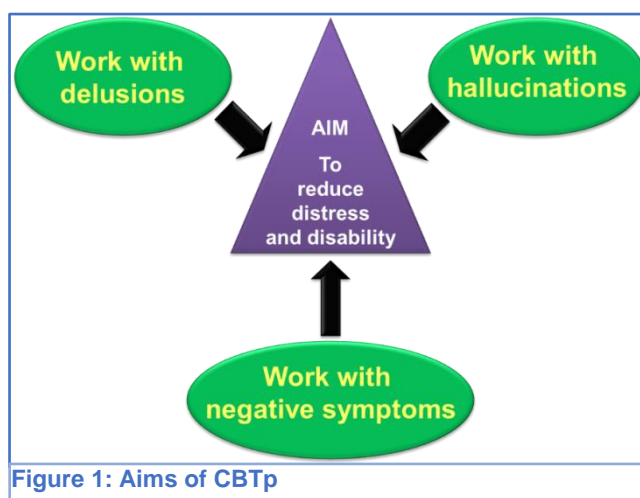


Figure 1: Aims of CBTp

CBTp was developed by Dr. Aaron Beck, an American psychiatrist who is largely regarded as the father of Cognitive Behavioral Therapy. The first documented application of CBT to psychotic symptoms was Beck's outpatient treatment of chronic schizophrenia patients with delusions, published in 1952 (Beck, 2009). Clinician-scientists in the UK especially began to study the effectiveness of CBTp, and in 1994 the first clinical trial of CBTp was published (Garety, Kuipers, Fowler, Chamberlain, & Dunn, 1994). Within the last 15 to 20 years, CBTp has gained traction in the United States as the intervention has become manualized and more widely applied (Chadwick, Birchwood, & Trower, 1996; Fowler, Garety, & Kuipers, 1995; D. Kingdon, Turkington, & John, 1994). Currently, there are more than 40 randomized clinical trials and multiple meta-analyses of these trials published.

CBTp is a clinically validated intervention for psychosis, with research indicating a 20-40% reduction in distress related to psychotic symptoms when CBTp is employed in conjunction with medications, and 50-65% of patients displaying reduced symptomology when treated with CBTp

(R. A. Gould, Mueser, Bolton, Mays, & Goff, 2001; Pilling et al., 2002; Wykes, Steel, Everitt, & Tarrrier, 2008). Furthermore, studies have indicated that treatment with CBTp is related to improvements in therapeutic relationships, changes in beliefs about self and others, changes in reasoning style, improvements in functioning, and learning to cope among people with psychosis (R. A. Gould et al., 2001; Pilling et al., 2002; Wykes et al., 2008). A study which compared the efficacy of CBTp to befriending interventions in medication-resistant schizophrenia demonstrated that both interventions significantly reduced positive, negative and depressive symptoms, but that there was sustained improvement at follow-up seen with CBT only (Sensky et al., 2000). CBTp has been recommended as a frontline treatment in treatment guidelines for schizophrenia published by the American Psychiatric Association (APA), Patient Outcomes Research Team (PORT), and the National Institute for Health and Care Excellence (NICE) in the United Kingdom.

American Psychiatric Association – “persons with schizophrenia who have residual psychotic symptoms while receiving adequate pharmacotherapy may benefit from cognitive behaviorally oriented psychotherapy.” (Lehman et al., 2004)

Patient Outcome Research Team – “persons with schizophrenia who have persistent psychotic symptoms while receiving adequate pharmacotherapy should be offered adjunctive cognitive behaviorally oriented psychotherapy to reduce the severity of symptoms. The therapy may be provided in either a group or an individual format and should be approximately 4–9 months in duration” (Dixon et al., 2010; Kreyenbuhl, Buchanan, Dickerson, Dixon, & Schizophrenia Patient Outcomes Research, 2010)

National Institute for Health and Clinical Excellence guidelines -“CBT should be offered to all patients with schizophrenia. This can be started either during the acute phase or later, including inpatient stay.” (National Institute for Health and Clinical Excellence, 2009)

A2. Theoretical Models of Psychosis and CBTp

A2.1. The ABC Model: CBT works by (1) collaboratively identifying problems that are most troublesome, (2) looking at how a person tends to think about them (“thinking habits”), (3) looking at how a person reacts to them (“behaving habits”), (4) considering whether or not these thinking and behaving habits are unrealistic or unhelpful and deciding whether there are other ways of thinking or reacting that would be more helpful in solving the issue, and (5) ultimately trying out these new ways of thinking and behaving, and choosing the ones that work. CBT operates on the principle that an individual’s emotional reactions are determined by their perception of events (Beck’s Model of Emotional Difficulties).

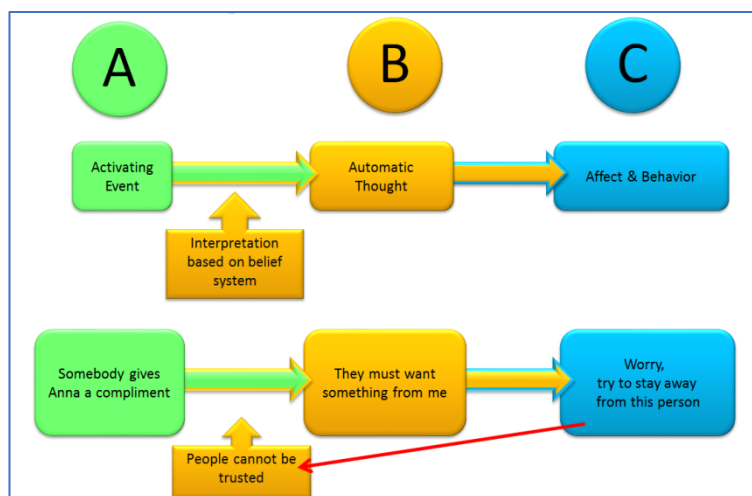


Figure 2: Example of ABC Model

For the purposes of CBT, the cognitive process can be simplified into the acronym “ABC,” wherein:

A is an activating event - any specific, observable experience.

B is a belief – it includes both thoughts and beliefs about the aforementioned event.

C is a consequence – the emotional and behavioral consequences of thoughts and beliefs.

Core beliefs are interpretations based on long-standing beliefs about ones’ self and the world, and may also be a part of the model, as they may impact the beliefs generated by an activating event. The ABC model is taught to patients so that they can learn to construct their own ABC models of distressing experiences and become more adept at recognizing the relationship between beliefs and emotional/behavioral consequences.

