Cognitive Therapy for Psychosis

… *or*

'Good Clinical Practice'

David Kingdon

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Southampton, UK

AGENDA

- Controversies about evidence
- Availability
- What is CBTP?
- Language
- New studies & applications

Evidence for CBT for Psychosis

(Wykes et al, 2008)

- Average effect size for target symptom (33 studies*) = .40
- Average effect size for "rigorous" RTCs (12 studies) = .22
- Significant effects (ranging from .35 – .44) for:
  - Positive symptoms (32 studies)
  - Negative symptoms (23 studies)
  - Functioning (15 studies)
  - Mood (13 studies)
  - Social anxiety (2 studies)

**20 from UK, 5 from USA, 2 from Germany, Australia, Netherlands, 1 from Canada, Italy, Israel; 27 individual CBTp, 7 group CBTp*

Psychological Medicine (2010), 40, 9–24. © Cambridge University Press 2009
doi:10.1017/S003329170900590X

REVIEW ARTICLE

Cognitive behavioural therapy for major psychiatric disorder: does it really work? A meta-analytical review of well-controlled trials

D. Lynch[1], K. R. Laws[2] and P. J. McKenna[3,4]*

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Cochrane Review of CBT v supportive therapy

Psychological Medicine, Page 1 of 3. © Cambridge University Press 2009
doi:10.1017/S0033291709990201 Printed in the United Kingdom

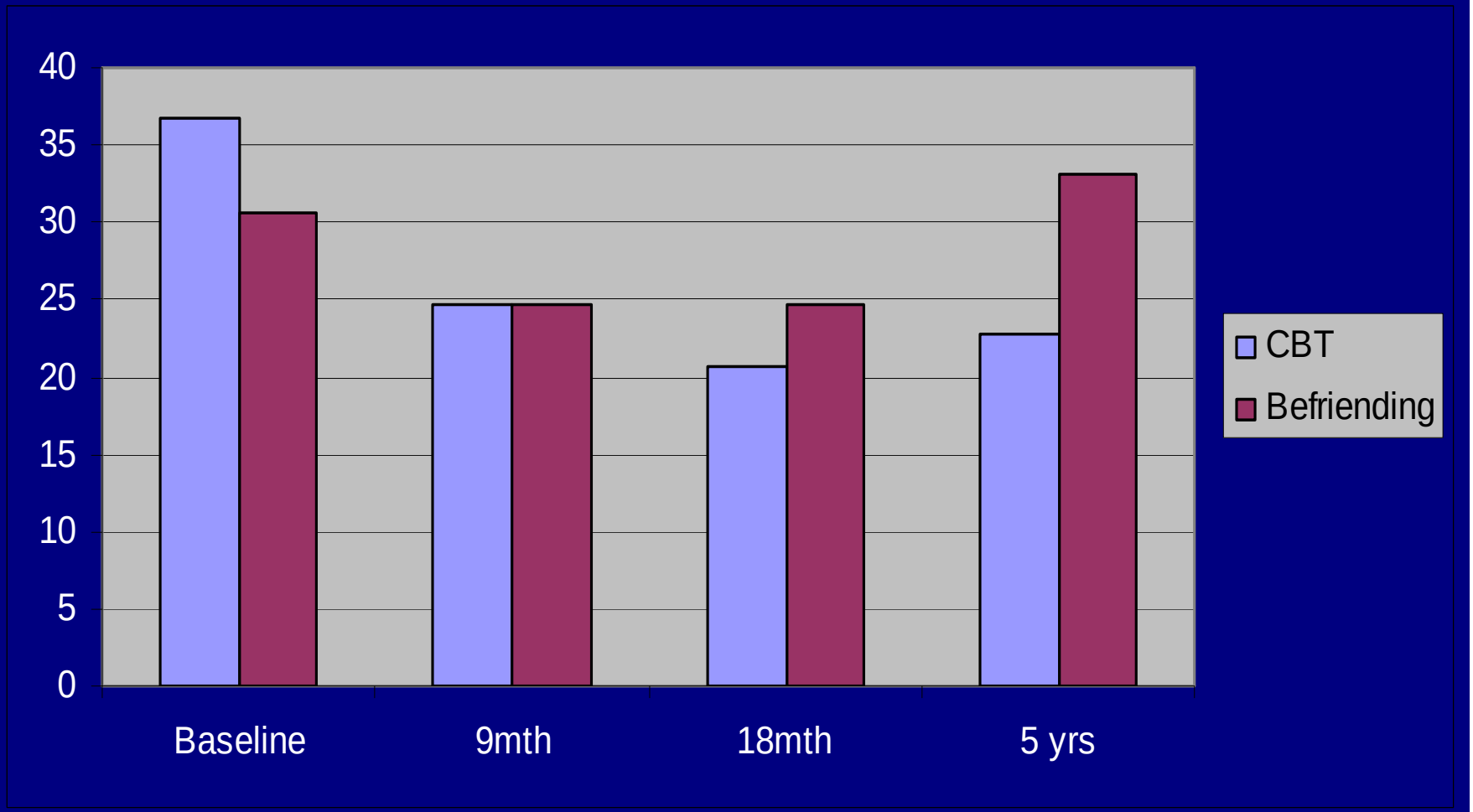
COMMENTARY

Over-simplification and exclusion of non-conforming studies can demonstrate absence of effect: a lynching party?

A commentary on 'Cognitive behavioural therapy for major psychiatric disorder: does it really work? A meta-analytical review of well-controlled trials' by Lynch *et al.* (2009)

D. Kingdon*

CBT and ‘befriending’ in schizophrenia resistant to medication

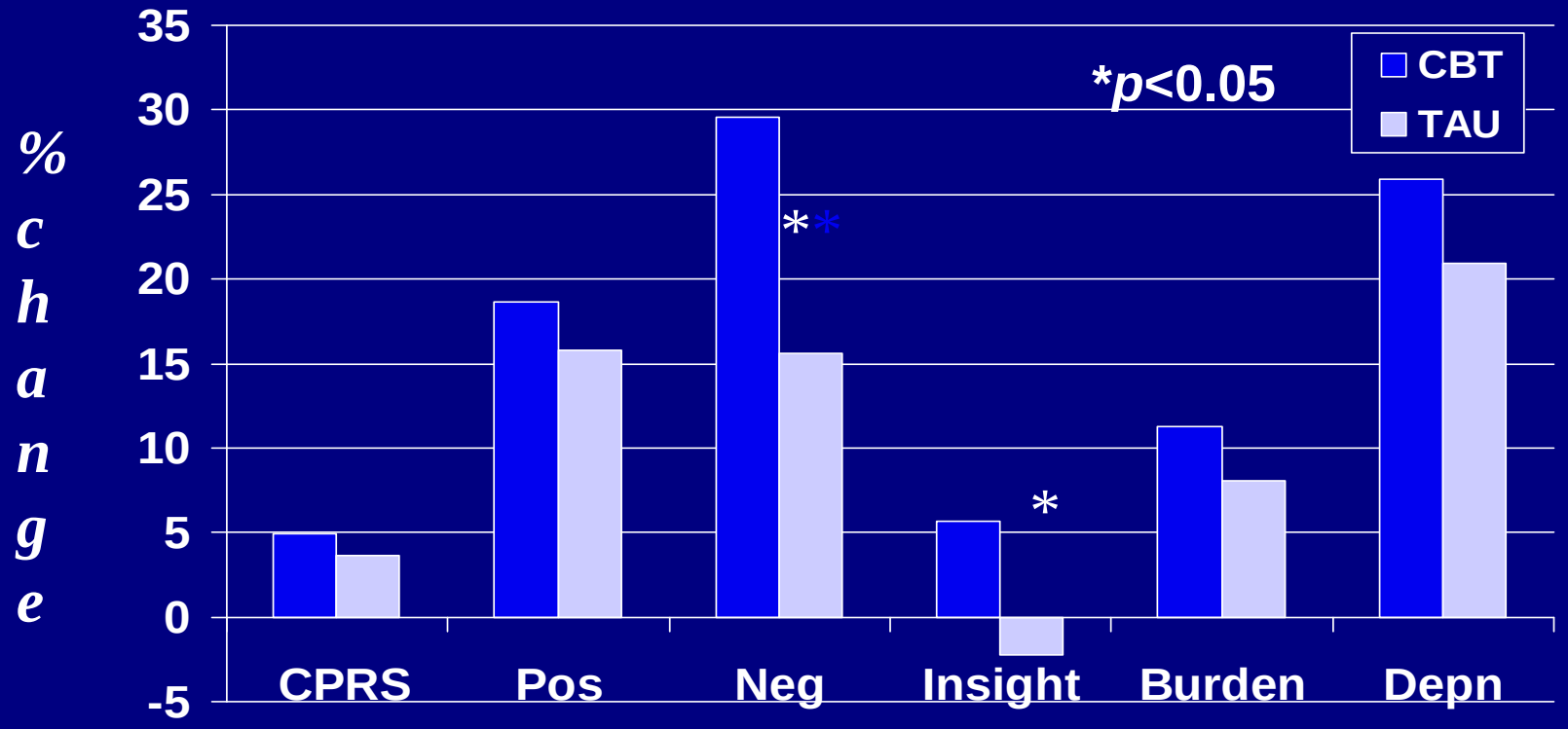


SANS – Scale for Assessing Negative Symptoms

Sensky et al, 2000: Turkington et al, 2008

Brief CBT Intervention Study

Results: at 1 yr (n=336)

