CBT for Psychosis (CBTp)

This section describes the knowledge and skills required to carry out CBT for people with psychosis (CBTp)

Effective delivery of CBTp depends on the integration of this competence list with the knowledge and skills set out in the CBT competence framework (accessed at: www.ucl.ac.uk/CORE/).

Knowledge of CBTp and its implementation

- An ability to draw on knowledge that CBTp is predicated on the development and realisation of a collaborative working relationship with the client, and that all activities associated with the intervention take place within this context
- An ability to draw on knowledge that in CBTp the central focus is on a maintenance model (the factors that drive and maintain distress and dysfunction), and that this concern with maintenance factors shapes both the assessment and the intervention, and that:
  - a primary aim of assessment is to identify a maintenance model that helps to explain the individual client's distress and dysfunction
  - maintenance models will usually include, and be supported by, a developmental formulation
  - any decision about the timing, focus and content of interventions should follow from this maintenance model
  - because each client's maintenance model will be different, the focus and content of a CBTp intervention can and should vary from person to person
- An ability to draw on knowledge that assessment and formulation of each client's difficulties will determine the degree to which the maintenance model needs to focus on proximal and/or distal (developmental) maintaining factors

- An ability to draw on knowledge that because each client will have a different formulation the structure of CBTp interventions will differ from person to person, but an indicative order might be:
  - Engaging the client, including a focus on:
    - coping skills
    - normalisation / validation of the client's experience
    - affect regulation
    - working with the client to identify the changes they would value and wish to work towards
    - helping the client weigh the advantages and disadvantages of change
    - instilling a sense of hope and optimism
  - Graded work on symptoms, usually starting with verbal evaluation and introducing behavioural experiments in relation to the client's readiness to undertake them (or where the experiment is 'no lose' and therefore unthreatening)
  - Identification and evaluation of core beliefs regarding the self and others
  - A focus on ending that includes:
    - consideration of strategies for staying well (relapse prevention)
    - consideration of, and support for, the client's social functioning, social support and social relationships
    - consideration of, and support for, the client's understanding of themselves and their sense of empowerment
  - An ability to draw on knowledge that the aims (and therefore the content) of therapy need to reflect the time available for the intervention

- An ability to draw on knowledge that because the content of CBTp reflects the client's current needs and concerns, the focus for clients who are in, or close to, an acute episode will be different to that for individuals who are between episodes (e.g. where "meaning-making" may be more appropriate and relevant)
- An ability to draw on knowledge that in CBTp engagement, assessment, formulation and intervention are best seen as iterative (rather than distinct) phases, and that:
  - each area is likely to be revisited as contact proceeds
  - therapists need to adopt a flexible (rather than linear) approach to each phase, tailored to client need and capacity
  - the need for a thorough assessment and formulation does not preclude the introduction of focused interventions that can promote engagement by helping the client experience early gains (e.g. using 'no loss' behavioural experiments to test-out ideas, or introducing specific techniques such as behavioural activation)
- An ability to draw on knowledge that the length of time needed to assess and formulate a client's difficulties can vary markedly, and will be influenced by factors such as:
  - progress in building the therapeutic alliance
  - the client's needs, capacities and concerns (e.g. their ability to concentrate, their level of suspiciousness, and the complexity of their presentation)

Knowledge about cognition and information processing

- An ability to draw on knowledge that clients may have difficulties in cognitive functioning (e.g. in memory or attention) and/or intellectual functioning, and that:
  - this may be relevant to their presentation and capacities
  - can be accommodated by appropriate adjustments (e.g. reducing cognitive demand by keeping to a short agenda, shorter but more frequent sessions, or flexibility over location)
- An ability to draw on knowledge of the information processing biases and distortions which are commonly observed in cognitive therapy, as well as those biases which may be relevant to the formation of delusional beliefs e.g.:
  - selective abstraction (focusing on negative details taken out of context, ignoring other salient features, and drawing conclusions on the basis of this "fragment" of experience)
  - jumping to conclusions – data gathering bias (a tendency to draw conclusions which are not warranted from available information)
  - belief inflexibility (the extent to which an individual can consider alternative positions or alternative hypotheses)

ENGAGEMENT

Ability to engage the client and build a collaborative approach to assessment

- An ability to orient the client to the assessment process (and to respond to their concerns or queries) by conveying the fact that the assessment will usually:
  - be wide-ranging (e.g. focusing on the past as well as the present)
  - include detailed consideration of their specific experiences (e.g. hallucinations, delusional beliefs)
  - be conducted over an extended period of time (rather than in one or two initial sessions)
- An ability to check with the client that the content and scope of assessment conforms to their expectations, and to their needs

An ability to convey the importance of undertaking a careful assessment before attempting to initiate change
an ability to introduce discrete elements of CBT technique during the assessment if this is likely to foster engagement and give the client a direct experience of the CBT model) e.g.:
validating or normalising the client's experiences
introducing behavioural activation
keeping a diary of voices
An ability to foster a positive alliance with the client by (for example):
explicitly encouraging the client to talk openly about their experiences and concerns
maintaining a consistently empathic position
being alert both to what the client says and what they convey nonverbally (through their tone of voice, behaviour and body language).
showing that the client's comments are taken seriously, regardless of content (e.g. taking a neutral stance in relation to the content of a delusional belief and collaboratively weighing evidence for and against this way of thinking (while explicitly acknowledging its reality for the client))
validating the client's experiences by helping to show how thoughts, emotions, and behaviours are understandable (e.g. in the context of their past history)
showing an understanding of how the client makes sense of their voice(s) and empathising with their reactions to the experience of hearing voice(s)
making judicious use of humour (e.g. to normalise a client's experience or to reduce tension)
helping the client to maintain their focus by offering frequent summaries of pertinent themes

Ability to respond when the client is suspicious of, or hostile towards, the therapist