A2.2. The Stress-Vulnerability Model: The Stress-Vulnerability Model (Zubin & Spring, 1977)

is another central concept of CBTp, which serves to highlight the relationship between stress and symptomatology, as well to help normalize anomalous experiences by illustrating that at different levels of distress all people are capable of having such experiences.

The Stress-Vulnerability model posits that there is a bi-directional relationship between stress and vulnerability to psychotic experiences, whereby the more vulnerable people are to certain types of stress, the more prone they are to developing psychotic symptoms. The stress-vulnerability model

accounts for both biological predisposition and various stressors that patients experience throughout life, including formative events in childhood, environmental factors, cognitive factors, and reasoning and attribution deficits which, cumulatively, may trigger psychosis. Psychotic experiences themselves also have the potential to increase level of stress, thereby creating a negative feedback loop in which psychotic symptoms and related distress feed one another in vicious cycle. Thus, the goal of CBTp is to reduce distress caused by psychotic symptoms by changing patient interpretations and beliefs about the nature and consequences of the symptoms.

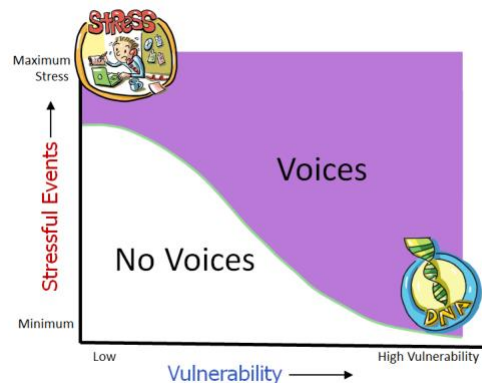


Figure 3. The Stress Vulnerability Model

A3. Therapeutic Process

In CBTp, the therapeutic process is conceptualized through a series of essential steps that can help reduce the patient's symptoms and disability by changing beliefs about these symptoms. In CBTp, the development of a strong therapeutic alliance is essential to the success of the treatment. The therapist takes an approach of "collaborative empiricism," working together with the patient as equals to better understand their experiences, thoughts, feelings and goals. The therapist utilizes empathy and normalizing to engage the patient, and works to understand the problem as the patient sees it. Rather than using an authoritative, directive, or exert style, the therapist uses what is called "Columbo Style" (after the famous television detective) to gently help the patient describe their experiences, how they arrived at their conclusions, and how they developed their specific beliefs. Engagement continues throughout the therapeutic relationship, but can be thought of as the first step in the therapeutic process. The therapeutic process of CBTp is outlined below:

Engagement: Empathy, normalizing, resolving ambivalence, & Columbo style

Assessment: Understanding the first episode in detail, ABC assessment model, & narrative approach

Formulation: Information on current beliefs and how the patient were arrived at these beliefs is assembled into a formulation. The goal of formulation is to develop a shared psychological understanding of the patient's problem(s)/symptom(s)

Goals: Goals are based on the patient's problem list and formulation

Interventions: Set appropriate interventions and evaluate effectiveness (e.g. reality testing/behavioral experiments; focusing on reasoning style, schema, and automatic thoughts)

Relapse Work: Relapse cognitions, assessment, personal pattern of relapse, and relapse prevention interventions

Within each session, maintaining the CBTp structure is crucial, as it maximizes predictability (thereby decreasing anxiety), increases patient investment and involvement in the treatment, helps exercise memory and meta-cognitive skills, and serves as a role model on how to behave/function. Below is an outline of CBTp session structure.

In the first few minutes of the session, the patient and the therapist:

- Complete mood check.
- Quantify symptom severity.
- Set up session agenda.
- Set up order of topics to be discussed.

During the session, the therapist:

- Reviews homework assignment (if applicable).
- Assesses progress during session and transitions.
- Relates topics discussed to previous sessions.
- Relates topics discussed to agenda of entire treatment.

Then, in the final minutes of the session, the following points are addressed:

- Review topics that were discussed in the session.
- Make plans for next session.
- Assess patient's view of the session (what was helpful what was not helpful?)
- Complete mood check.
- Review homework assignment (if applicable).

More detailed explanations of each step in the therapeutic process are outlined below.

A3.1. Engagement

In the engagement stage of CBTp (which continues throughout the therapeutic process) the therapist begins to develop a rapport with the patient, build the patient's level of trust and openness, and increase motivation to engage in treatment. CBTp techniques to be employed during this stage include Resolving Ambivalence, Normalizing, and Columbo Style, defined below.

Resolving ambivalence is a strategy that the CBTp clinician employs if the patient is ambivalence about a course of action to help them make choices. Resolving ambivalence may entail any or all of the following:

- Eliciting and exploring what the patient considers to be the available options for action
- Suggesting options for action that the patient may have overlooked
- Eliciting and exploring what the patient considers to be the good and bad aspects of the options
- Suggesting benefits and drawbacks that the patient may have overlooked
- Discussing any apparent discrepancies between the patient's present or planned behavior and their broader values and goals
- Focusing on and reinforcing adaptive attitudes and behaviors by:
 - Reflecting selectively
 - Reframing
 - Summarizing
 - Encouraging the client to expand on their adaptive attitudes
 - Using paradoxical interventions or role changes (i.e. asking the client to adopt the role of the therapist)

Normalizing experiences is another technique used to engage with the patient in order to avoid catastrophic or stigmatizing cognitions about insanity and to recognize that psychotic experiences are shared by other people who are not ill and are on continuum with normal experience. Normalizing aims to help the patient understand that despite their distressing experiences, they are not radically different from other people and should not be treated in radically different ways than other people (e.g. being incarcerated). Often times, therapists use

famous or distinguished figures who experience psychotic symptoms to show that success is attainable despite life-long psychiatric problems. For reference, lists of confirmed voice-hearers can be viewed on websites such as <http://www.intervoiceonline.org>.

An explanation of the vulnerability-stress model may aid this process, emphasizing that all people have some level of vulnerability to psychotic symptoms and that even people with a low vulnerability could develop psychotic symptoms if they face sufficient stress. (See section A2.) Furthermore, studies have indicated that particular kinds of stress (e.g. sleep deprivation, sensory deprivation, solitary confinement) can lead to hallucinations and paranoid ideation in almost any individual displaying otherwise 'normal' functioning.