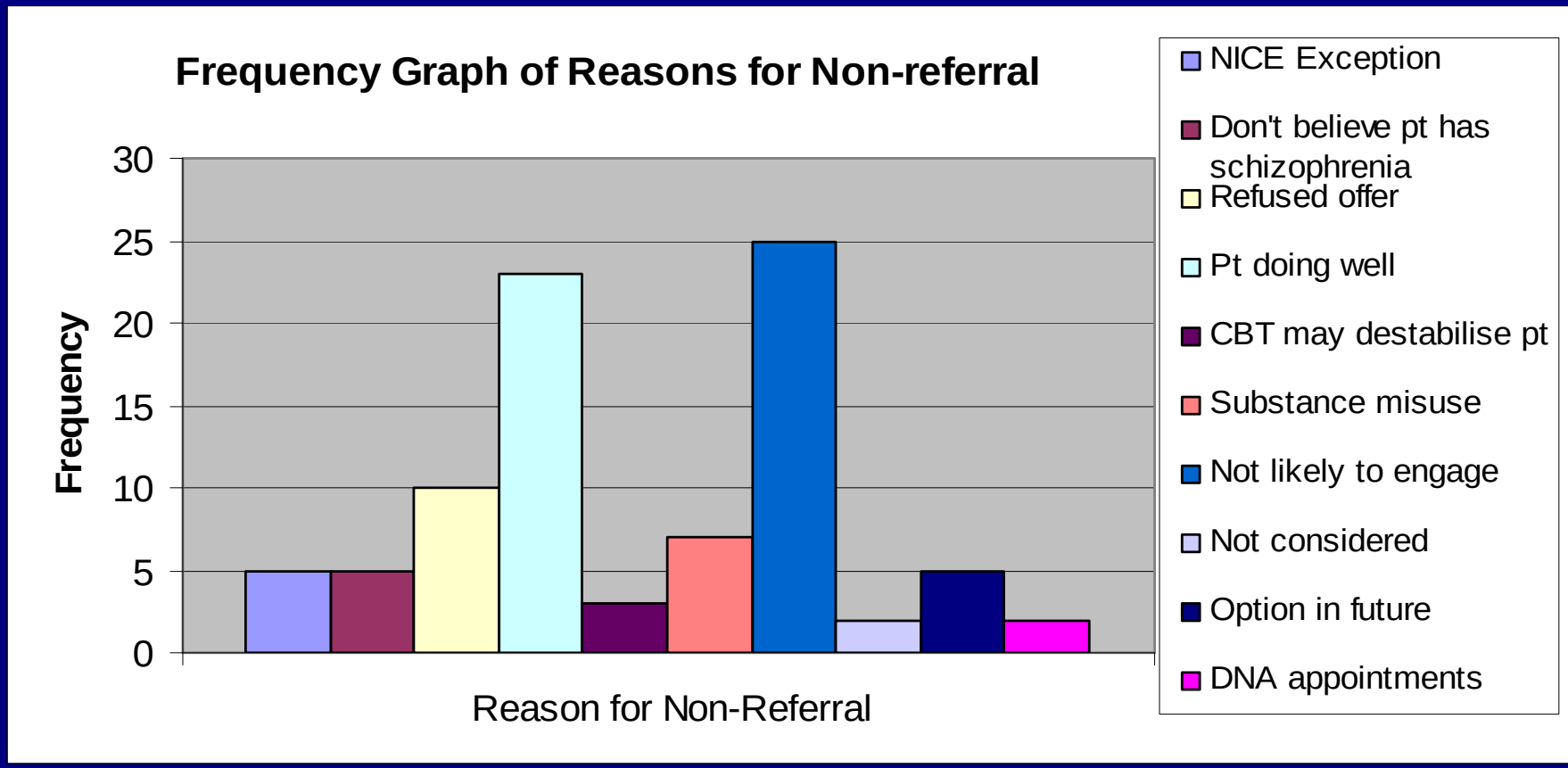


Brief CBT significantly reduced time spent in hospital for those who relapsed (CBT mean 47 days vs TAU mean 80 days) and delayed time to rehospitalisation (OR, 1.837, 1.108, 3.04, p=0.018).

Turkington et al, 2006

Availability of CBT

(West Southampton - Kirschen & Kingdon, 2006**)**



142 patients identified with schizophrenia (expect about 200)

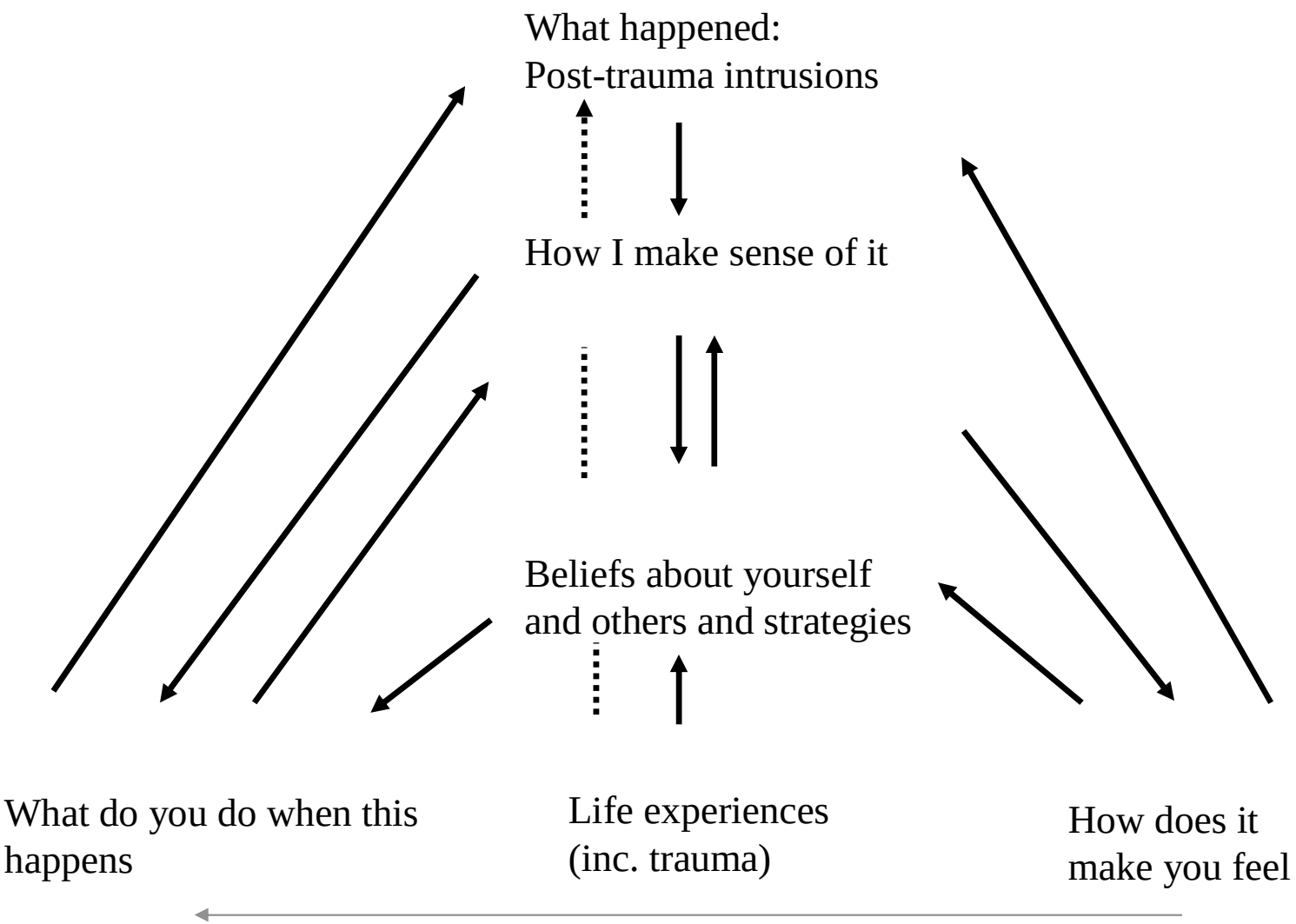
69 (49%) had been referred for CBT

IAPT-SMI: Demonstration sites & Competency framework

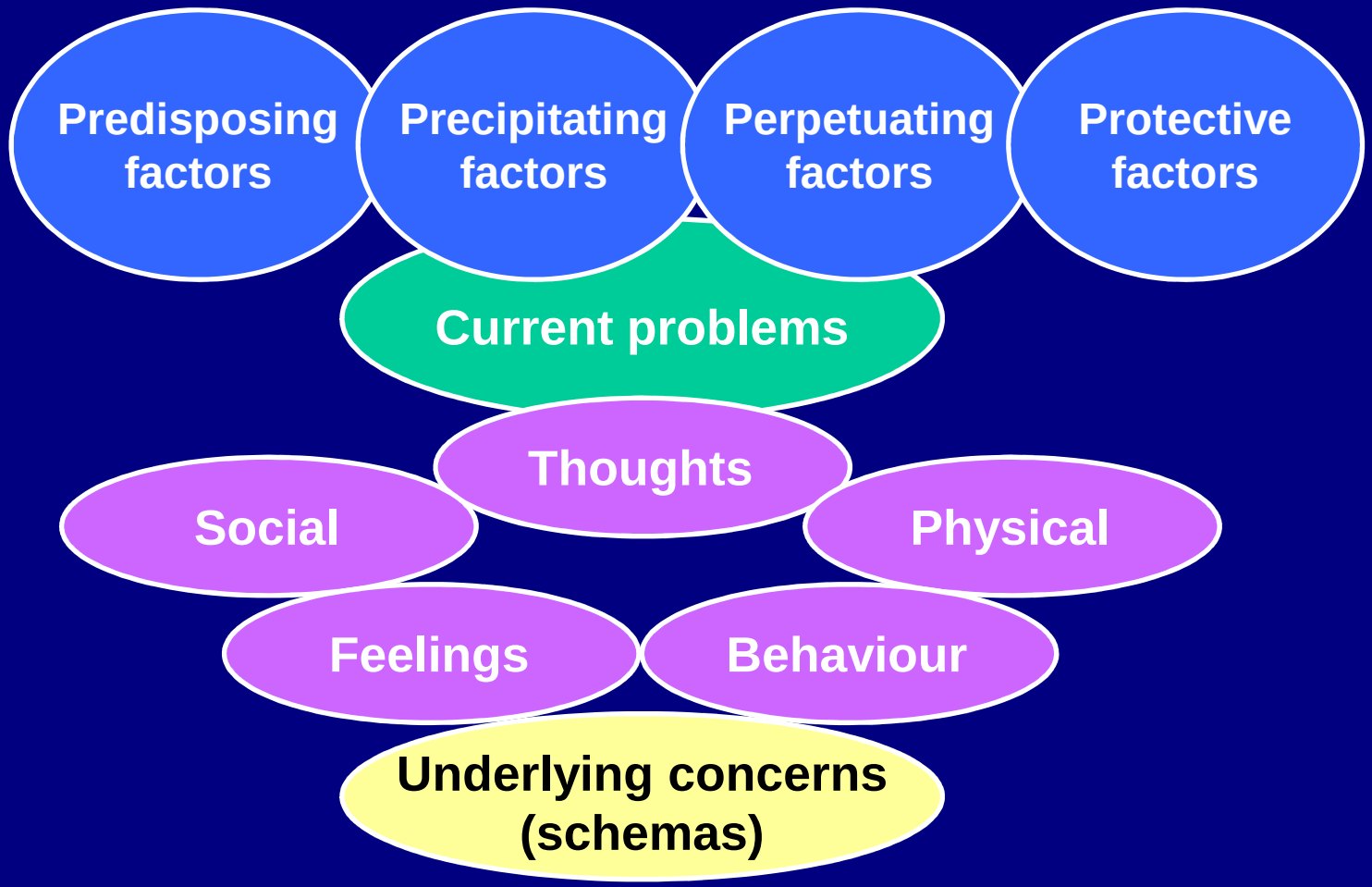
Therapeutic process of CBT

- There is a strong focus on *individualised* engagement of the patient building on good psychiatric practice
- Agendas are less explicit, feelings are elicited with great care and homework is used sparingly
- Assessment is based on clinical practice
- Emphasis is placed on understanding the first episode in detail, which may hold the key to current beliefs
- Information on current beliefs and how they were arrived at is assembled into a formulation