An ability to counter any negative beliefs or suspicions the client may have about the therapist by:
trying to understand (rather than react to) suspicion or hostility by holding in mind a formulation that encompasses the client's likely interactions with the therapist and others
making judicious use of self-disclosure (so as to help assuage concerns that could arise if the therapist is seen as distant, cool and 'hard to read')
demonstrating a capacity for patience and persistence if the client presents as paranoid, hostile, reticent or incoherent (e.g. by acknowledging that the client may be finding it challenging to be with the therapist but expressing a commitment to working with them)
An ability for the therapist to be conscious of the impact of their nonverbal communications when a client presents as paranoid and/or aggressive (e.g. taking care not to mirror a client's body language).
An ability to anticipate the possibility that voices may be commenting negatively on the therapist by discussing this openly with the client (e.g. "sometimes people say that their voices don't like people like me discussing them; is this the case for you?").
an ability to work collaboratively with the client to develop strategies to manage if voices make it hard to proceed with the session (e.g. agreeing with the client that they can stop discussion of the voices whenever they wish)

Ability to personalise and adapt session content to the individual client

An ability to draw on knowledge of ways in which clients for whom normalisation is appropriate can be helped to "normalise" their psychotic experiences and beliefs (i.e. to see them as being on a continuum with the experiences and beliefs found in the general population), for example, by:
discussing the prevalence with which people in the general population hear voices
introducing the concept of a "continuum" of experience with the general population
noting that the attribution biases that can lead to delusional beliefs do not differ from those used by most people (it is the way that they are applied that can be different)
An ability to be alert to factors that will influence the client's receptiveness to an assessment and continued therapy, including:
their mental state (e.g. experiencing psychotic symptoms in the session)
past experiences of services (e.g. unhappy at 'yet another' assessment)
their expectations regarding being believed and/or criticised by the clinician
their beliefs about their diagnosis and mental illness
their attitude toward therapy
An ability to tailor the ways in which information is conveyed to the client's needs (e.g. aiding retention by using written information for the client to take away and/or making recordings of the therapy session for them to listen to at a later time).
An ability to work collaboratively with the client to set an agenda for sessions that is efficient and appropriately flexible (i.e. responsive to the client's state of mind and capacities)

Ability to help the client experience shared control of session content

An ability to maintain a collaborative and flexible approach to the assessment, adapting its structure, content and length in relation to the client's capacity and needs
An ability to 'check-in' regularly with the client to determine:
their sense of the helpfulness of what is being discussed
their readiness to move on to new areas of discussion, or to try out new strategies
their capacity to manage any emotional discomfort or difficulties that a new procedure may introduce
An ability to help the client retain a sense of shared control by:
being willing to stay with neutral topics of discussion (e.g. those reflecting the client's personal interests or hobbies) where this shift of focus reflects the client's attempt to 'regulate' emotional discomfort
being willing to be flexible about the settings in which sessions take place
finding a shared language and terminology congruent with the client's phraseology and understanding
using a recovery oriented stance so as to maintain a focus on the client's goals, motivations and strengths
An ability to "change tack" in response to high levels of distress, discomfort, or evidence of the unhelpfulness of a strategy.

Ability to deal with the emotional content of sessions

An ability to draw on knowledge of the importance of creating a safe environment within which the client can discuss and express their emotional reactions
An ability to assess the client's capacity to focus on negative or painful emotions, (for example, by being guided by their capacity to acknowledge, label and manage emotions)

An ability to help the client 'regulate' affect in the session, for example by:	
	jointly considering when it is appropriate to explore potentially sensitive areas (e.g. not "forcing" the disclosure of delusional ideation)
	helping the client signal if they are feeling emotionally aroused
	collaboratively redirecting discussion if the client seems to be finding topic areas too emotionally arousing (e.g. by focussing on areas which are non-problematic, or engaging in everyday social discussion)
	making it clear that the client has control over whether to stop, to continue, or to return to difficult topics at a later stage
	helping the client make use of 'grounding' strategies
An ability to help the client access, differentiate and experience their emotions in a way that facilitates change	
An ability to help the client process emotions by acknowledging and containing emotional levels that are too high (e.g. anger, fear, despair) or too low (e.g. apathy, low motivation).	
An ability to work with emotional issues that interfere with effective change (e.g. hostility, anxiety, excessive anger, avoidance of strong affect).	

ASSESSMENT

Knowledge of the scope of the assessment

An ability to draw on knowledge that assessment should include consideration of:	
	the client's experiences of psychosis
	any "anomalous experiences" (e.g. distortions in time perception or sense of salience) and how these relate to delusions
	co-occurring affective difficulties (e.g. depression, anxiety, trauma, , substance abuse)
	co-occurring cognitive difficulties (e.g. learning difficulties)
	associated "metacognitive" beliefs (attributions and beliefs about the significance of symptoms)
An ability to draw on knowledge that the broad domains of an assessment include:	
	the cognitive, affective, behavioural and physiological components of any difficulties
	open exploration of the client's beliefs and attitudes about medication (e.g. their appraisal of their effectiveness, experience of side effects and their attitudes towards taking medication)
	the client's use of drugs and other risk behaviours
	the client's level of functioning across all aspects of their life (including their coping strategies, activities of daily living, and the extent to which they engage in activities that give them a sense of pleasure or mastery)
	the client's interpersonal environment (including their family and social functioning, degree of social support, and level of over/under stimulation)
	any external stressors to which the client is exposed (e.g. vocational/ financial concerns, abusive others or living in an unsafe neighbourhood)
	an appraisal of the client's strengths and the resources available to them
An ability to draw on knowledge of that different components of the client's presentation are likely to be inter-related (e.g. distress associated with auditory hallucinations may be managed by taking street drugs; social isolation may lead to more frequent auditory hallucinations)	