Normalizing cognitive processes may help patients feel more confident in their cognitive processes, and is accomplished by discussing the 'understandability' of a patient's explanation of the situation. It may help to point to evidence that indicates that people who hold strong beliefs (e.g. political beliefs) select information that supports their beliefs, ignore information that appears to contradict them, and interpret ambiguous information in line with their beliefs. It may also be helpful for the therapist to discuss the ways in which long standing beliefs or strong emotions can influence the way everybody perceives and makes sense of any new information—especially in ambiguous situations.

Columbo Style refers to a non-confrontational way of eliciting information from patients regarding their beliefs and experiences. It can be contrasted with the "Sherlock Holmes" style, which tends to use direct questions to deduce implicit meanings from the individual's account. When employing the Columbo Style, the therapist shows interest in the patient's account, keeping in mind that empathic communication may make the patient more willing to disclose distressing experiences. The therapist should avoid confronting the patient directly with the gaps, contradictions, and inconsistencies in their accounts and should instead take the approach that the patient's perception of events is logical but that the therapist is confused or missing something and needs further explanation from the patient to fully understand. Finally, the therapist determines the series of events and assumptions upon which the beliefs are based on and the evidence that is used to maintain them.

A3.2. Assessment: Assessment is an important part of the therapeutic process in CBTp, and is itself an intervention. The success of treatment depends upon collaboratively creating with the patient a formulation of the development and maintenance of psychotic symptoms, for which information discovered during the assessment process is crucial. Assessment in CBTp involves: assessing psychotic experiences, longitudinal assessment of early experiences, core beliefs, and dysfunctional rules or assumptions; cognitive components (e.g., biases, distortions, intrusions, appraisals); behavioral components (e.g., safety behaviors); affective components; physiological components; and triggers and mediators.

The **primary goals** in CBTp assessment are:

- Identifying problems
- Gathering information to guide the formulation
- Gathering information to test hypotheses
- Monitoring symptoms

A3.2.a. Assessing Psychotic Experiences

In assessing psychotic experiences, the main goal is to understand the first episode of psychosis *in detail*. There are two main ways to do this: the ABC Model and a Narrative Approach. In order to use the ABC Model in assessment, the *activating event*, *belief*, and *consequence(s)* must be identified as they relate to the first episode. There are a number of details to be uncovered about each psychotic symptom:

- Form
- Content
- Frequency
- Duration
- Conditions under which they typically occur(ed)
- Consequences
- Impact
- Ascribed meaning
- Conviction in this meaning
- Quality/intensity
- Distress
- Preoccupation

Using the narrative approach, clinicians help patients to construct a narrative account of their experiences as a meaningful sequence of events. With the narrative approach, clinician and patient are:

- Developing an evolutionary story to try and make sense of a series of often seemingly unrelated experiences
- Focusing on a sequence of events and experiences to help the patient to ‘stand back,’ observe the pattern, and develop a new perspective.
- Switching between a narrow and a broad focus to help the patient to develop an understanding of underlying themes and causes.
- Introducing other information or perspective and integrating it with the patient’s version.

A3.2.b. Recognizing Problems

An important technique during the assessment process of CBTp is recognizing problems and assisting patients in identifying problems. Insight is often poor among people suffering from schizophrenia and other psychotic disorders, and in some cases may even be completely absent. Poor insight can make it difficult for the therapist to engage patients in discussions about their problems if the patient does not recognize any or all of the problems that exist. Within a CBTp framework, the therapist remains empathic and open when recognizing problems. It is important that the patient lead the therapeutic process and feel empowered, and the discussion about problems should always be collaborative. Below are guidelines for recognizing problems in CBTp treatment.

Recognizing Problems- How To Do It

- Highlighting the “stress” that the patient has been experiencing as one rational for further discussion and enquiry.

- Normalizing and validating particular experiences and helping the patient to feel safe to discussing particular problems without fear of judgment.
- Contrasting the patient’s perspective with that of important people in his/her life and exploring possible reasons for any discrepancies.
- Pointing out that some of the experiences that the patient has reported or some of the behaviors the therapist has observed, or heard about, might be considered to be problems requiring solutions.
- Highlighting inconsistencies between the patient’s denial of problems and other statements or behaviors of the patient (e.g. such as willingly accepting medication in a psychiatric hospital).

A3.3. Formulation

After assessment, the next step in the therapeutic process is developing a Formulation, or explanatory model of the development and maintenance of psychotic symptoms. According to Persons (1989), “Case Formulation is a hypothesis about the nature of the psychological difficulties underlying the problems on the patient’s problems list”. The goals of developing a formulation are: (1) to validate the patient’s existing explanation of their experiences by presenting an understandable account of why they came to conclusion they did, and (2) to explore alternative explanations of experiences that may be more adaptive and less distressing.