Formulation (Morrison)



A formulation for making sense of patients' beliefs and experiences



Making sense

Predisposing	Precipitating	Perpetuating	Protective

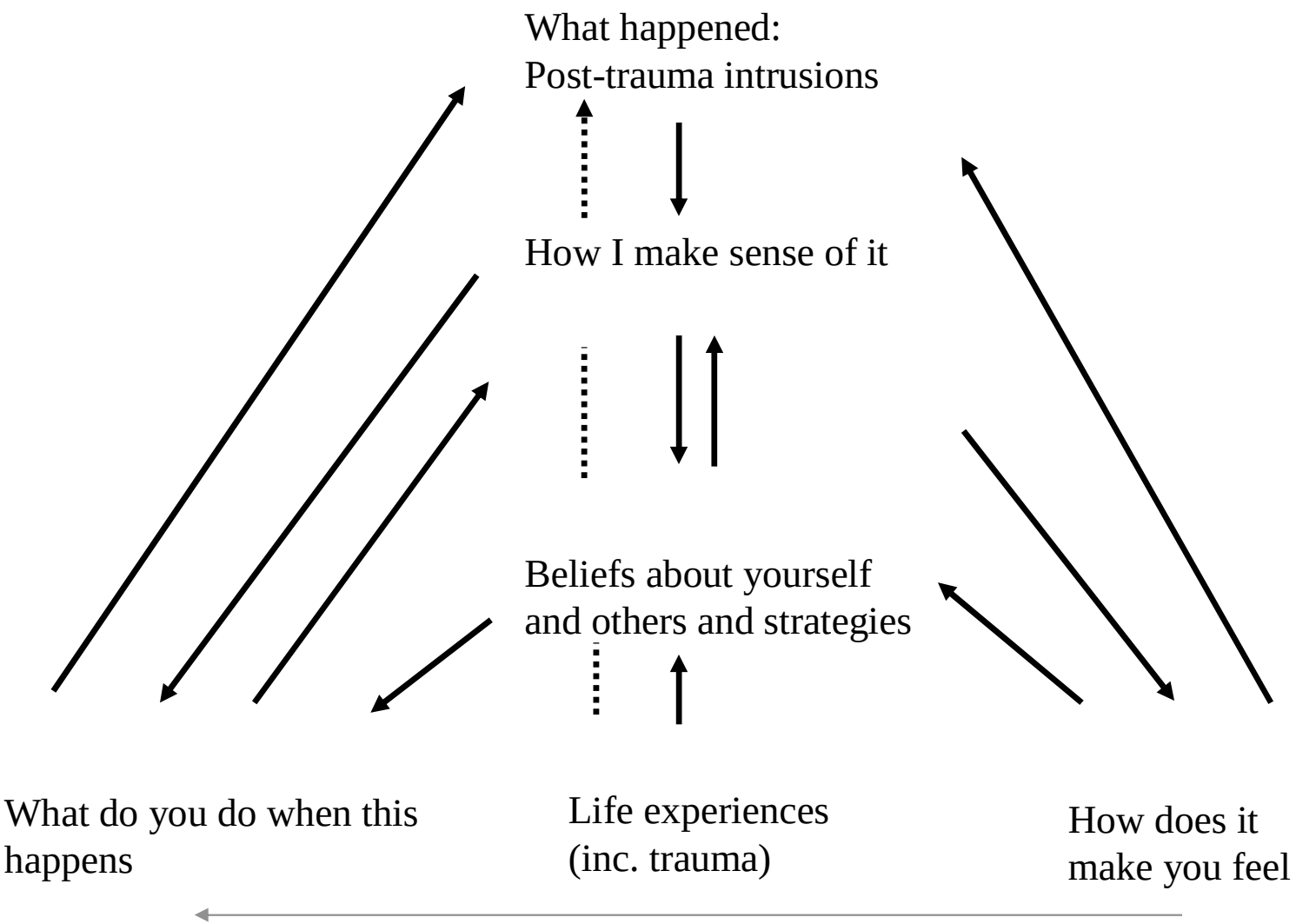
Current concerns

THOUGHTS	FEELINGS	ACTIONS

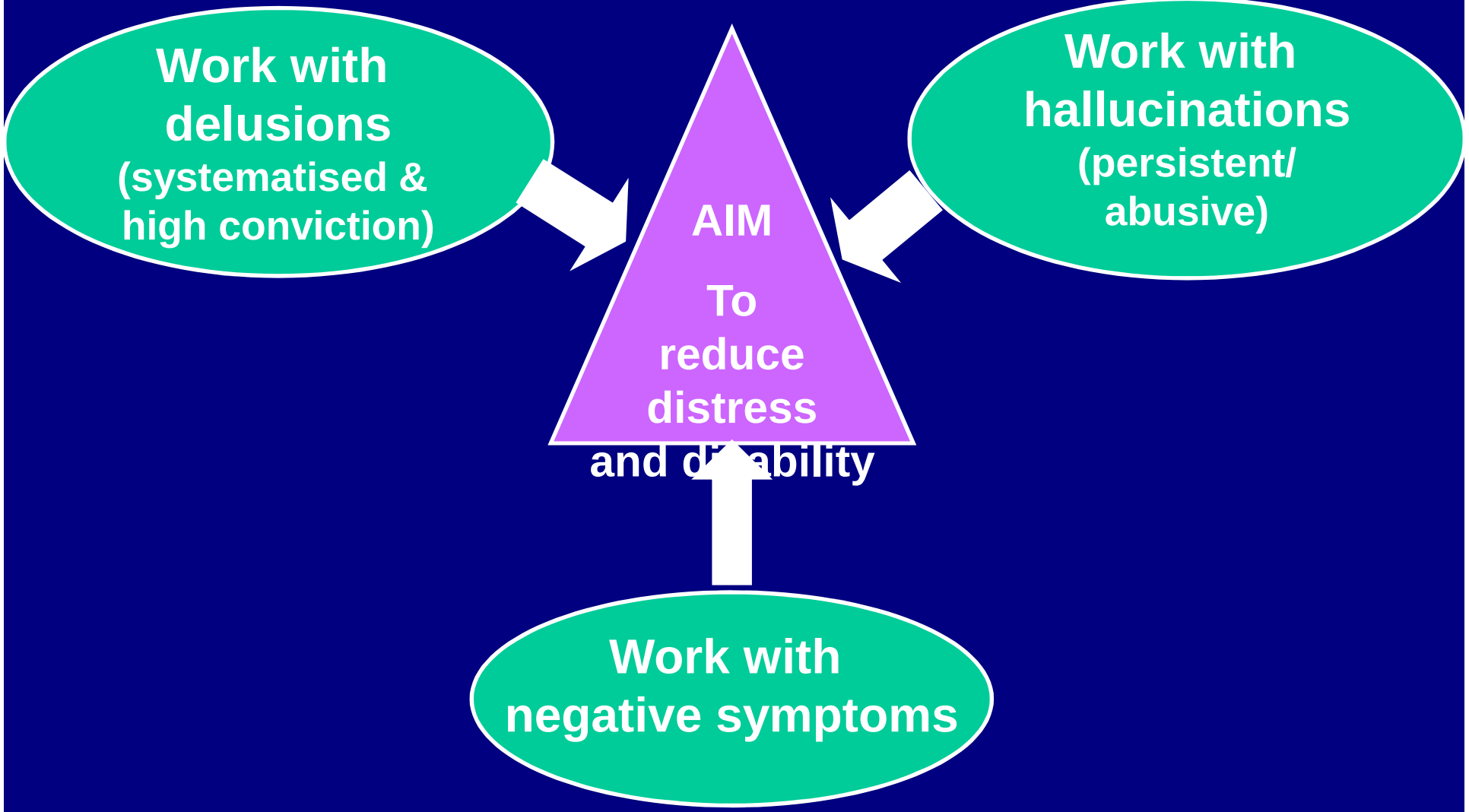
SOCIAL	PHYSICAL

UNDERLYING CONCERNS

Formulation (Morrison)



Overall aim of CBT for schizophrenia



Work with delusions

"I propose we trade services - you cure me of my delusions and I'll protect your navy."

Resistant delusions

- if going round in circles
  - *'Agree to differ'*
  - review key issues & concerns that have emerged: e.g. 'I don't want to end up like my mother', 'I haven't got a girlfriend', 'I'm useless'
  - it may be possible now to work directly with these
  - behaviour often changes first …..
- Other psychological techniques may be helpful: e.g. inference chaining

Work with voices

I KEEP HEARING THESE VOICES, DOC.

