Cognitive-behaviour therapy in psychosis (CBTp) is gaining an increasing body of evidence. This module has described a number of clinical scenarios where cognitive therapy interventions could be helpful for clinicians.

The aim of the module was to raise awareness and encourage practitioners who are interested in CBTp to seek appropriate training and clinical supervision. We have provided a theoretical overview of CBTp, reviewed the current evidence base and provided a useful framework for clinicians to use when working with clients.

Theoretical overview

- CBT in psychosis has a long history in clinical practice. Aaron T Beck was the first clinician to describe successfully treating a patient with systematised paranoid delusions, and since then the empirical evidence base for CBTp has flourished.
- Although antipsychotics remain the first-line treatment for psychosis, there is now growing evidence that up to 75% of patients discontinue their pharmacological treatment.
- NICE recommends that CBT for schizophrenia should consist of at least 16 planned sessions over a minimum of nine months, with specially trained therapists.
- While antipsychotics are based on pharmacological theories such as the dopamine theory, CBTp is based on the ‘stress-vulnerability model’, which hypothesises that everyone has some vulnerability to developing schizophrenia, suggesting that biological, psychological and social factors contribute to this vulnerability.
- Normalising is a key component of CBTp, and involves reducing the fear and anxiety associated with catastrophic beliefs by introducing the fact that psychotic experiences are not limited to people with mental illness but are relatively common in the general population.
- The fundamental difference between CBT and a traditional medical approach is that a formulation, as opposed to a diagnosis, lies at the heart of the intervention.
- The ABC model provides a framework for understanding and intervening with psychotic symptoms: the person’s voices/auditory hallucinations are the ‘A’, or activating event; ‘B’ represents the person’s beliefs about the voices, and ‘C’ represents the emotional and behavioural consequences.
- Engagement is essential when working with people experiencing delusions. Using a Socratic dialogue can help to build therapeutic alliance and can provide opportunities to explore events (internal or external) that have contributed to the development of delusional ideas.

Clinical examples of working with clients with psychosis

When working with clients with psychosis, it would be helpful to:

- work out a joint problem list
- offer information on the prevalence of voices in the general population
- ask about the impact the voices have (emotions, physiology, behaviour and functioning) and the client’s understanding of them
- elicit and rate the level of distress associated with the voices; explore beliefs about power and control (using a rating scale of 0–10)
explore the precipitating factors that led to the onset of the voices (i.e. cannabis, trauma, bereavement, breakdown of relationship)

develop a collaborative case formulation to identify treatment interventions and start the process of normalising

acknowledge the distress associated with the beliefs; be aware of your language, avoid diagnostic terms and show that you are empathising with how difficult this experience is

ask the client how it feels to be able to talk about their difficulties; suggest the possibility of using CBT sessions to explore, understand and talk about what is happening.

How CBT can be used in complex cases

Complex cases of psychosis can involve factors such as: insight difficulties; aggressive behaviour; comorbid drug or alcohol misuse; absence or intolerance of social network; and involvement of the criminal justice system.

Complex cases involve dual issues of risk and the need for rehabilitation in terms of activity and relationships. Here, the CBT therapist plays a slightly different role: partly therapist, but also an advisor to the treating team to achieve these twin objectives (which can be mutually contradictory at first sight).

When working with a client displaying symptoms of complex psychosis, CBT formulation can help to identify risk potential and predict difficulties that may arise. CBT would enable the clinician to:

- begin the process of normalising
- assess beliefs about power, identity and controllability in relation to voices
- explore links between the experience of voices, suicidal thinking and risk potential
- develop and prioritise a problem list
- explore initial goals of therapy
- develop a shared formulation to help identify treatment interventions.

Further reading