Ability to adopt a flexible approach to assessment

An ability to be flexible about the order in which information is collected (e.g. rather than holding to a set structure, responding to indications of client discomfort by staying with topics that the client seems willing to discuss and returning to other areas at a later stage)
An ability to undertake the assessment in a manner congruent with the client's "recovery style", and to accept that this will influence the extent to which information can be gathered, e.g.:
a client with an integrated recovery style may be more likely to reflect on their psychosis in the wider context of their life and their broader sense of self
a client who 'seals over' may have a fixed and negative view of their psychosis and may be reluctant to consider placing their psychotic experiences in the wider context of their lives

Ability to assess the client's history and current circumstances

An ability to undertake a detailed assessment of the client's first episode of psychosis in order to help clarify the origins of their past and present beliefs (potentially drawing on a number of sources (such as previous records) and informants (such as family)
An ability to set up and make use of behavioural experiments in order to clarify areas of assessment that may be hard for the client to articulate (e.g. where a client cannot articulate what makes them anxious about crowded environments, working with them to design an experiment that helps them to identify their cognitions, affects and behavioural responses when placed in these contexts)
An ability to work with the client to undertake a recent incident analysis that identifies links between events, thoughts, feelings and subsequent behaviours
An ability to conduct a functional analysis, e.g.:
of socially undesirable / impulsive behaviours or behaviours the client indicates that they do not wish to engage in)
of functional relationships between a specified set of target behaviours or experiences (e.g. delusional beliefs; hallucinations or negative symptoms)
An ability to assess for core beliefs by exploring:
events within the therapeutic relationship
events within imagery
memories
thematic analysis of a client's automatic thoughts records
An ability to undertake "thought chaining" with the client (e.g. working on the basis that the client's inferences are true and helping them consider the implications of this, 'chaining' thoughts so as to progress from surface inferences through to a deeper evaluation)
An ability to help the client translate vague or abstract complaints into more concrete and discrete problems
An ability to help the client identify, select and prioritise target problems, and to rank those that are the most distressing/ amenable to change (e.g. using client ratings of distress, conviction of beliefs and preoccupation)

An ability to assess and act on indicators of risk (of harm to self or others) that emerge from exploration of thoughts, affects and behaviours during the assessment

Ability to detect (and respond to) the client's cognitive and emotional capacities

An ability to identify potential cognitive deficits in the client (e.g. poor "processing speed", or low intellectual functioning), and to appraise their likely impact on the client's day-to-day life and functioning in therapy:
an ability to identify when formal assessment of cognitive functioning is required (e.g. when there is uncertainty about the extent of cognitive deficits)
An ability to gauge the client's capacity to think about themselves psychologically (e.g. their capacity to reflect on their circumstances, or to be reasonably objective about themselves and their circumstances).
An ability to gauge the client's "stress tolerance"
An ability to respond to the client's emotional capacity and cognitive needs by:
adapting the pace of the session
repeating material (e.g. if there are indications that the client has not been able to retain information)
moving fluidly between engagement, assessment, formulation and intervention (e.g. suspending a specific intervention and refocusing on engagement if the client becomes suspicious or hostile)

Assessment of coping behaviours and safety behaviours

An ability to draw on knowledge that the coping strategies that clients develop in order to manage their symptoms can have both positive and negative consequences e.g.:
helping the client to manage their symptoms (e.g. if social contact tends to make voices worse a client may choose to stay at home alone most of the time)
maintaining (and sometimes exacerbating) symptoms (e.g. social isolation may make the client feel more depressed and hence more vulnerable to hearing voices)
An ability to draw on knowledge in order to distinguish coping behaviours (which have a sustained positive benefit) from 'safety-behaviours' (which can be unhelpful in the longer term) requires an appraisal of their functional impact:
coping behaviours result in better management of difficulties and a positive sense of coping, and these benefits are sustained over time
safety-seeking behaviours reduce anxiety in the short-term, but restrict opportunities for learning different and potentially more adaptive ways of coping with problems (e.g. because they prevent clients from learning that their worst fears won't happen)
An ability to draw on knowledge that safety behaviours can be both overt and covert, and that both can be relevant to the development and maintenance of the client's problems
An ability to draw on knowledge of the importance of helping the client to desist from safety-seeking behaviours, and of the potential role of residual safety seeking behaviours in relapse

Ability to use measures and diaries

An ability to help the client keep a diary/log of specified difficulties, by:
agreeing the content and the format of the diary with the client, so as to encourage a sense of 'ownership'
developing a shared understanding of the relevance of diary completion to personal goal achievement
An ability to select and use standardised measures appropriate to the client's difficulties and capacities (e.g. reading ability and concentration), as well as using personalised measures of progress (as defined by the client or by the service)
An ability to establish a baseline against which to measure change and re-administer measures at appropriate intervals

Formulation and Treatment planning

An ability to consider the nature and scope of the intervention being planned in order to decide (in collaboration with the client) the degree to which the formulation needs to include both distal and proximal events, and the level of detail that is required

Ability to develop a cognitive behavioural formulation of the client's difficulties

An ability to draw on knowledge of relevant evidence-based cognitive models, choosing the most appropriate to create a client-specific conceptualisation of their difficulties that:	
	accounts for the development and maintenance of symptoms and problems
	links the client's symptoms and problems with the core beliefs and attributional biases that underpin them
	identifies the events or experiences (including affect) that activate unhelpful beliefs
An ability (as part of the formulation) to consider how the client's long-standing beliefs about themselves and others (including the therapist) and the impact of current unusual experiences and beliefs upon such beliefs	