Coping strategies

- **Behavioral control**
  - e.g. relaxation, warm bath, go for walk
- **Socialisation**
  - e.g. friends, day centres
- **Medical care**
  - e.g.. control of medication, call care worker
- **Symptomatic behaviour**
  - e.g. get drunk or drugged, punch policeman
- **Cognitive control**
  - e.g.. TV, music, crosswords,

Develop a dialogue

Work with negative symptoms

NEGATIVE SYMPTOMS

- manage positive symptoms
  - especially ideas of reference, voices & thought broadcasting which can be reactivated as social and other activity increases
- manage any depression, anxiety & agoraphobia/social phobia
- optimise medication regimes

NEGATIVE SYMPTOMS

- **Consider the protective function of the symptoms, e.g.:**
  - **avoidance of over-stimulation**
  - **protection from relapse of positive symptoms**
- **Assess how much pressure the patient and family perceive:**
  - **Reduce pressure where possible**
  - **Review immediate expectations**
  - **Use realistic long-term planning, e.g. ‘take a year off then reconsider going to college when you feel ready’**
  - ***Reduce* level of activity if it is causing distress**

Insight scores
(David's Insight Scale 1990)

- **Three components:**

  a. Acceptance of need for treatment

  b. Acceptance that they have an illness

  c. Acceptance that voices or delusions are originating from themselves

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- **Three components:**
  - a. Acceptance of need for treatment
  - b. Acceptance that they have an illness
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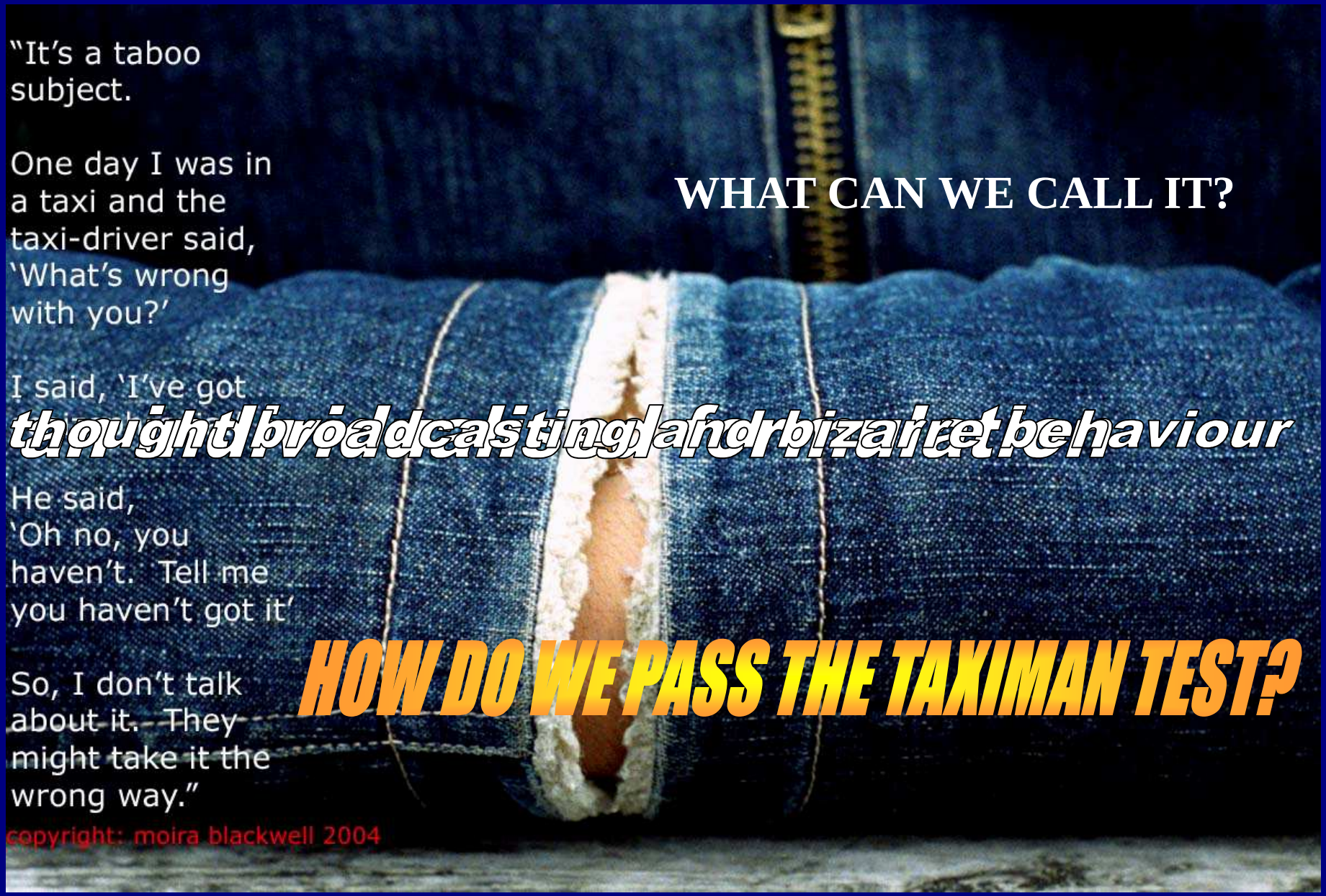
- **Improvements in a. & c. correlate with improved overall outcome**

Insight scores
(David's Insight Scale 1990)

- **Three components:**
  - a. Acceptance of need for treatment
  - b. Acceptance that they have an illness
  - c. Acceptance that voices or delusions are originating from themselves
- **Improvement in b. correlates with increased depression**


"It's a taboo subject.
One day I was in a taxi and the taxi-driver said, 'What's wrong with you?'
I said, 'I've got
He said, 'Oh no, you haven't. Tell me you haven't got it'
So, I don't talk about it. They might take it the wrong way."
copyright: moira blackwell 2004
WHAT CAN WE CALL IT?
thought broadcasting
HOW DO WE PASS THE TAXIMAN TEST?

Down with schizophrenia

Lumping together a diverse range of conditions under a name that patients fear and doctors don't understand helps no one, says **David Kingdon**

IN 2011, schizophrenia will be 100 years old. This also happens to be the year in which the main classification systems for psychiatric disorders are due to be revised. The question is: does the term "schizophrenia" deserve to survive into its second century?

Most patients would say no. In my work I find the diagnosis very difficult to use because it depresses patients and their carers and stigmatises them at home and at work. Patients constantly tell me how unhelpful they find it, and many simply reject the term.

Indeed, the classification has little if any scientific basis. Previously known as "dementia praecox" – early-onset dementia – schizophrenia has been used to cover a collection of diverse states ever since Swiss psychiatrist Eugen Bleuler coined the name in 1911. Conditions continued to be added until the 1970s, when it was decided that the classification had become impossibly wide. The "solution" was to focus on the nature of the symptoms (whether a patient has certain types of delusions, for example, or hears voices) but to ignore the content of those symptoms (what the patient is afraid of, or what the voices say). There is now a checklist of symptoms that helps doctors decide whether someone has schizophrenia.

recently renamed "integration disorder") will not change the root cause of the stigma – general ignorance of mental illness.

The problem with this argument is that a century of trying to unpick the biological basis of schizophrenia has made very little progress, and has been

"The classification of schizophrenia has little if any scientific basis"

has transformed the way that voices are considered, and helped many individuals to cope with stigmatisatio and unhelpful labels, and to deal with their hallucinations more positively.

Psychosocial research into schizophrenia is also beginning to reveal the impact of environmental factors such as stimulant and hallucinogenic drugs, stress and childhood trauma. This has led to the idea of subgroups of the condition, such as stress-sensitivity psychosis, traumatic psychosis, anxiety psychos and drug-related psychosis. Although more research is needed to better delineate these groups, this terminology is proving to be much more acceptable to patients. It is also more accurate, and may be less stigmatising. Our studies recently found that where 63 per cent of diagnosed patients have negative attitudes towards the term schizophrenia, only 16 per cent were negative about such new terms. Medical students asked to contrast these terms with schizophrenia were twice as likely to hold positive views about a patient's chance of recovery (*BMJ*, vol 334, p 221).

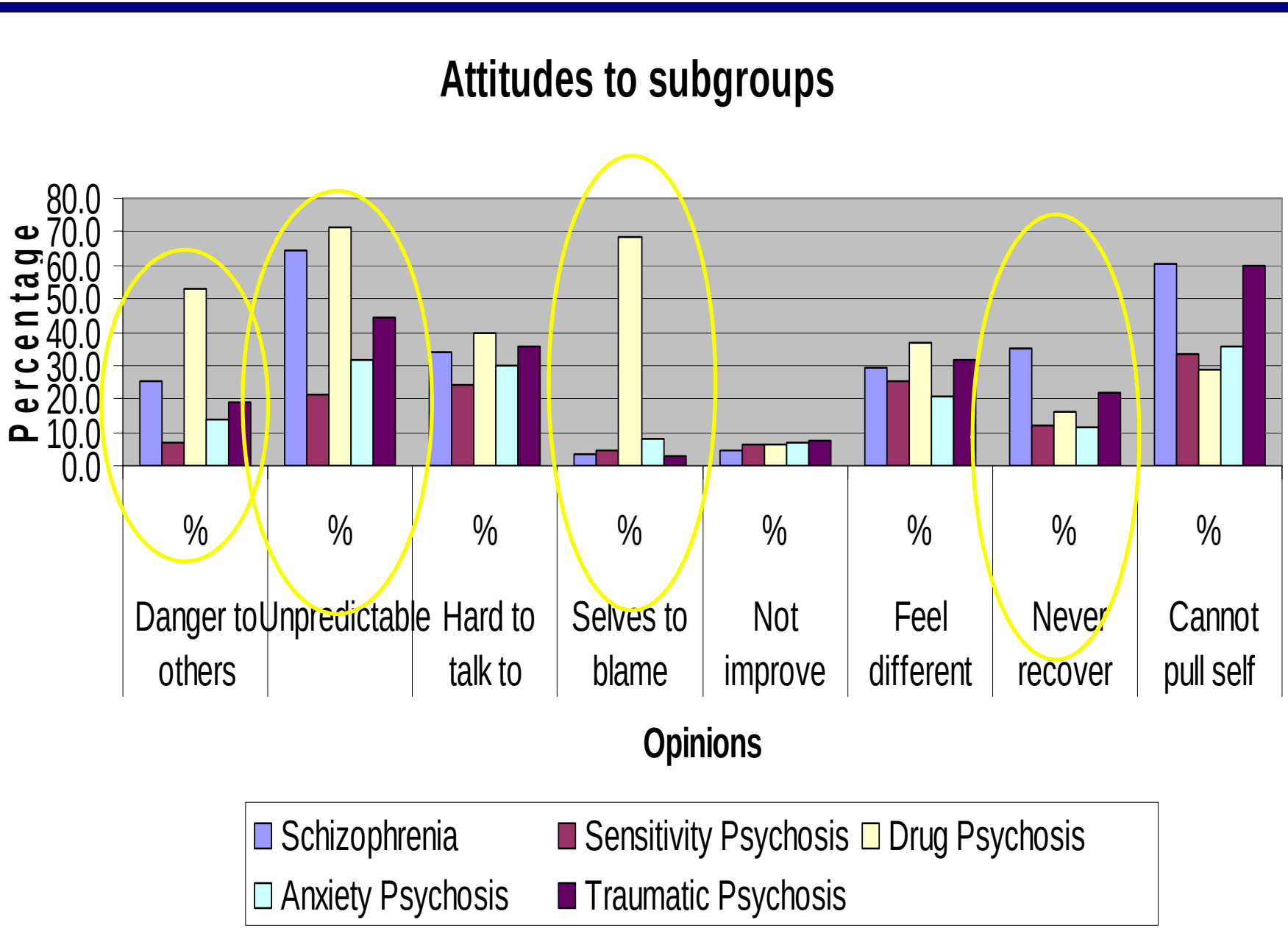
Renaming schizophrenia is highly controversial. It is difficult for psychiatrists and researchers to acknowledge that the concept they have been using for almost 100 years makes no sense. The drug industry is also likely to be resistant. Dividing patients into smaller groups means that not every drug will work in every group, reducing the potential market