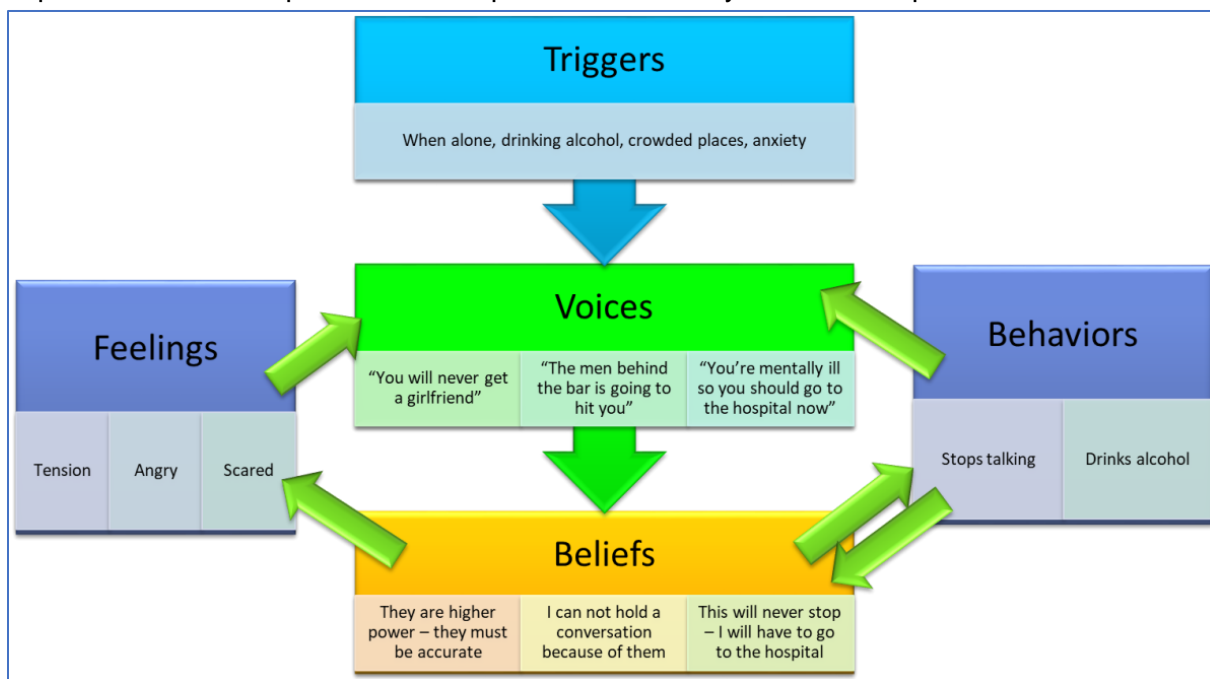


Figure 3. Model of Formulation of Maintenance of Voices

Some examples of information that may be part of a formulation include the patient’s current problems, hypotheses about underlying mechanisms, precipitation of the current problems, the maintenance cycle of the current problems, the origins of the central problems, and predicted obstacles to treatment.

A formulation is important because it helps:

- Understand the relationships between problems
- Choose a treatment modality
- Choose an intervention strategy
- Choose an intervention point
- Predict behaviors, understanding and managing non-compliance
- Redirect an unsuccessful treatment

There are two types of formulations: the “*here and now*” *account* of symptom maintenance and the *historical account* of symptom development. Developing a formulation involves the following steps:

- Normalizing information
- Introducing models to help patient understand current feelings of distress
- Introducing models of particular symptomatology (e.g. voices, delusions, anxiety, etc.)
- Understanding problem occurrence: stress-vulnerability model
- Constructing historical formulations for understanding problem development and vulnerability

In developing a formulation, therapists consider patient’s goals, patient’s needs for information, patient’s priorities at the time, patient’s stage of treatment, and patient’s cognitive deficits and limitations.

In CBTp, therapists take the following approach in developing a formulation:

- Ask patient about his or her own formulation.
 - Provide information and ideas a little at a time and wait for the patient’s reactions before proceeding.
 - Try to express the ideas in language (and diagrams) that would be easy for the patient to understand -- use his or her own terms and avoids terms that the patient objects to.
 - Convey that everything said is open to negotiation.
- Assess the effectiveness of formulation together with the patient.

A3.4. Goals: The course of treatment for CBTp is based on the patient’s goals, which they identify collaboratively with the therapist based on their problem list. Goals are generated in the beginning phase of treatment and may be returned to throughout the course of therapy as certain goals are met and new needs and issues arise. Goal identification comes from setting both general and specific goals. The problems are negative, exist in the past and future, and are usually generalized, whereas the goals should be positive, based on the future, and very specific. These goals can be short-term, medium-term, or long-term, but they must be specific, measurable, achievable, realistic, and time-limited. It is important to note that the patient may identify goals that seem unrealistic or at odds with the therapist ideas of the course of treatment. In this case, the therapist should work to frame patient goals in such a way that they are feasible. Again, the ultimate goal is to reduce patient distress and disability caused by psychotic symptoms. In outlining goals the therapist should use the techniques outlined in the Identifying Problems technique, section A3.2.b.

A3.5. Interventions: Interventions selected will be based on the patient's goals and the case formulation. Often a case formulation will highlight a number of different intervention points, such as working with a patient to identify and reduce triggers; helping patient to gather evidence for and against various beliefs; setting up reality testing and behavioral experiments; providing education on cognitive distortions; teaching reasoning skills; and working on core beliefs and automatic thoughts. Interventions should always be applied within the context of the therapeutic relationship and at the patient's pace and level of comfort. Suggesting a behavior experiment or challenging a belief without first developing a rapport and demonstrating that the patient's understanding of events and situations makes sense given the current information is unlikely to be successful and may cause the patient to feel defensive. Although CBTp is a structured intervention, the CBTp therapist remains flexible and can also assist the patient with non-therapy related tasks that relate to larger goals and improve quality of life, such as completing an application for supported housing or fixing up a resume. The overall role of the therapist in CBTp is to create an alliance, let the patient lead the process, set treatment goals, promote homework, offer structure, understand the patient's beliefs, protect and enhance self-esteem, and help the patient to discover their own best way of coping. The CBTp therapist avoids imposing their own view, acting as an expert, minimizing the patient's experience, and being interpretive or inconsistent.

A3.6. Relapse Work: Relapse work ensures that the patient can feel reasonably confident in their ability to utilize skills and techniques to ensure that psychotic symptoms are managed. The therapist begins by assessing for previous relapse(s), which may involve the following considerations:

- What is the form, content and duration of the previous relapses
- What are antecedents of the previous relapse?
- What are the patient's appraisals of this experience?
- What is the impact of previous relapse?

When assessing for these factors, the therapist should also consider the patient's appraisal of the most recent relapse. What caused it? How and to what extent was the patient able to control the relapse? Are there any aspects of the relapse that patient finds exciting or rewarding (e.g. enjoyed the sensation of finding the world's answers, beautiful hallucinations, conviction that they have special talents)?

Next, the therapist assesses for any early warning signs and triggering events for relapse. They may introduce examples of early warning signs to help the patient determine the typical timeline of a relapse. The therapist may also encourage the patient to review any changes in their thoughts, perceptions, emotions and behaviors that preceded the most recent relapse. They may also try to invoke a recollection of any events that may have triggered the recent relapse.

Finally, the therapist assesses the patient's relapse cognitions. Identifying the cognitions relating to the relapse will inform the development of a relapse prevention plan. The patient's knowledge of the process by which relapse occurs, as well as their thoughts, assumptions and beliefs about relapse are all related to the cognitive basis of the relapse prevention plan.