Ability to share the formulation with the client

An ability to draw on knowledge that clients can experience strong cognitive and emotional reactions to the formulation, and that responses can be positive or negative, and change over time	
An ability to discuss the formulation with the client in a tentative manner, with the aim of helping them:	
	consider alternative ways of understanding their delusional beliefs (with the intent of providing a less distressing and more helpful account)
	gain an appreciation of the history, triggers and maintaining features of their problem and how this might be relevant to their achieving their goals
	identify and discuss any predictable difficulties in implementing therapy (e.g. by considering how changes in one area might lead to changes in another)
An ability to monitor the client's affective response to sharing the formulation	
An ability to work collaboratively with the client to agree a shared understanding of the development of their psychotic symptoms:	
	using the cognitive model to explain the links between their problems, their perceptions and interpretations and their emotional and behavioural responses
	recognising that at times it may be necessary to work within a delusional system or set of cultural beliefs (e.g. initially accepting the veracity of some beliefs in order to begin work with more amenable beliefs)
An ability to develop the client's understanding of the cognitive model by "socializing" them to it using their own material	
An ability to gauge whether the client understands the rationale for the intervention, has questions or (for example) is sceptical about it, and a capacity to respond to these concerns openly and non-defensively in order to resolve any ambiguities	

Ability to use the formulation to plan treatment

An ability to collaboratively develop a treatment plan that:
identifies the goals of the intervention
is directly linked to the hypotheses contained in the formulation
identifies any likely obstacles to implementing the intervention, and helps to guide the therapist's response to their emergence
aims to promote the experience of success, e.g. by focusing initially on:
less distressing and more malleable problems, thoughts and beliefs, before progressing to more difficult and challenging beliefs
distressing beliefs where there is good evidence that these are amenable to rapid change (e.g. beliefs about alienation, difference or distress)
An ability to discuss CBT treatment components with the client, helping them consider the order of strategies they wish to follow in light of their therapy goals (e.g. implementing activity scheduling before voices or core belief work)
An ability to select cognitive and/ or behavioural change strategies on the basis of:
their acceptability (identified through negotiation with the client)
the likelihood of success (identified through the formulation)
An ability to use the formulation to identify when CBT may not be appropriate, or may not represent the best option, and to discuss this with the client, e.g., where:
the client's difficulties are not primarily psychological
the client indicates that they do not wish to consider psychological issues
the client has a clear preference for an alternative approach to their problems (e.g. a preference for medication rather than psychological therapy)
An ability to formulate a therapy plan for each session that helps the client to identify and modify unhelpful thinking and behaviour and to recognise and to step back from the patterns leading to dysfunctional ideation and behaviour
Where the formulation identifies factors that may threaten the efficacy of CBT, an ability to address these by implementing (or referring the client to) relevant interventions (e.g. family work or neuropsychological testing)
In the light of emerging clinical information, an ability to revise and update the formulation, and hence the treatment plan
An ability to work with the client to implement CBT in a manner that is tailored to their needs, and which is flexible and accommodates all significant aspects of the client's presentation

CBTp intervention strategies

An ability to draw on knowledge that the principal aim of CBTp is to address the factors that directly contribute to the maintenance of the client's difficulties, and that as such interventions may focus on:
both psychotic and non-psychotic symptomatology
the client's social and interpersonal circumstances and resources
the client's understanding of, and views about, their difficulties and their aspirations for their life

General CBT strategies – promoting engagement

An ability to draw on knowledge that the sense of fear and powerlessness experienced by individuals who hear voices or are paranoid can be qualitatively different and more intense than the experience of individuals with anxiety and depression
an ability to hold in mind that the intensity of affect may challenge the client's capacity to stay in therapy, and to be alert and responsive to this risk
An ability to maintain an awareness that clients may be hyper vigilant for signs that the therapist does not believe them, or is part of their mistreatment/ persecution
an ability to elicit feedback from the client regarding these possibilities, and to respond in an open, non-defensive manner
An ability to maintain a consistently collaborative stance, working with the client at their own pace and their readiness to change (e.g. building on and discussing the client's own doubt rather than trying to impose a conclusion regarding a belief)
An ability to ensure that clients are ready for (and willing to engage in) an intervention strategy by checking their agreement to proceed throughout the intervention (i.e. not assuming that agreement in the past constitutes continuing consent)
An ability to work with the client to identify the changes they would value and wish to work towards

An ability to draw on knowledge of the importance of identifying and targeting the beliefs and behaviours that drive distress, and being aware that these may not always be delusional beliefs
An ability to work with the client to explore the relationships between life experiences, beliefs about the self and the content of psychotic symptoms
An ability to work with the client to help them reflect on possible explanations of their psychotic symptoms, considering each in turn with the aim of finding alternative explanations of the client's difficulties which are acceptable to them but are also more adaptive
an ability to use Socratic questioning to draw out and increase the client's critical capacity regarding unhelpful beliefs
When it emerges that supposedly delusional beliefs have some foundation, an ability to take appropriate action (e.g. supporting the client if worries about being harmed are well-founded)
An ability to help draw the client's attention to progress by monitoring changes in belief and any attendant reductions in distress/ dysfunction
An ability to optimise learning and generalisation from therapy (e.g. by recruiting professional colleagues or significant others to help with behavioural experiments across a range of different contexts)

General CBT strategies - Homework

Planning practice assignments

An ability to integrate practice assignments (homework) into therapy by offering the client a clear rationale for homework, by clarifying the client's attitude to homework and checking their understanding of its importance
An ability to ensure the client can give clear feedback regarding their understanding of the rationale for undertaking homework (to test out ideas, try new experiences, predict and deal with potential obstacles, and experiment with new ways of responding)
An ability to tailor homework to the individual client, ensuring that this is appropriate to the stage of therapy and in line with the case conceptualisation
An ability to work with the client to agree appropriate and manageable homework tasks with

clear and specific precise goals that relate to the content of sessions
An ability to work with the client to identify strategies which will help ensure that homework tasks are carried out
An ability to work collaboratively with the client to consider the reasons for non-completion of homework tasks (within the framework of the cognitive model)

Reviewing practice assignments

An ability to ensure that homework that the client has undertaken is carefully discussed and reviewed with them in the next session, with the aim of helping them identify what they have learned from their experiences	
An ability to help clients appraise the outcomes of homework:	
	when outcomes are in line with the prior expectations of the therapist and client
	when there is a different outcome from that which has been predicted
An ability to integrate learning from homework into the session, and to build on this learning in identifying further homework assignments	