Use of alternative terminology

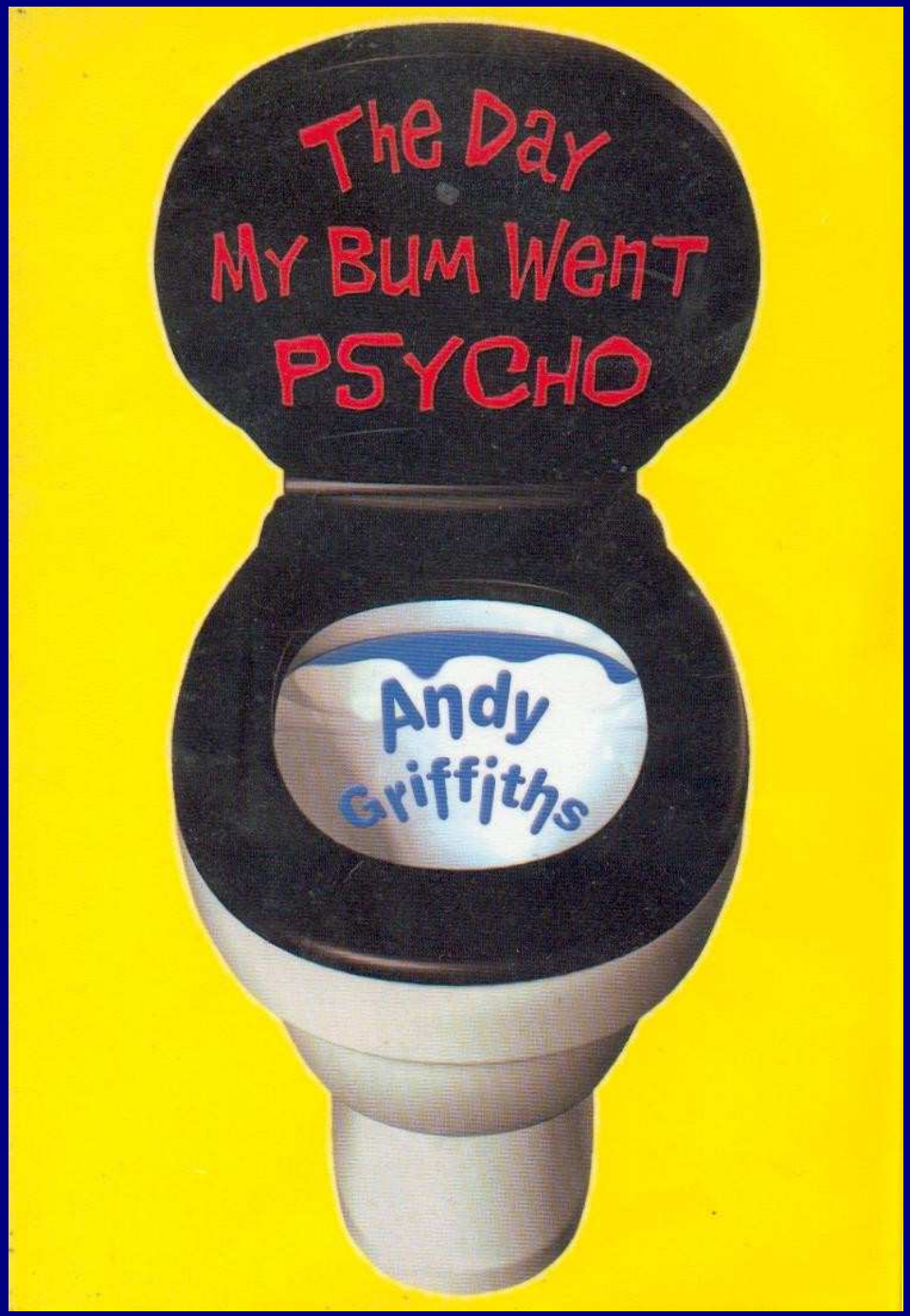
- User views of ‘schizophrenia’ & newer terms
  - Negative: 63% schiz v. 16% *(Kingdon et al, 2010)*
- Correlation between case note diagnosis & selection of group
  - Users (n=59): poor
  - Carer (n=20): moderate
- Reliability (agreement) of selected case note diagnosis: four psychiatrists blind-rating: ICC – 0.81
- *Structured clinical interview for psychosis subgroups (SCIPS)* *(Kinoshita et al, 2012)*

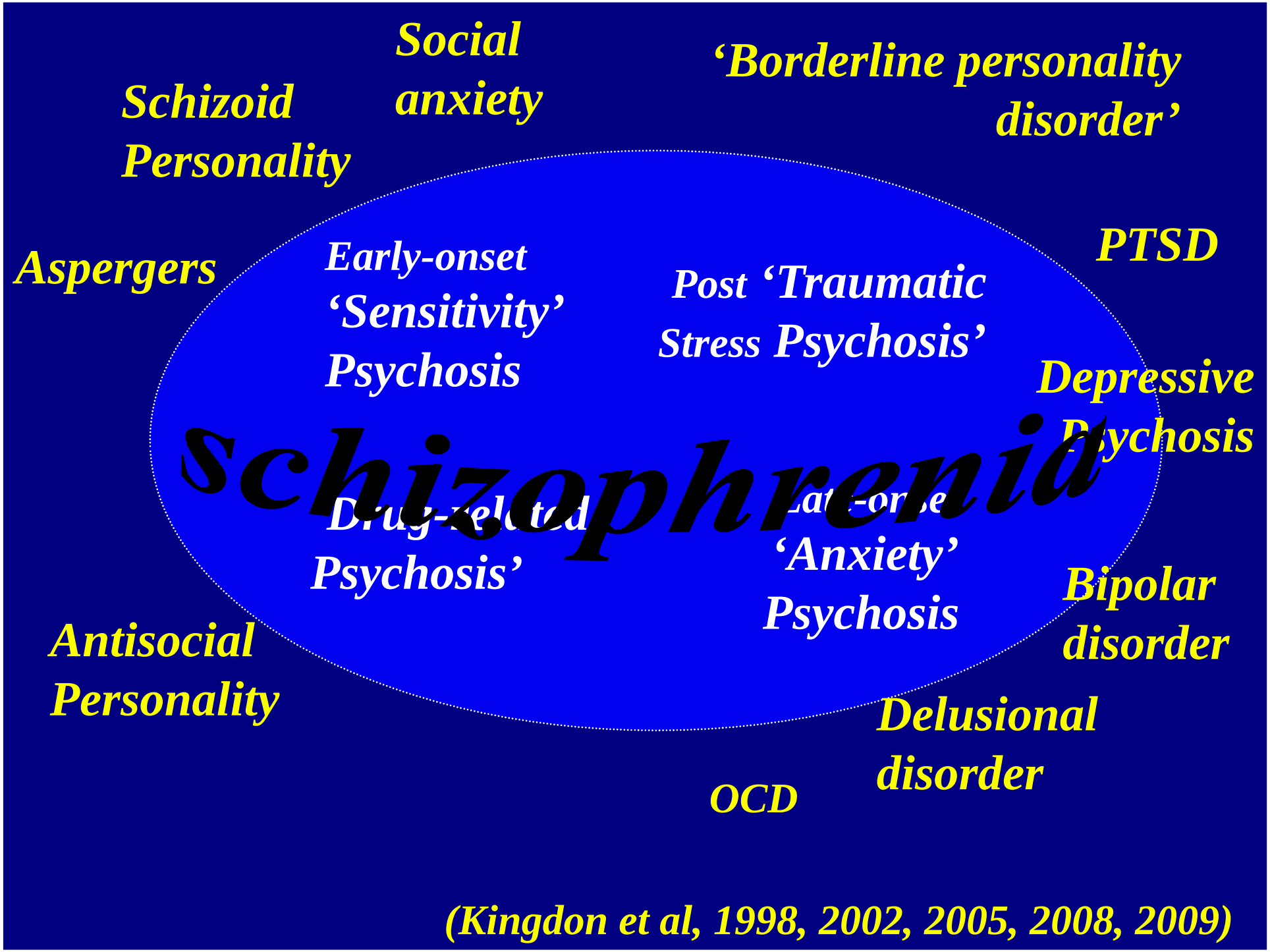
Attitudes to schizophrenia: does changing terminology make a difference?

(Kingdon, D., Selveraj, S., Vincent, S., Mehta, R. & Turkington, D, 2008)



[% expressing negative opinion]


The Day
My Bum Went
PSYCHO
Andy
Griffiths


Social anxiety
'Borderline personality disorder'
Schizoid Personality
PTSD
Aspergers
Early-onset 'Sensitivity' Psychosis
Post 'Traumatic Stress Psychosis'
Depressive Psychosis
schizophrenia
Drug-related Psychosis'
Late-onset 'Anxiety' Psychosis
Bipolar disorder
Antisocial Personality
Delusional disorder
OCD
(Kingdon et al, 1998, 2002, 2005, 2008, 2009)

Participants meeting DSMIV criteria for borderline personality disorder and schizophrenia

- 3 groups (n=111):
  - 59 with a diagnosis of schizophrenia
  - 33 with a diagnosis of BPD,
  - 19 with a diagnosis of both BPD and schizophrenia
- No difference in characteristics of ‘voices’ across the groups (except distress in BPD)

Prevalence of trauma

- **Those with a diagnosis of schizophrenia reported significantly less total trauma than those with BPD or both schizophrenia and BPD ($p<0.001$).**
- **Significantly lower levels in schizophrenia with all five types of trauma than the other two groups:**
  - **emotional abuse ($p<0.001$),**
  - **physical abuse ($p<0.01$),**
  - **sexual abuse ($p<0.001$),**
  - **emotional neglect ($p<0.001$)**
  - **physical neglect ($p<0.005$)**
- *Emotional abuse is the key predictor*

Journal of Consulting and Clinical Psychology
2008, Vol. 76, No. 2, 259–271

0022-006X/08/$12.00 DOI: 10.1037/0022-006X.76.2.259

A Randomized Controlled Trial of Cognitive–Behavioral Treatment for Posttraumatic Stress Disorder in Severe Mental Illness

Kim T. Mueser, Stanley D. Rosenberg, Haiyi Xie, M. Kay Jankowski, Elisa E. Bolton, and Weili Lu
Dartmouth Medical School and Dartmouth Psychiatric Research Center

Jessica L. Hamblen
Dartmouth Medical School and National Center for Posttraumatic Stress Disorder

Harriet J. Rosenberg, Gregory J. McHugo, and Rosemarie Wolfe
Dartmouth Medical School and Dartmouth Psychiatric Research Center

- **Dealing with trauma/abuse experiences in psychosis**
- **Focus on managing distress and beliefs – shame, guilt, anger - rather than experiences**

Cognitive therapy for command hallucinations: randomised controlled trial

PETER TROWER, MAX BIRCHWOOD, ALAN MEADEN, SARAH BYRNE, ANGELA NELSON and KERRY ROSS

BRITISH JOURNAL OF PSYCHIATRY (2004), 184,

Results Large and significant reductions in compliance behaviour were obtained favouring the cognitive therapy group (effect size=1.1). Improvements were also observed in the CTCH but not the control group in degree of conviction in the power and superiority of the voices and the need to comply, and in levels of distress and depression. No change in voice topography (frequency, loudness, content) was observed. The differences were maintained at 12 months' follow-up.