The therapist's goal is to work with the patient to develop shared psychological understanding of their relapse profile. The formulation includes:

- The context and triggers of relapse
- Early warning signs, subtle emotional changes
- The nature/characteristics of relapse
- The patient's appraisals of relapse, impact of appraisals
- Common features between relapses and general vulnerability and how they may play out in the context of patient's life experiences
- Areas for relapse prevention interventions
- Rationale for relapse prevention plan

Relapse prevention interventions are formulated in a number of steps. After assessing for relapse and devising a formulation, the therapist develops individually appropriate relapse prevention strategies (action plan) based on the formulation. Next, CBT techniques are employed to challenge and re-appraise maladaptive cognition around relapse. Next, the therapist reviews the patient's current use of self-regulatory strategies and making a plan that they continue to use effective ones if needed in the future. Then, the therapist discusses with the patient how to monitor warning signs or who could monitor them. Finally, the therapist discusses difficulties implementing the plan and works collaboratively with the patient to resolve any problems that they might foresee.

B. Working with Delusions

Delusions are a major symptom of schizophrenia. According to the DSM-IV definition, delusions are *false beliefs* based on incorrect inferences that are firmly sustained despite evidence to the contrary and not accepted by other people within the same culture. According to the DMS-5, delusions are *fixed beliefs* that are not amenable to change in light of conflicting evidence. The distinction between a delusion and a strongly held idea is sometimes difficult to make and depends in part on *the degree of conviction* with which the belief is held despite clear or reasonable contradictory evidence regarding its veracity. Delusions are deemed bizarre if they are clearly implausible, not understandable to same-culture peers, and do not derive from ordinary life experiences.

B1. Understanding Delusions

Karl Jaspers, one of the key figures in psychosis research, theorized that a delusion is a combination of sensory experience and implicit meaning and is incomprehensible due to its origin in direct experience of new meaning. This also led to a belief that delusions are impossible to work with because we cannot understand them (Jaspers, 1963). Delusions can be perceptual or reasoning deficits and biases that cause an individual to misunderstand what is happening in the world (Bental, 1994; Frith, 1992; Blackwood et al., 2001). They can also be motivated beliefs that serve some intra-psychic function: paranoid delusion may be a product of complex processes of defense against negative schemata and in order to protect self-esteem (Chadwick et al., 1996; Taylor & Kinderman, 2002) (Faught & Parkinson, 1979). Another way to perceive delusions is complex behaviors contributing to formation and maintenance of beliefs: isolation, avoidance, not sharing feelings and experiences (Freeman et al., 2005; 2001).

More recent understanding of delusions has been more positive: Maher asserted that impossible explanations are rather common in general, and delusions are attempts to make sense of abnormal experiences (Maher, 1974) (Maher, 1988). In essence, Maher claimed that a delusional person's ability to apply logic to their experience is perfectly functional – their experiences cannot be explained otherwise. Indeed, magical explanations for external phenomena are also quite common, as evidenced by one survey that indicated over 25% of respondents believed in ghosts, over 50% believed in foretelling of the future, over 50% believed in telepathy, over 60% believed in God, and over 85% believed in angels (Gallup & Jones, 1989) Thus, illogical explanations themselves are not indicative of delusions, but certain cognitive mechanisms underlying such beliefs can indicate delusions.

Finally, the most recent breakthrough in the study of delusions came with the application of cognition to the understanding of the role of attentional, attributional, and reasoning biases (Richard P. Bental, 1992; Freeman & Garety, 2003)(Garety, 1989). The cognitive processes (or cognitive biases) that may be related to the formation and maintenance of delusional beliefs include: a tendency to jump to conclusions; emotional reasoning; decreased belief flexibility; negative beliefs about self; theory of mind deficits; tendency to make external personal attributions for negative events; selective attention to threat.

B2. Working with Delusions

When working with patients displaying delusions, the therapist may need to concentrate on working with cognitive biases prior to working with delusional content. In the context of the therapeutic relationship, the following techniques may be employed:

B2.a. Delusion-specific assessment of beliefs: In assessing beliefs, a comprehensive understanding of the patient's belief structure must be obtained, including:

- Content
- Conviction
- Preoccupation
- Distress (emotional impact)
- Behavioral impact (safety behaviors)
- Current triggers
- Initial formation
- Positive and Negative Consequences
- Current coping strategies

B2.b. Formulation: After the belief is assessed, a formulation must be made collaboratively with the patient. Reasons for adapting the belief must be weighed against the reasons for maintaining the belief, which will help build a foundation from which to challenge the belief.

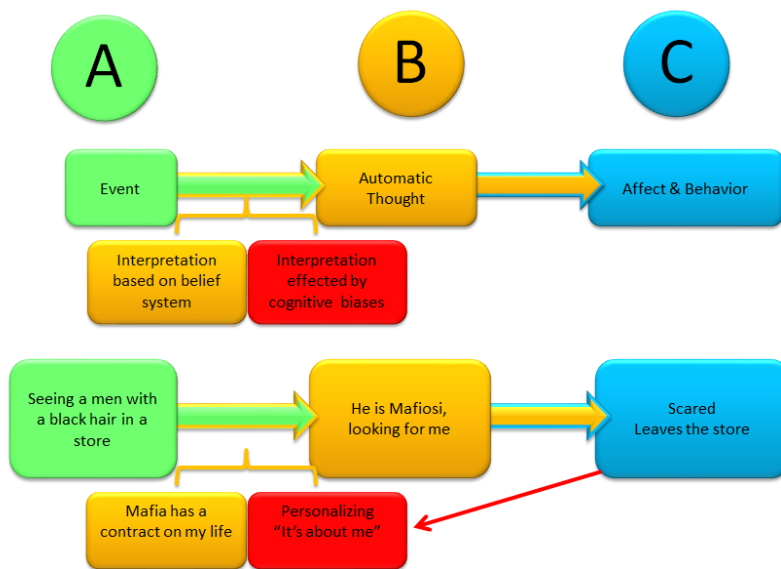


Figure 4. Example Formulation of Delusions

B2.c. Re-evaluating beliefs: Here it is vital to help the individual review the evidence they have presented. Start with evidence for the delusions on a day-to-day basis. It can be helpful to offer alternative explanations for the patient's beliefs, and to gently point out inconsistencies and fallacies in the patient's belief structure. The alternative explanation can either be pointed out by the therapist or elicited from the patient. Through this collaborative process, the therapist

encourages the patient to weigh out delusional beliefs and alternative interpretations in the light of available evidence. Remember that delusion is a reaction to puzzling or threatening experiences, and thus it follows that the patient would attempt to find meaning when frightened, anxious, or confused. Offering alternative explanations may reduce these feelings.

B2.d. Reality testing: Encourage the patient to engage in specific behaviors for the purpose of testing the validity of her/his belief. Make predictions about external events so that outcome of these events could serve as tests of those predictions. The therapist will develop an experiment collaboratively with the patient. The following questions should be considered when devising the experiment.