Enhancing coping skills, psychoeducation and normalisation

Enhancing coping skills

An ability to help the client make use of coping strategies that can help manage specific symptoms e.g.	
	behavioural strategies, such as relaxation techniques, increasing activity levels, social engagement or disengagement, or "drowning out" hallucinatory voices (e.g. by listening to loud music or putting on the TV)
	cognitive strategies, such as attention switching or attention narrowing, or modifying self-statements/ practising positive self-talk
An ability to practise coping strategies with the client, and to facilitate their generalisation by agreeing homework tasks	
	an ability to help the client modify and adapt coping strategies on the basis of their experience of applying them in their everyday lives
An ability to ensure that while, working on developing coping strategies, both therapist and client remain alert to the risk of adopting these as safety behaviours	

Psychoeducation

An ability to draw on knowledge that because psychoeducation is not usually effective as a "standalone" intervention in people with psychosis it should be delivered as part of a CBT intervention (rather than in isolation)	
An ability to draw on knowledge that because psychoeducation may increase the client's distress, this needs to be monitored and addressed (e.g. feeling more pessimistic about their future or viewing themselves more negatively)	
An ability to tailor psychoeducation to the client's needs e.g.:	
	the particular difficulties they are experiencing, and the areas which concern them
	the personal and cultural explanatory models to which they ascribe
	the extent to which their explanatory models represent flexible or fixed views
	their intellectual ability
An ability to decrease distress by undertaking 'reframing' with the client, using a wide variety of explanations (e.g. stress-vulnerability model; information processing biases) and linking this to their experiences	
An ability to check the client's understanding of, and agreement with, psychoeducation materials	

Normalisation

An ability to draw on knowledge that the use of normalising should usually be restricted to clients who hold beliefs about their experiences being abnormal (and for whom, therefore, normalising is likely to decrease their distress)	
	an ability to draw on knowledge that for some clients normalisation is likely to be unhelpful and inappropriate (e.g. where their beliefs are such that they consider themselves unique and special)
An ability to decatastrophise the client's experiences by discussing the ways in which similar psychological processes or experiences occur (or could be triggered) in the general population, with the aim of:	
	promoting the client's understanding of their symptoms
	facilitating reattribution of hallucinations/ alternative explanations of delusions;
	improving self-esteem and reducing a sense of isolation
	reducing a sense of stigma
An ability to ensure that a normalising stance does not ignore or minimise the degree of distress experienced by the client	

Affect regulation

An ability to observe and enquire about affective issues and concerns that are impacting on the client, e.g.:	
	depression
	anxiety and worry
	affective issues that linked to past psychotic experience (e.g. post-psychotic depression, anxiety, worry, shame)
	anger (e.g. with services)
An ability to work with the client to notice and to manage distress, drawing on knowledge of the appropriate repertoire of cognitive behavioural techniques relevant to the presenting problem/ issues	

Activity monitoring, scheduling and working with social withdrawal

Activity monitoring

An ability to help clients complete an activity chart in order to monitor their activities
An ability to help clients rate degrees of pleasure and mastery associated with activities
An ability to review activity charts with the client, identifying:
activities which are over- or under-represented
activities which are associated with high or low levels of pleasure and mastery
conclusions about these patterns of activity
An ability to work with the client to identify and plan specific changes to activities, identifying any thoughts (assumptions or beliefs) which might make it difficult for them to implement these changes

Activity scheduling

An ability to use the activity chart to help clients schedule activities for the forthcoming week (e.g. pleasurable activities, previously avoided activities, therapy homework)
An ability to help clients record both predicted and actual levels of pleasure and mastery associated with scheduled activities

Addressing social isolation

An ability to help the client use diaries, behavioural experiments and activity scheduling to identify links between inactivity, low mood, and unusual beliefs (and hallucinations)

An ability to help the client to reflect on the function of their social withdrawal and to identify its advantages as well as its disadvantages for them (e.g. while withdrawal may help to decrease paranoid thoughts it may increase depression)
An ability to help clients who completely avoid social situations to consider how they could engage in more “strategic” avoidance (so as to reach a better balance between managing symptoms and improve their quality of life)

An ability to work with the client to identify individuals within their social network who might provide support or act as a confidant (including helping the client reinitiate contact with individuals from whom they have become estranged)
An ability to work with the client to identify areas that might benefit from focusing on, modifying or adapting their social skills (for example to facilitate social contact or change unhelpful behavioural patterns)

Ability to work with safety behaviours/ coping strategies

An ability to work with the client to differentiate between safety behaviours and coping strategies, guided by their function and their consequences
An ability to work with the client to identify the ways in which specific safety behaviours maintain their distress and/ or impaired functioning
An ability to work with the client to consider more functional alternatives to their safety behaviours, ensuring that their sense of risk and distress stay at a manageable level during this process

Ability to plan and conduct behavioural experiments

An ability to draw on knowledge that when working with individuals experiencing psychosis, behavioural experiments can be used to:	
	test beliefs directly (e.g. addressing predictions that something bad will happen if the individual engages in or desists from a specified behaviour)
	address predictions that an activity will result in a strong affective response or difficulties in coping

An ability to devise behavioural experiments which can directly test the validity of client’s beliefs or assumptions about themselves or the world, which help clients construct and/or test new, more adaptive beliefs, and which can be carried out in the session or as homework
An ability to ensure that the form, timing and content of behavioural experiments are congruent with their intended aim
An ability to plan experiments which are likely to have positive outcomes
An ability to ensure that experiments are planned collaboratively, so as to ensure that any reservations held by the client are fully accounted for

Conducting behavioural experiments

An ability to ensure that the aim of the experiment is clear to, and understood by, the client, and that the client is aware of the cognitions being targeted by the experiment
An ability to help the client anticipate any possible problems, along with ways of overcoming these
An ability to help the client anticipate their likely reactions should the experiment confirm their fears