- Clarify beliefs about voices
- Discuss belief that you have to do what voices say
- Re-assess risk

Cognitive–behavioural therapy *v.* social activity therapy for people with psychosis and a history of violence: randomised controlled trial

Gillian Haddock, Christine Barrowclough, Jennifer J. Shaw, Graham Dunn, Raymond W. Novaco and Nicholas Tarrier

Background
Aggression and violence are serious problems in schizophrenia. Cognitive–behavioural therapy (CBT) has been shown to be an effective treatment for psychosis although there have been no studies to date evaluating the impact of CBT for people with psychosis and a history of violence.

Aims
To investigate the effectiveness of CBT on violence, anger, psychosis and risk outcomes with people who had a diagnosis of schizophrenia and a history of violence.

Method
This was a single-blind randomised controlled trial of CBT *v.* social activity therapy (SAT) with a primary outcome of violence and functioning assessors at 6 and 12 months (trial registration: NRR NO50087441).

Results
Significant benefits were shown for CBT compared with control over the intervention and follow-up period on violence, delusions and risk management.

Conclusions
Cognitive–behavioural therapy targeted at psychosis and anger may be an effective treatment for reducing the occurrence of violence and further investigation of its benefits is warranted.

BJPsych The British Journal of Psychiatry (2009) 194, 152–157. doi: 10.1192/bjp.bp.107.039859

- **Anger management is very relevant – reduces incidents**
- **Alongside CBTP**

Cognitive–behavioural therapy and family intervention for relapse prevention and symptom reduction in psychosis: randomised controlled trial†

Philippa A. Garety, David G. Fowler, Daniel Freeman, Paul Bebbington, Graham Dunn and Elizabeth Kuipers

Background
Family intervention reduces relapse rates in psychosis. Cognitive–behavioural therapy (CBT) improves positive symptoms but effects on relapse rates are not established.

Aims
To test the effectiveness of CBT and family intervention in reducing relapse, and in improving symptoms and functioning in patients who had recently relapsed with non-affective psychosis.

Method
A multicentre randomised controlled trial (ISRCTN83557988) with two pathways: those without carers were allocated to treatment as usual or CBT plus treatment as usual, those with carers to treatment as usual, CBT plus treatment as usual or family intervention plus treatment as usual. The CBT and family intervention were focused on relapse prevention for 20 sessions over 9 months.

Results
A total of 301 patier
outcome data were

The CBT and family intervention had no effects on rates of remission and relapse or on days in hospital at 12 or 24 months. For secondary outcomes, CBT showed a beneficial effect on depression at 24 months and there were no effects for family intervention. In people with carers, CBT significantly improved delusional distress and social functioning. Therapy did not change key psychological processes.

Conclusions
Generic CBT for psychosis is not indicated for routine relapse prevention in people recovering from a recent relapse of psychosis and should currently be reserved for those with distressing medication-unresponsive positive symptoms. Any CBT targeted at this acute population requires development. The lack of effect of family intervention on relapse may be attributable to the low overall relapse rate in those with

BJPsych | The British Journal of Psychiatry (2008) 192, 412–423. doi: 10.1192/bjp.bp.107.043570

wledgements.

- **Engage early – not when patients are trying to put experience behind them**
- **Don’t forget negative symptoms**

Psychological Medicine (2009), 39, 1627–1636. © Cambridge University Press 2009
doi:10.1017/S0033291709005467 Printed in the United Kingdom

ORIGINAL ARTIC

Cognitive behaviour therapy for improving social recovery in psychosis: a report from the ISREP MRC Trial Platform study (Improving Social Recovery in Early Psychosis)

D. Fowler[1*], J. Hodgekins[1], M. Painter[2], T. Reilly[3], C. Crane[2,4], I. Macmillan[3], M. Mugford[1], T. Croudace[4] and P. B. Jones[2,4]

Conclusions. The primary study comparison provided no clear evidence for the benefit of CBT in a combined sample of patients. However, planned analyses with diagnostic subgroups showed important benefits for CBT among people with non-affective psychosis who have social recovery problems. These promising results need to be independently replicated in a larger, multi-centre RCT.

- **Beck et al (2011) CBT for negative symptoms targeting self–defeating attitudes (50 sessions!)**

Studies (ongoing)

- MRC COMMAND – completed recruitment (2-300)
- Texas RCT – cognitive remediation + CBT: recruiting
- RfPB ACTION – CBT for medication-refusers

- US Veteran's Admin RCT – on-going (70/120)
- Beijing RCT – good unpublished results
- NIMH RAISE – Early intervention 'package'
- MRC EME – 'Worry intervention'
- NIHR – Mindfulness for voices
- NIHR DIALOG+ - patient feedback + CBT response
- HTA CBT for Clozapine-resistant psychosis
- DoH DRE Adapted CBT for diverse communities

Freeman et al. Trials 2012, 13:223
http://www.trialsjournal.com/content/13/1/223

TRIALS

STUDY PROTOCOL Open Access

The effects of reducing worry in patients with persecutory delusions: study protocol for a randomized controlled trial

Daniel Freeman[1*], Graham Dunn[2], Helen Startup[3] and David Kingdon[3]

Abstract

Background: Our approach to advancing the treatment of psychosis is to focus on key single symptoms and develop interventions that target the mechanisms that maintain them. In our theoretical research we have found worry to be an important factor in the development and maintenance of persecutory delusions. Worry brings implausible ideas to mind, keeps them there, and makes the experience distressing. Therefore the aim of the trial is to test the clinical efficacy of a cognitive-behavioral intervention for worry for patients with persecutory delusions and determine how the worry treatment might reduce delusions.

Methods/Design: An explanatory randomized controlled trial - called the Worry Intervention Trial (WIT) - with 150 patients with persecutory delusions will be carried out. Patients will be randomized to the worry intervention in addition to standard care or to standard care. Randomization will be carried out independently, assessments carried out single-blind, and therapy competence and adherence monitored. The study population will be individuals with persecutory delusions and worry in the context of a schizophrenia spectrum diagnosis. They will not have responded adequately to previous treatment. The intervention is a six-session cognitive-behavioral treatment provided over eight weeks. The control condition will be treatment as usual, which is typically antipsychotic medication and regular appointments. The principal hypotheses are that a worry intervention will reduce levels of worry and that it will also reduce the persecutory delusions. Assessments will be carried out at 0 weeks (baseline), 8 weeks (post treatment) and 24 weeks (follow-up). The statistical analysis strategy will follow the intention-to-treat principle and involve the use of linear mixed models to evaluate and estimate the relevant between- and within-subjects effects (allowing for the possibility of missing data). Both traditional regression and newer instrumental variables analyses will examine mediation. The trial is funded by the UK Medical Research Council (MRC)/NHS National Institute of Health Research (NIHR) Efficacy and Mechanism Evaluation (EME) Programme.

Discussion: This will be the first large randomized controlled trial specifically focused upon persecutory delusions. The project will produce a brief, easily administered intervention that can be readily used in mental health services.

Trial registration: Current Controlled Trials ISRCTN23107625

Worry intervention for delusions

(Freeman et al, 2012, 2013)

- Psychoeducation about worry,
- Reviewing of positive and negative beliefs about worry,
- Increasing awareness of the initiation of worry and identification of individual triggers,
- Learning to ‘let go’ of worry,
- Use of worry periods,
- Substituting problem-solving in place of worry,
- Relaxation exercises,
- A simple individualised formulation of each person’s worry was developed and homework between sessions was agreed,
- Written information was provided in the form of a leaflet called ‘winning against worry’.

Mindful awareness

(Chadwick at al, 2009; M4V)

‘Mindfulness is a new relationship with experience, where we

- Accept/Welcome all experience
- Experience it with full awareness
- Understand that it is just a fleeting object of awareness, so do not define self by it (not me, not mine)
- Let it go
- Judge neither it nor self’

How satisfied are you with your…..

mental health?

physical health?

job situation?

accommodation?

leisure activities?

friendships?

partner/family?

personal safety?

medication?

practical help you receive?

consultations with
mental health professionals?