- What is the thought that you need to test out?
- What would be a good way of finding out what you need to know?
- What exactly information is needed?
- How may this be measurable?

After the experiment:

- How does the outcome relate to the original thought?
- How much do you believe that thought now?
- To what extent were your original predictions confirmed or disconfirmed?
- On the basis of the experiment, what is the most realistic and helpful view of the situation?

The “3 C’s” is one way to teach patients to begin practicing reality testing on their own. An outline of the process is below.

Catch It:

- What is the automatic thought?
- What was going through your mind?
- Is this thought helping me reach my goal?

Check It:

- How did it make you feel/do?
- What is the evidence for/against it?
- What would you say to a friend with that thought?
- Is this a mistake in thinking (e.g., “jumping to conclusions”; “all or none”)?

Change It:

- What is an alternative? Another possibility?
- Could you think anything else about it?
- Does the new thought help you reach your goal?

B2.e. Verbal Challenges of Delusions: In CBTp, clinicians verbally challenge patients’ delusions in a gentle and unthreatening manner. The therapist can gently point out inconsistencies in the patient’s belief system and then elicit alternative interpretations of the evidence. If necessary, the therapist can also gently offer alternative explanations. The therapist

then encourages the patient to weigh out the delusional beliefs and the alternative beliefs in light of the existing evidence.

B2.f. Normalizing Cognitive Processes: To help patients make sense of and deal with delusions, the therapist needs to convey that a delusion is a reaction to a puzzling or threatening experience, such as hearing a voice or panic. The therapist portrays the delusion as a reasonable attempt to find meaning when the patient was frightened or anxious, and highlights that in the moment it functioned to reduce the sense of confusion and feelings of fear.

C. Working with Hallucinations

A hallucination happens when people hear, smell, feel or see something – but there isn't anything (or anybody) actually there to account for it. Despite being a key feature of schizophrenia, hallucinations are not unique to schizophrenia, and have been identified in a host of other disease states such as alcoholism, stroke, epilepsy, syphilis, AIDS dementia, nutritional deficiency, and more. Thus, researchers have deduced that hallucinations most likely arise from a capacity latent in the normal brain, widely distributed throughout the general population.

C2. Voice Hearing Phenomenology

The most common type of hallucination among schizophrenia sufferers is auditory verbal hallucinations (AVH), with around 53% of sufferers hearing voices (Landmark, Merskey, Cernovsky, & Helmes, 1990). Despite its high prevalence among schizophrenia patients, voice-hearing is not only experienced by individuals with schizophrenia. Around 2-5% of the general population hears voices. (Tien, 1991) To most who experience AVH, the voices sound real and seem to be coming from outside the individual's body, although other people can't hear them. Some voice-hearers may hear them in different places or may hear them coming from a particular object, such as a television. To others, voices may talk to a person directly, or they may talk to each other about a person, as if the voice-hearer is overhearing a conversation. Finally, voices *can* be pleasant but are often rude, critical, abusive or irritating. For many voice-hearers, AVH can become a prevalent aspect of one's life but may cause varying amounts of distress depending on the individual. A variety of cognitive process can explain the prevalence of AVH. First, AVH can be viewed as the verbal thoughts of inner speech, externally attributed mental events (Gallagher, Dinan, & Baker, 1994; L. N. Gould, 1948; Inouye & Shimizu, 1970). Next, misattribution of intrusive thoughts can influence AVH, because they are incompatible with meta-cognitive beliefs (Morrison, 1995). Finally, AVH can be attributed to the failure of source monitoring (the skill of identifying the source of experience) (R. P. Bentall, 1990).

The following statistics can be shared with patients to help normalize voice hearing (Nayani & David, 1996)

- Number: 66% of people hear more than 1 voice
- Timbre: 57% crowds talking; 34% middle aged man; 10% young adult female
- Accent: 71% of voices have a different accent than the voice hearer

- Class: 30% of upper class people hear voices, 17% of middle class people hear voices, and 11% lower class people hear voices
- Identity: 15% delusional identity; 46% real people
- Distress: 47% of individuals are severely distressed by voices, and 53% experience moderate to no distress
- Recurrence: 68% of people experience the same voices recurring
- Conscience: 46% of people said the 'voices' have replaced the 'voice of conscience'
- 68% reported abusive voices 25% approving
- 70% of patients initiated a dialogue in response to the voice's judgments
- 50% reported 'voices' asking questions.
- All but a few patients reported getting answers to their questions.
- 47% heard 'voices' telling them something they didn't already know

C3. Working with Voices in CBTp

In CBTp the aim is to work with distress caused by voices by exploring beliefs about the voices. As indicated by a study by Chadwick and Birchwood (1994), voices themselves do not cause distress. Rather, the presence of voices influences beliefs regarding the voices, which in turn cause distress (Chadwick & Birchwood, 1994). Research has shown that appraisals of voices are stronger predictors of distress and response to voices than the frequency and severity of voice hearing experiences. Beliefs about omnipotence of voices are related to distress, and beliefs about malevolence of voices are related to resistance to treatment (Emmanuelle Peters, Sally Williams, Michael Cooke & Elizabeth Kuipers, 2006).

When working with patients who are experiencing hallucinations, a clear understanding of the distress caused by hallucinations must be established. Utilizing the ABC model of cognition, the therapist starts with the consequence (C), then works back to activating event (A), then explores the belief (B). During this process, the following should be considered:

When working with hallucinations, therapists and patients collaborate to:

- Gently challenge beliefs about voices
- Establish the identity of voices (malevolent or benevolent)
- Understand the power of voices
- Learn how to control the voices
- Recognize resistance or compliance to the voices
- Uncover the origins of the voices
 - One way to do this is through *reality testing* (e.g., ask if others can hear them, tape record them, etc.)

Outlined below are aspects of the therapeutic process in working with hallucinations in CBTp.

3C.a. Establish whether hallucinations are distressing: The goal in addressing hallucinations is to work on beliefs that are not correct, not productive, and not adaptive. Once identified, the therapist will attempt to work with these beliefs to hopefully change the original thought. Thus, it is essential to understand everything about the voices--the behavioral (resistance vs. compliance with the voices), emotional (level of distress), and impactful (on functioning) aspects of the hallucination.

3C.b. Clarify nature of voices/visions: Assess the hallucination for information regarding frequency, loudness, content, number, and location. Ask the patient about any visions they may have had.