Reviewing behavioural experiments

An ability to help the client assess their reactions to the experiment by recording the outcome and the learning which has occurred
An ability to review the outcome of experiments (whether positive or negative) with the client in order to help them identify its impact on their thinking or behaviour, and the meaning the outcome of the experiment has for them
On the basis of review of the learning which has taken place, an ability to help the client build on this learning by identifying further behavioural experiments

Working with beliefs

Ability to work with beliefs and core beliefs

An ability to draw on knowledge that core belief work with clients with psychosis is based on the same principles as are employed for clients with other mental health difficulties
An ability to draw on knowledge that because core beliefs can underpin psychotic symptoms, direct work on the core-belief can reduce the distress/ dysfunction associated with the psychotic symptoms.
An ability to draw on knowledge that core belief work with clients with psychosis can focus on challenging negative self- schema and creating a positive self-schema, and/or helping the client to accept that both negative and positive self-schema are valid parts of experience of self
an ability to help the client consider the impact of defining their identity in terms of 'illness' and to work towards a sense of self that is not solely defined by mental health difficulties (including the pros and cons of shifting their sense of self)

Ability to identify, and help the client modify, metacognitive beliefs

An ability to identify metacognitive beliefs and their contribution to the maintenance of the clients difficulties (e.g. worry, rumination or paranoia)
An ability to work with the client to consider the utility of metacognitive beliefs, by weighing their advantages and disadvantages
An ability to help the client challenge metacognitive beliefs (e.g. by evaluating evidence, generating alternative explanations and conducting behavioural experiments)

Symptom Specific Interventions

Delusional and paranoid beliefs and beliefs about voices

Knowledge of delusional beliefs

An ability to draw on knowledge that there is no single defining characteristic of delusional beliefs, but commonly these are:
firm beliefs that are strongly held, and that lead to disability or distress
based on incorrect inferences about external reality that persist despite evidence to the contrary
not ordinarily accepted by other members of the person's culture or subculture

An ability to draw on knowledge that because (once formed) delusions can lead to the reinterpretation of past experiences, it is important to obtain information about events that occurred *prior* to the formation of the delusion(s) from the client (and if possible, relevant others)
An ability to draw on knowledge that querying the basis of delusional beliefs should only take place once the therapist has a thorough understanding of their content, that enables the therapist to:
make sense of the client's behavioural and affective responses to their beliefs
be clear about links between the client's attributions and their beliefs
have a sound basis for entering into a Socratic dialogue about the belief (making it less likely that the client will respond by introducing information which the clinician was unaware of)
An ability to draw on knowledge that delusional beliefs may arise and/or be shaped by difficulties in social understanding which could arise as a result of limited learning opportunities
An ability to draw on knowledge that the client's conviction regarding the validity of a delusional belief, and their interpretations of events, will often fluctuate over time

Knowledge of paranoid beliefs

An ability to draw on knowledge that paranoid ideation can be determined by identifying:
whether the client perceives interpersonal threat (including harm), in the present or in the future
the client's beliefs about harm being intended/ directed towards them
whether other people can provide evidence about the objective reality of the client's concerns (e.g. whether they have been the victim of violence/ abuse)
An ability to draw on knowledge that paranoia can be conceptualised in at least two distinct ways, both of which can co-exist in the same person:
"bad me" (in which the persecution is seen as a deserved punishment)
"poor me" (in which the persecution is believed to be undeserved)
An ability to draw on knowledge of reasoning biases thought to be associated with paranoia e.g.:
attributing the causes of negative events to external factors
a strong bias to interpret events in a way that confirms prior beliefs
a tendency towards "jumping to conclusions" (on the basis of limited 'data' collection)

Knowledge of beliefs about voices

An ability to draw on knowledge that not all people who hear voices are distressed by them or seek assistance from psychiatric services
An ability to draw on knowledge that the client's degree of distress or dysfunction is not dependent on whether they experience voices as internal or external
An ability to draw on knowledge that the client's reactions to hearing voices will depend on their beliefs about their:
power
identity
malevolence or benevolence
omniscience and consequences of compliance/ non-compliance
voice content and idiosyncratic meaning
An ability to draw on knowledge that the client's reactions to hearing voices will be influenced by the extent to which they believe them to be "omnipotent" and "omniscient", and that in those who seek help from services:
voices are usually experienced as powerful (omnipotent), whereas the hearer is experienced as weak and dependent (and hence unable to control or influence the voice)
voices are usually perceived as omniscient (e.g. as knowing the person's present thoughts and past history, and able to predict the future), and this is experienced as proof of the voice's power
An ability to draw on knowledge that the client's emotional and behavioural reactions to hearing voices also will be influenced by their beliefs of the voice's "malevolence" and "benevolence", and that:
while some voice hearers believe their voices to be benevolent, others believe them to be malevolent and persecutory
malevolent voices are usually associated with negative affect and resisted, while benevolent voices are usually associated with positive affect and are engaged with by the client, and that:
hearers may appease voices, and that such responses can be conceptualised as "safety-behaviours" (because while they reduce the threat posed by the voices they also make it less likely that beliefs about the power of voices will be challenged)

An ability to draw on knowledge that (as a consequence of their sense of powerlessness in relation to their voices) voice hearers are often moderately depressed, and that low mood (along with other affects such as anxiety and shame) can act as a trigger that initiates voices
An ability to draw on knowledge that clients experience themselves as being in an intimate and inescapable "interpersonal" relationship with their voice(s)

An ability to draw on knowledge that individuals may have multiple voices with different characteristics (e.g. some benign and some malign) and that any intervention will need to be tailored to account for this

Assessing the content of delusional beliefs

An ability to draw on knowledge that assessment should aim to identify and focus on the beliefs causing the most distress/dysfunction, and/ or on those beliefs closely linked to the client's goals (rather than on every belief)
An ability to help the client provide a detailed account of their experience of psychosis (including triggers, specific details of symptom(s) and associated beliefs, conviction, preoccupation and distress, and impacts on the individual's functioning)
An ability to distinguish the actual content of voices from the client's beliefs about them
An ability to identify the client's delusional beliefs regarding compliance with voices (especially if such behaviour transgresses social rules).