DIALOG

SOLUTION-FOCUSED
PROBLEM SOLVING

WORK WITH SYMPTOMS

HEALTH CHECKS

EMPLOYMENT SUPPORT

HOUSING SUPPORT

LEISURE OPTIONS

SOCIAL SKILLS

RELATIONSHIP SUPPORT

ADVICE & SUPPORT

INFORMATION & DISCUSSION

ASSESS OPTIONS

ADVOCACY AND OTHER OPTIONS

PROBLEMS WITH VOICES – PARANOIA – MOTIVATION

Developing culturally-sensitive CBT for psychosis

- **Differing help seeking pathways/ behaviours**
- **Access and referral routes differ – imams, faith healers, etc: effective or impact on early intervention**
- **Collaboration/individualisation does not compensate for lack of understanding of cultural background**
- **Language/ terminology – e.g. patois in AC**
- **Individualism vs collectivism (family) – esp. SA Muslim**
- **Religion – impact in SAM & African-Caribbean**
- **Gender & family issues**
- **Interpreters – family complications, confidentiality**
- **Supernatural vs Scientific**
- **Expectations of therapist**
- **Self-disclosure: key for AC – not so for SAM**

(Rathod et al, 2010)

Schizophrenia Research 143 (2013) 319–326

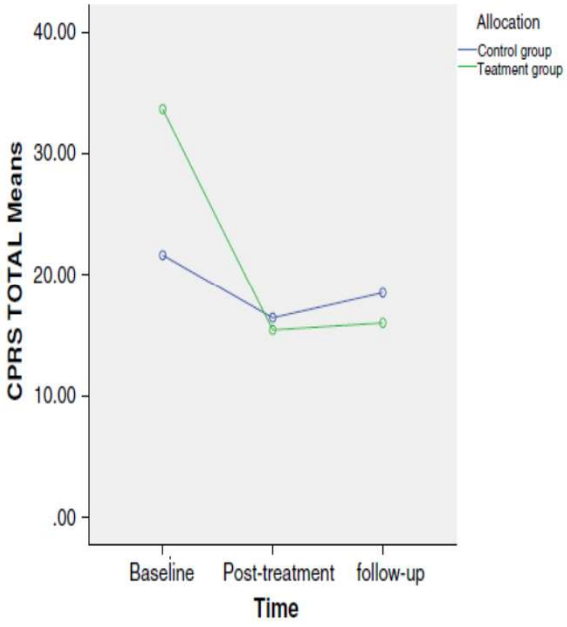
Contents lists available at SciVerse ScienceDirect

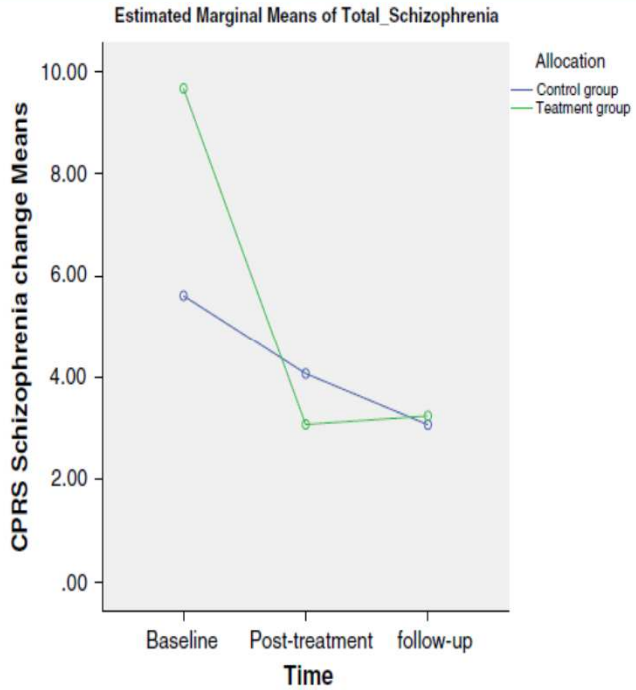
Schizophrenia Research

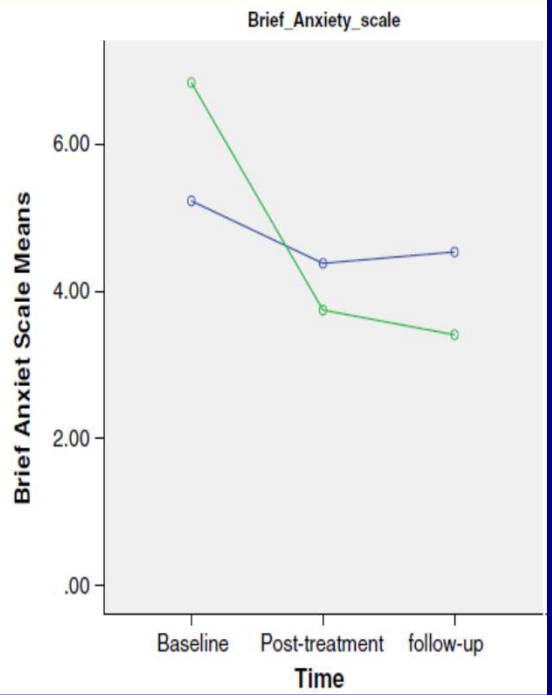
journal homepage: www.elsevier.com/locate/schres

Cognitive behaviour therapy for psychosis can be adapted for minority ethnic groups: A randomised controlled trial ☆

Shanaya Rathod [a], Peter Phiri [a,b,*], Scott Harris [c], Charlotte Underwood [a], Mahesh Thagadur [a], Uma Padmanabi [a], David Kingdon [b]





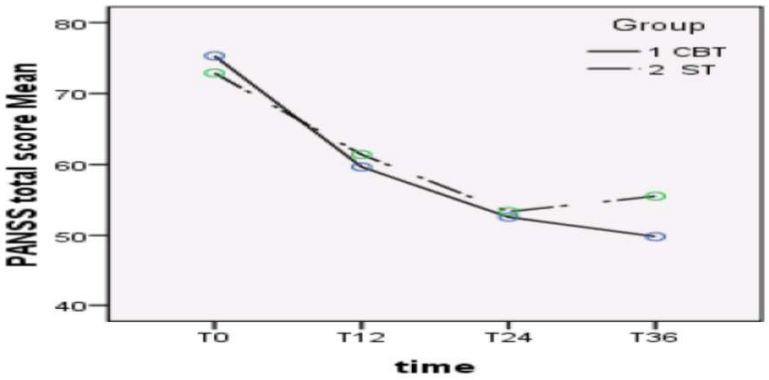


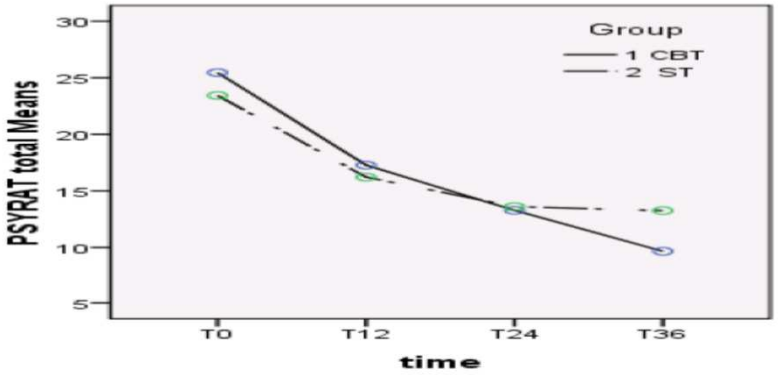
Anding Hospital Beijing

Drs Li & Xiyan

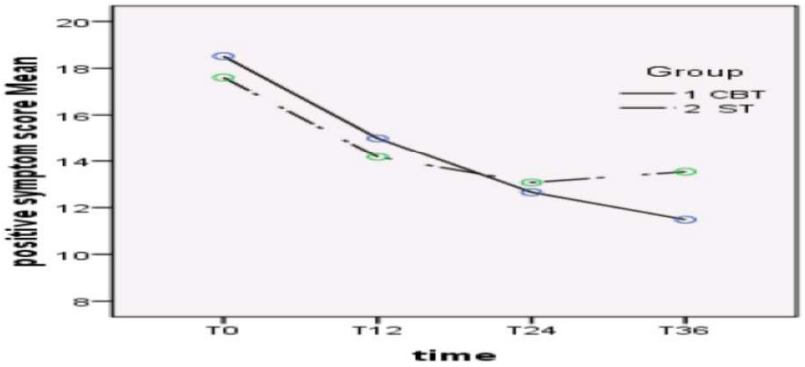
RCT CBT in Schizophrenia (Beijing n=60)

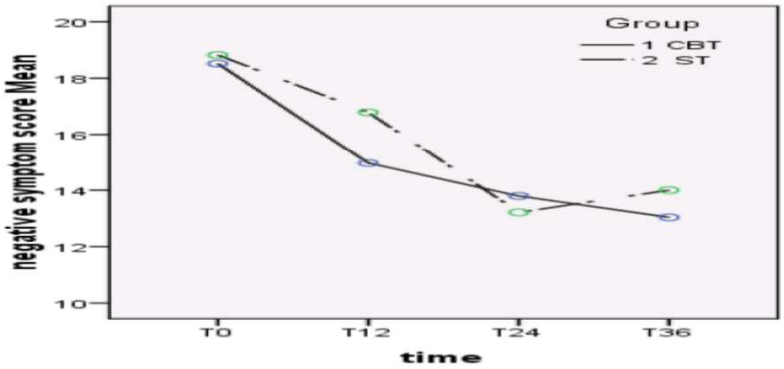
(a)





(d)