3C.d. Review beliefs about the focus and origin of hallucinations: Triggers of a hallucination must be identified. For instance, environmental (where, when), internal (anxiety), cause/origin (what causes them? Where do they come from?). Then, the nature of the voices must be determined: Identity (who are they? Are they helpful or harmful?), power (how powerful are they?), control (how much control does person have over the voices?)

3C.e. Introduce ‘normalizing’ alternatives: Research supports the idea that hallucinations occur in other diagnoses and even within an otherwise healthy population. The therapist should convey the message that it’s possible to experience voices and still lead a normal, productive, and happy life. Normalizing the patient’s experience may entail referring to famous and successful people such as Anthony Hopkins. Such examples may potentially inspire hope and reassurance for the patient’s future wellbeing.

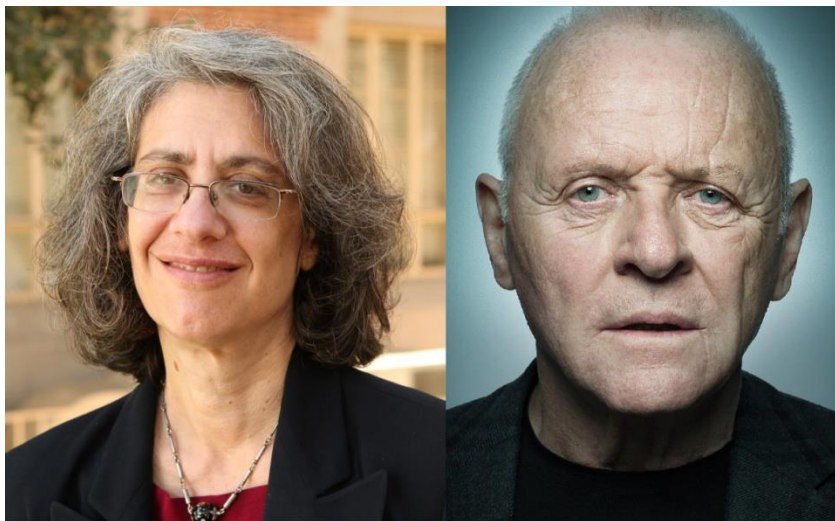


Figure 5. Elyn Saks (left), law professor at the Gould Law School; Sir Anthony Hopkins (right), Academy Award-winning actor. Both are voice-hearers.

3C.d. Aim to assist in the appropriate attribution of voices: If assessed voices are shown to be associated with anxiety or depressed mood, techniques for anxiety and depression should be employed to target associated symptoms first. If the patient misattributes ambiguous stimuli such as noise from outside as voices and has distressing beliefs about this experience, the therapist should explore cognitive explanations and evidence using CBT interventions.

3C.e. Examine the content of voices / visions: Can the content of the voices be shown to be untrue (e.g. is patient always a bad person)? Do voices tell lies? As in working with thought disorder (see below), the therapist must gather contextual evidence to examine beliefs, fears, and meaning underlying hallucinations.

3C.f. Enhance coping: The therapist should work with the patient both to enhance existing coping strategies and to find new techniques. Some examples of coping strategies for auditory hallucinations include: self-monitoring (noticing triggers), anxiety management, and distraction (talking to someone, listening to music, going for a walk). Another coping technique is *focusing*. In focusing, the individual will focus on cognitive distortions, which are maladaptive beliefs about

voices, and try to respond to them rationally. They could also respond rationally to the voice content if it is negative and attempt to dismiss the voices, and then list evidence in favor of the voice content and against the voice content. When practiced for ten minutes at a specific time each day, this intervention has been shown to decrease distress. Some other aspects of focusing include reminding oneself that no one else can hear the voice(s) and giving the voices a ten minute time slot each day. The therapist should be aware that coping *may not be effective* if and when (1) voices have clear meaning or represent a long-standing relationship, and (2) coping conflicts with central beliefs (the voices have malevolent power, religious beliefs).

D. Group Interventions of Delusions and Hallucinations

A number of CBTp group-based treatment manuals have been developed to treat various symptoms of psychosis. Research has shown that Group CBTp can result in: a reduction in negative symptoms (Andres, Pfammatter, Garst, Teschner, & Brenner, 2000) (Johns et al., 2002); reduced co-morbid social anxiety and avoidance, as well as improved mood and quality of life (Halperin et al., 2000); reduced positive symptoms and an increase in coping (Lecomte, 1999; 2006); improvement in symptoms and a lower relapse rate (Bechdolf et al., 2004); reduced feelings of hopelessness and reduced rates of low self-esteem (Barrowclough et al., 2006); and a decrease in delusional severity, delusional conviction and changes in cognitive biases targeted in treatment (Y Landa, Silverstein, Schwartz, & Savitz, 2006). There are several possible benefits of Group CBTp Interventions. Groups can: (1) reduce isolation and provide support; (2) help normalize patients' experiences; (3) provide unique learning opportunities; (4) help patients may more easily recognize thinking errors made by others and learn from them; (5) allow patients to give feedback to one another; and (6) allow more patients to receive treatment. The following models have been tested in clinical trials:

- Group CBT for Auditory Hallucinations (Chadwick, Sambrooke, Rasch, & Davies, 2000; Wykes, Parr, & Landau, 1999)
- Group CBT for Negative Symptoms (Andres et al., 2000) (Johns, 2002)
- Group Cognitive Social Skills Training for Older Adults (McQuaid, (2000))
- Group CBT for First Episode Patients (Lecomte et al., 2007)
- Group CBT for Delusions (Y Landa et al., 2006)
- Family and Group Based CBT for Youth at Risk for Paranoia (Y. Landa et al., 2016)

D1. Selecting Patients for CBTp Groups

The following considerations should be made when selecting patients for CBTp groups:

- Target specific domains for treatment & recruit patients with need in target area (e.g. paranoia)
- Maximize patients' level of shared experience (e.g. same phase of illness)
- Minimize heterogeneity in cognitive ability
- Counterbalance motivated and unmotivated individuals

The primary exclusion criteria for CBTp groups is when patients do not wish to be in the group. Depending on the therapist and group model, other exclusion criterion may apply, such as aggressive behavior or active substance use.