Where there are a number of delusional beliefs, an ability to assess each in turn, prioritising these with the client and, (if appropriate), usually starting with the least threatening and least firmly held
An ability to obtain information (from the client or relevant others) that can help to determine the extent to which the content of the belief is shared by other members of the cultural and faith groups to which they belong
An ability to help the client keep a diary/log of psychotic symptoms in order to track when they occur and when they are absent, and the internal and external triggers that influence the presence or absence of symptoms (including affective changes)
Where client's distress during the session relates to their experiencing voice(s), an ability to help them use both their existing and alternative coping strategies, e.g.:
validating the effort the client puts into dealing with the voice(s)
drawing on discussions of the triggers that cue and control their voices in order to find ways to help the client exert more control
offering information about strategies that other people have found useful
asking the client whether they would like to change the topic of conversation
An ability, to move away from examining symptom content or beliefs directly associated with the symptom to assess the client's beliefs about self, others and others view of self and how/ if these are associated with their delusions

Orienting the client to working with the content of delusional beliefs

An ability to begin applying the cognitive model to delusional beliefs by helping the client to consider the possibility that these are beliefs rather than facts, ensuring:
that this is done tentatively
is carefully timed (i.e. building on the client's own expression of doubt)
An ability to help the client consider the possibility that the extent to which a belief is considered to be true or false can be changed e.g.: by starting:
with a belief that the client has held in the past but now views differently
with a current belief held with less than than 100% conviction that the client is prepared to question)
An ability to help the client identify the ways in which distress is linked to their beliefs rather than (for example) there being a causal relationship between a triggering event and distress
An ability to explore with the client the "pros and cons" of delusions (e.g. while vigilance is a good strategy for staying out of danger, it can lead to isolation and loneliness)
Where the client holds delusional beliefs about the therapist, an ability to engage in an open discussion that reflects on the likely feeling or meaning conveyed by the delusional content (rather than focusing on the content itself)
An ability to help the client to utilise their own critical evaluation of their belief(s) and reflect on possible anomalies, rather than attempting to directly challenge them

Working with delusions and beliefs about voices

An ability to draw on knowledge that CBTp aims to help the client:
understand that delusion(s) and beliefs about voices represent a reaction to (and an attempt to make sense of) disturbing experiences/ events, and that these reactions can have a psychologically-protective function (e.g. by reducing anxiety)
recognise that delusions and beliefs about voices are not facts, but can be seen as hypotheses or inferences (and as such, may or may not be true)
come to recognise that the delusion/ belief is unhelpful (by using collaborative discussion and direct testing) and that alternative explanations may be plausible ways of making sense of an experience/ event
recognise that the distress and disturbance associated with delusions/beliefs about voices is not an inevitable, direct consequence of these experiences (e.g.it is the beliefs about voices that drives distress, rather than the voice itself)

An ability to draw on knowledge that CBTp does not require beliefs to be fully rejected to be effective, and that working to modify part of a belief system can reduce distress
An ability to draw on knowledge that cognitive techniques target both the client's preoccupation with psychotic symptoms and the behaviours associated with experiencing them
An ability to draw on knowledge that where discussion seems to result in an adverse impact (e.g. reinforcing rather than diminishing the strength of belief, or generating upset or anger) it is more appropriate to refocus discussion onto more neutral ground
An ability to draw on knowledge that modifying delusions usually requires the consistent application of cognitive strategies over a long period of time

An ability to work with the client to consider the main examples of delusional beliefs, along with the evidence for and against them, before moving on to challenging beliefs
An ability to work with the client to reflect on the advantages and disadvantages of holding the delusional belief or experiencing a symptom (and hence to reassure them that the aim is to reduce distress rather than forcing a change of belief)
Ability to help client generate alternative explanations for their beliefs
Where a client has readily identifiable and potentially malleable triggers to psychotic symptoms, an ability to help them explore the controllability of symptoms (e.g. by spending more or less time in situations/ settings which act as triggers and observing the frequency of psychotic symptoms and associated affects)
An ability to link the client's negative evaluations of self, others and others view of self (if accessible) to the psychotic symptom
An ability to work with the client to use the cognitive perspective to understand the ways in which a delusional explanation of their anomalous experiences might have emerged

Thought Disorder

An ability to draw on knowledge that thought disorder can be conceptualised as a problem of disordered communication between the client and others	
	an ability to remain open-minded as to whether the client is presenting with thought disorder or whether the therapist needs to orient themselves to the client's style of communication, phraseology and concerns
An ability to draw on knowledge that thought disorder can increase when emotionally salient topics are discussed	
An ability to work towards a better understanding of the theme of the client's concerns by using a style of questioning that does not probe for details	
An ability to use information from the assessment, and from other relevant sources, to make more sense of content	
An ability to make suggestions about meaning and content, and to help structure the client's communications	
An ability, when the client *sometimes* presents with thought disorder, to collaboratively investigate with the client what triggers their change in communication	

Ability to work with Thought Disorder

An ability to draw on knowledge that the primary goal of interventions for thought disorder is to help the client to communicate in ways that make it more likely that they can be understood by others	
	an ability to draw upon knowledge that clients may or may not be aware of thought disorder, and drawing attention to it may promote engagement in some clients, but cause distress in others

- an ability to draw upon knowledge that thought disorder can be addressed directly, or indirectly (e.g. in the context of implementing cognitive models for managing stress)

An ability to prioritise work on thought disorder if this makes it difficult to understand the client and consequently to undertake any aspect of an intervention

An ability to address thought disorder and support more effective communication by the client, for example by:

- the therapist shortening their statements (so as to make communicative intent clear)
- asking clarifying questions when the client's meaning is not easy to discern
- if necessary, taking breaks throughout the session
- helping the client apply stress management skills

Problems in social functioning (negative symptoms)

Knowledge

An ability to draw on knowledge that the development and manifestation of negative symptoms can be formulated from a psychological perspective, and (for example) could be seen in the context of:

- hopelessness or depression
- the client's attempts to avoid anxiety provoking situations
- the client's reactions to trauma
- side effects from anti-psychotic or anxiolytic medication

An ability to draw on knowledge that negative symptoms include

- affective flattening – blunting of affect as seen in a decrease in facial responsiveness, vocal expressiveness and eye contact
- avolition – lack of motivation (e.g. a reduction in general activity or personal care)
- alogia – poverty of speech (e.g. a slowness to respond, or a reduction in content of speech)

An ability to draw on knowledge of hypothesised mechanism s that may account for negative symptoms, e.g.:

- "defeatist" beliefs about the value of pursuing an action (assuming that a task cannot be completed, and that part-failure is equivalent to complete failure)
- anticipating little reward for effort (assuming a major imbalance between the effort involved and the enjoyment to be gained)
- anticipating that efforts will not be rewarded with success
- perceiving resources to be limited (e.g. energy, motivation and capacity for attention)
- minimising social contact to reduce stress
- "social defeatism" (predicting rejection from others and hence having little motivation to pursue social contact):
  - assuming rejection is inevitable on the basis of having failed to meet cultural/ societal expectations
  - assuming rejection based on feeling of shame/stigma about the illness

Assessment of negative symptoms

An ability to assess negative symptoms, including:

- identifying if there are any explanations for the presence of negative symptoms (e.g. depression, medication side-effects)
- both the distal and proximal antecedents of negative symptoms, along with the consequences (in order to understand their development and maintenance, and any factors which alleviate negative symptoms)
- past and present levels of functioning, and the disparity between desired and actual functioning

an evaluation of cognitive appraisals and beliefs related to negative symptoms
any disparity between the level of emotion subjectively experienced and the ways in which these are (objectively) expressed by the client
the rate and flow of speech (over a number of sessions and contexts, allowing for contextual factors (e.g. the client saying little when a family member is present, or when they have first met the therapist)
Where it is difficult for the client to articulate an understanding of their negative symptoms, an ability to use techniques such as behavioural activation to test out (and hence clarify) factors associated with these symptoms
An ability to work with the client to formulate the relationships between negative symptoms and precipitating and maintaining factors, and to discuss with them which areas should be targeted, and in what order
An ability to use the formulation to identify when periods of "convalescence" may be appropriate (e.g. recognising when some level of social withdrawal may serve to regulate stress)
An ability (where the client's premorbid functioning was poor), to assess the need for/ desire to engage in work on skill deficits (e.g. literacy or dealing with demands of daily living)

Ability to work with negative symptoms

Ability to draw on knowledge that the form and sequence of intervention is dependent on whether negative symptoms are best formulated as "primary" negative symptoms or as secondary to positive symptoms

An ability to employ strategies that promote motivation and engagement in therapy, (e.g. spending part of the session doing something that the client finds enjoyable, or complementing the client for changes in behaviour, however small)
An ability to help the client set meaningful and realistic goals that take into account current and previous functioning and to ensure they (and significant others) have appropriate expectations of change
An ability to use the formulation to identify skill deficits that contribute towards the presence of negative symptoms, and to implement appropriate interventions (e.g. literacy work, social skills)
An ability to establish the role of negative expectancies about performance, pleasure, personal resources or social acceptability, and to conduct cognitive and behavioural work that addresses beliefs that interfere with the client achieving their goals

Trauma

Knowledge

An ability to draw on knowledge linking specific traumatic experiences to specific psychotic experiences
An ability to draw on knowledge of CBT techniques employed for the management of PTSD (as set out in the CBT competence framework)

Developing a narrative of the client's traumatic experience

An ability to validate (normalise) the difficulty client's may have in expressing and exploring difficult traumatic experiences
An ability to ensure that the client understands, and is in agreement, with an intervention that addresses the processing of traumatic memories and associated distress
An ability, should it be helpful and appropriate, to work with the client to develop a narrative of their traumatic experience and to relate this to the development of psychosis
An ability to work with the client to establish how they try to manage symptoms of trauma (such as flashbacks, intrusion and reliving experiences) so as to draw links between their traumatic experience and their reactions
An ability to apply standard cognitive restructuring techniques to help the client manage cognitions associated with the experiences characteristic of trauma (e.g. avoidance (both active and passive) re-experiencing, over-arousal and sleep difficulties)
An ability to help the client achieve their goals even where some trauma symptoms are still present (e.g. by addressing beliefs about being unable to change because of persistent symptoms)

Staying or keeping well (relapse prevention)

An ability to draw on knowledge that each client will display particular early warning signs and have idiosyncratic triggers, and that these include changes in the person's mood, behaviour and thoughts
An ability to work with the client to develop a timeline with clients who have recovered in order to identify problematic events (and their meanings) that have led to a deterioration in mental health in the past
An ability to enhance client's coping strategies by encouraging them to identify, overlearn and apply skills that foster a sense of control and instil hope (e.g. relaxation training, activity scheduling)
An ability to evaluate the efficacy of previous interventions for relapse prevention in the context of a developmental formulation in order to inform (and to improve) future relapse prevention strategies
An ability to identify and discuss the client's appraisals regarding the reemergence of symptoms (e.g. aiming to de-catastrophise changes in mood, behaviour and thoughts) , and to support their sense that they have a repertoire of strategies that can be employed to manage
An ability to recognise that for some clients symptoms will persist in spite of intervention, and to understand and discuss recovery and maintenance of gains from this standpoint