E. Working with Thought Disorder and Negative Symptoms

E1. Working with Thought Disorder

The Cognitive Model of Thought Disorder is central to CBTp treatment attitudes in thought disorder, and posits that communication disorder may be a more apt name for the phenomenon. Research indicates that thought-disordered patients are not *always* disordered. In one study, patients were retrospectively asked to explain thought disordered passages of speech, and were often able to explain their cognitive processes (Harrow & Prosen, 1979). In another study, patients were found to be more incoherent when discussing emotionally salient topics (Tai, Haddock, & Bentall, 2004). This research implies that it may be the language rather than the thought process that is idiosyncratic. Thus, it is the therapist's job to help the patient identify and verbalize their experiences. In addressing thought disorder, it is imperative to demonstrate a desire to understand the patient. When patients present as thought-disordered, working on communication may be the first step in the therapeutic process before a formulation can be developed. First, the following must be established: *Is emotional disturbance a significant feature of the disordered thought?* This can be assessed by noting whether thought disorder worsens when emotional salient topics are discussed. Next, *could the thought disorder be related to substance abuse?* Hallucinogenics correlate with increased rate of speech and distractibility, which may mimic or elevate the typical characteristics of thought disorder. Finally, *what is the conversational style of the patient?* For example, grandiosity may be related to certain speech patterns, ie "I am unique and speak in hyper-intelligent language. Just see if you can understand me". After assessing for these factors, communication can then be clarified. The following are guidelines for consideration when clarifying communication with a thought disordered patient.

Listen: Be nondirective, then structured. Enable a person to express their point of view. Link key words and reflect back in order to make an educated guess based on the context that has been provided. If flow of conversation incomprehensible, look for themes.

- *Example:* "she died" "Accident" "Painful"
- "Do you mean your mother?"
- "Are you referring to an accident that happened to you?"

Clarify: Ask for meaning of neologism, metaphor. Provide possible alternative words that may help gain a better understanding of the context or emotion. For example, if the patient uses the word "discreting" saying, "I don't really understand what you mean by 'discreting,' but it sounds unpleasant," and then later when it becomes clear, "I see--you mean disappointing."

Closed ("yes" or "no") questions: You may begin with closed questions first in order to gather initial context, then continue to more open questions once the conversation progress.

Keep patient on topic by interrupting: Redirect the conversation by asking for clarification on the context that has already been provided.

- *Example:* "...Hold on a minute... let's just see If I understood what you said about your concern about the FBI... Sorry if I am a bit slow today."

If further clarification is not proving successful, it may be necessary to move on and return to the topic at a later time. If questions are unwelcomed, the therapist may need to simply sit with the patient and listen.

E2. Working with Negative Symptoms:

In Kingdon and Turkington's approach to patients with negative symptoms, the therapist must understand that they will not be able to push patients out of negative symptoms, but may instead be able to open doors for them (D. G. Kingdon & Turkington, 2005). Thus, negative symptoms should be assessed for possible relation to other symptoms associated with schizophrenia (secondary symptoms) such as positive symptoms (delusions and hallucinations), anxiety, depression, or side effects from medications. The patient may also present with negative symptoms due to fear of relapse or avoidance of over-stimulation. If negative symptoms are secondary, the therapist should work with depression and anxiety, work with positive symptoms, or discuss relapse prevention.

Symptom	Description	Factors to consider
Affective flattening	Lack of emotional expression	Emotional unresponsiveness does not mean that subject is unimportant Trauma? Demoralization?
Anhedonia	Feeling of emptiness, reduced interest in activities, hopeless, demoralized	Higher level of negative emotions, similar to depression
Apathy/avolition	Limited in activity including school, work, physical care	Similar to depression? Under pressure and falling expectations - 'driven to a standstill'?
Alogia	Amount and content of speech restricted or interrupted, slowness to respond	Difficulty communicating? Poverty of environment? Reaction to criticism?
Social withdrawal	Reduced participation in relationship	A mechanism to reduce stress by lowering overstimulation?
Attention deficit	Difficulty in concentration and remembering	Overstimulation? Anxiety? Depression?

In working with negative symptoms it is imperative for the therapist to be empathic, building on meaningful engagement and identifying possible motivators for the client that will help 'open doors' for them. Setting goals now can become tricky; the patient might set high standards for him/herself and then become discouraged when the goals are not met. In order to avoid possible frustration and discouragement, it is important for the therapist to establish pressured areas, work on setting realistic goals, identify cognitive distortions, accepting flexibility, and dealing with setbacks.

E2.a. Interventions for Negative Symptoms: In developing an intervention for negative symptoms, CBTp focuses on building on meaningful engagement, identifying motivating factors, balancing between acceptance and pressure to change, and reducing pressure and immediate expectations. In CBTp, if negative symptoms are secondary, then therapists will

focus on the primary issues (e.g., depression, anxiety, positive symptoms, and relapse prevention interventions). Additionally, if premorbid development is poor, therapists and patients work on skills development (social, domestic, employment, etc.) and motivators. And if premorbid development is good, then therapists and patients work on reducing immediate pressures and expectations and taking time to recover. Negative symptoms may also be due to negative cognitions about activities. If there is a low expectancy of pleasure, the therapist may schedule meaningful activity, set an expected pleasure rating, identify cognitive distortion, consider, alternative evidence, keep pleasure ratings, and use feedback to shift low expectations as they arise. If there is low expectancy due to “high costs,” the patient is most likely perceiving the high personal costs of making an effort (“It’s not worth the effort”). In this case, it will be important for the therapist to review realistic goals, identify cognitive distortions, consider alternative evidence, prepare alternative balanced intervention, keep pleasure ratings, and use feedback to shift low expectations. Patients with psychosis may also have low expectancy due to stigma. In this case the therapist can provide assertiveness training, psychoeducation, and promote personal contact.

SUMMARY AND APPLICATIONS

CBTp is based on the cognitive model, and it is not simply a collection of techniques. In CBTp, engagement with the patient is seen as primary. Techniques such as a normalizing approach (based on stress-vulnerability model), non-confrontational “Columbo” style versus “Sherlock Holmes” style, “Collaborative Empiricism” (a collaborative investigation of various possibilities) are emphasized in CBTp. CBTp is a goal-centered and time limited treatment. Goals in CBTp are structured around relieving distress for the patient, making sense of psychotic symptoms, exploring the personal meaning of symptoms, and promoting self-regulation. The goals of the CBTp Program in the VA system are to deliver state-of-the art treatment, advance research, and provide training in CBTp. The ultimate goal is to make CBTp available to a large number of veterans.

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