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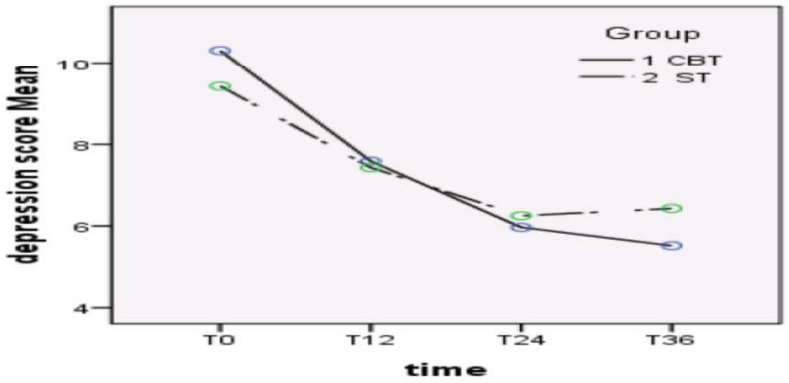
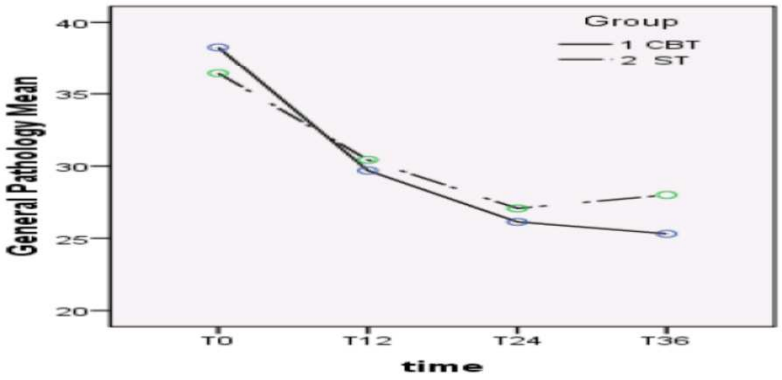
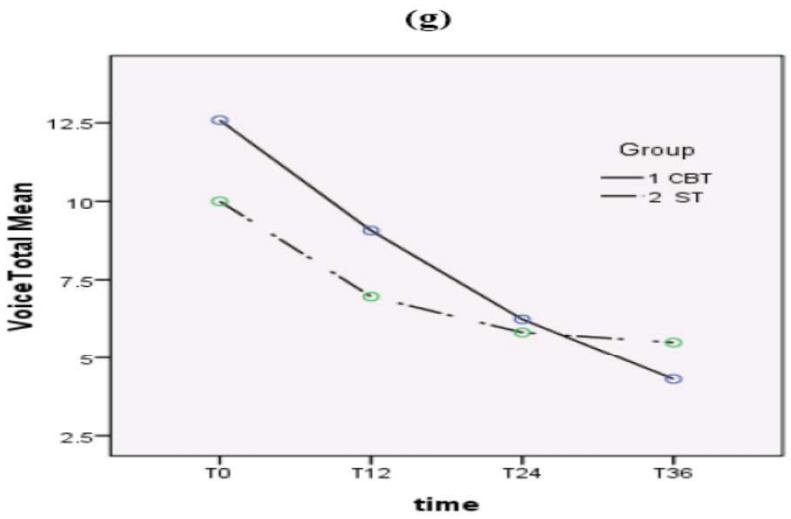
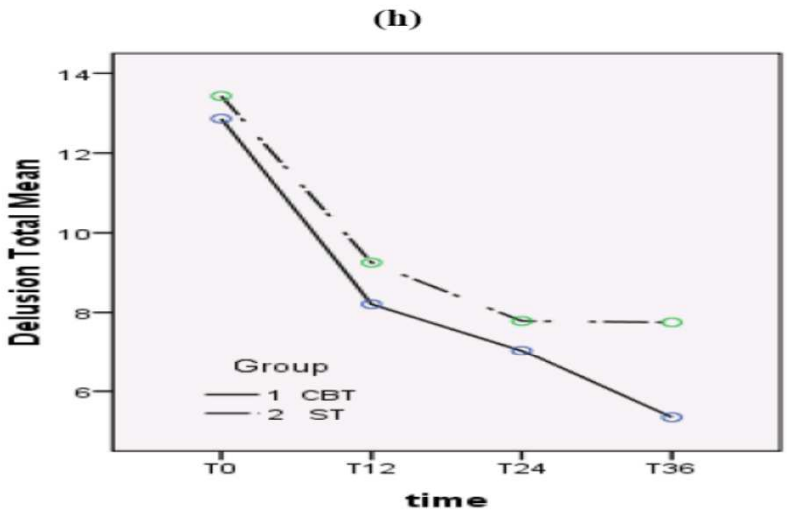
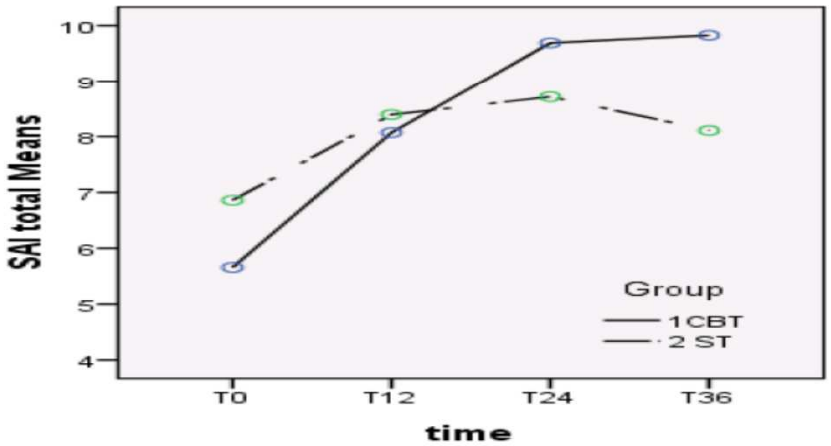


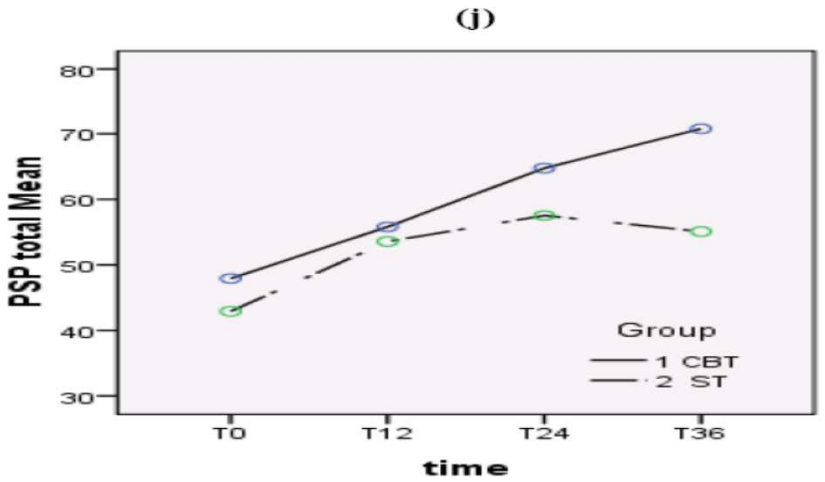


RCT CBT in Schizophrenia (Beijing n=60)

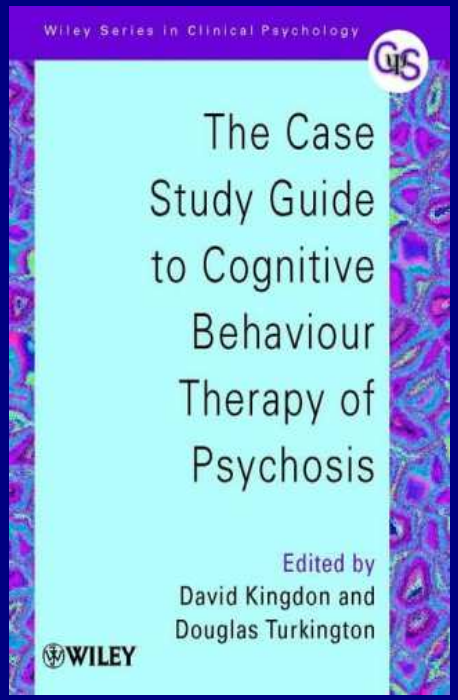








SAI – Scale for assessment of insight
PSP - Personal and Social Performance Scale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The Case Study Guide to Cognitive Behaviour Therapy of Psychosis
Edited by
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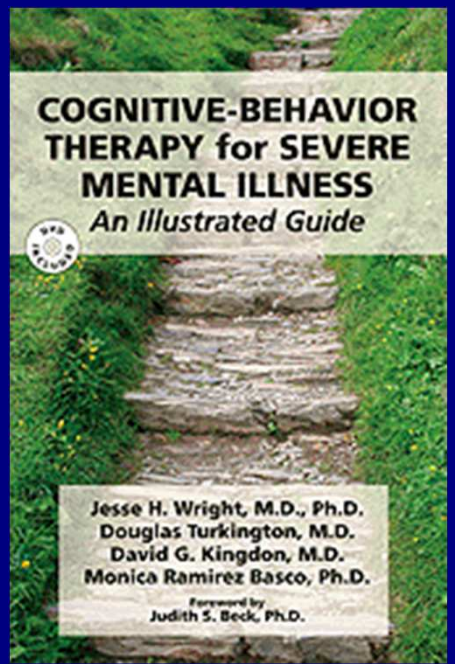
WILEY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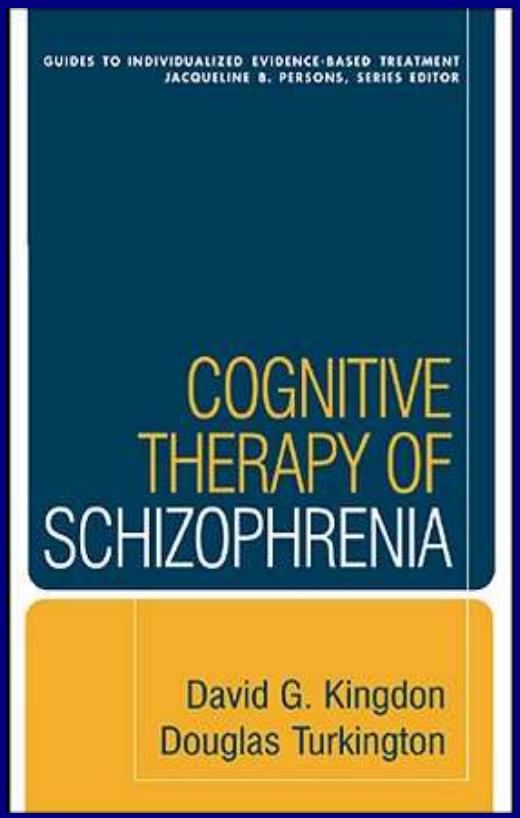
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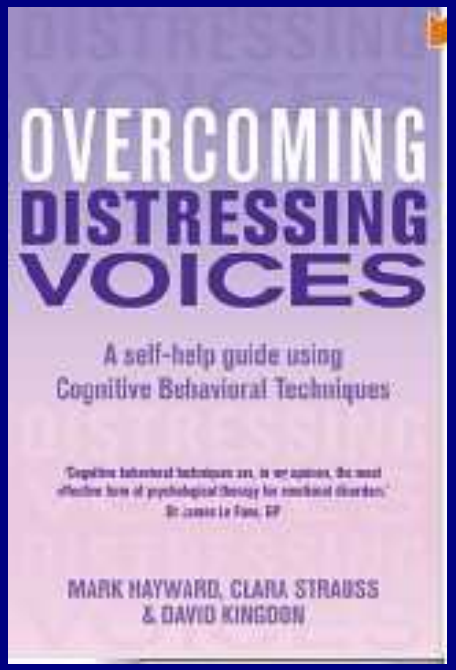
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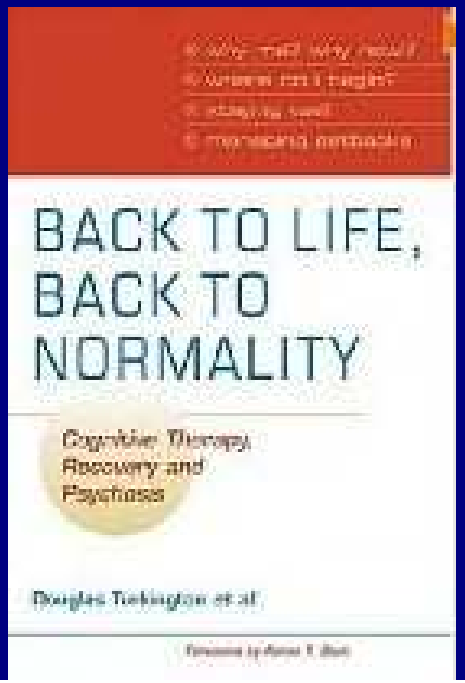
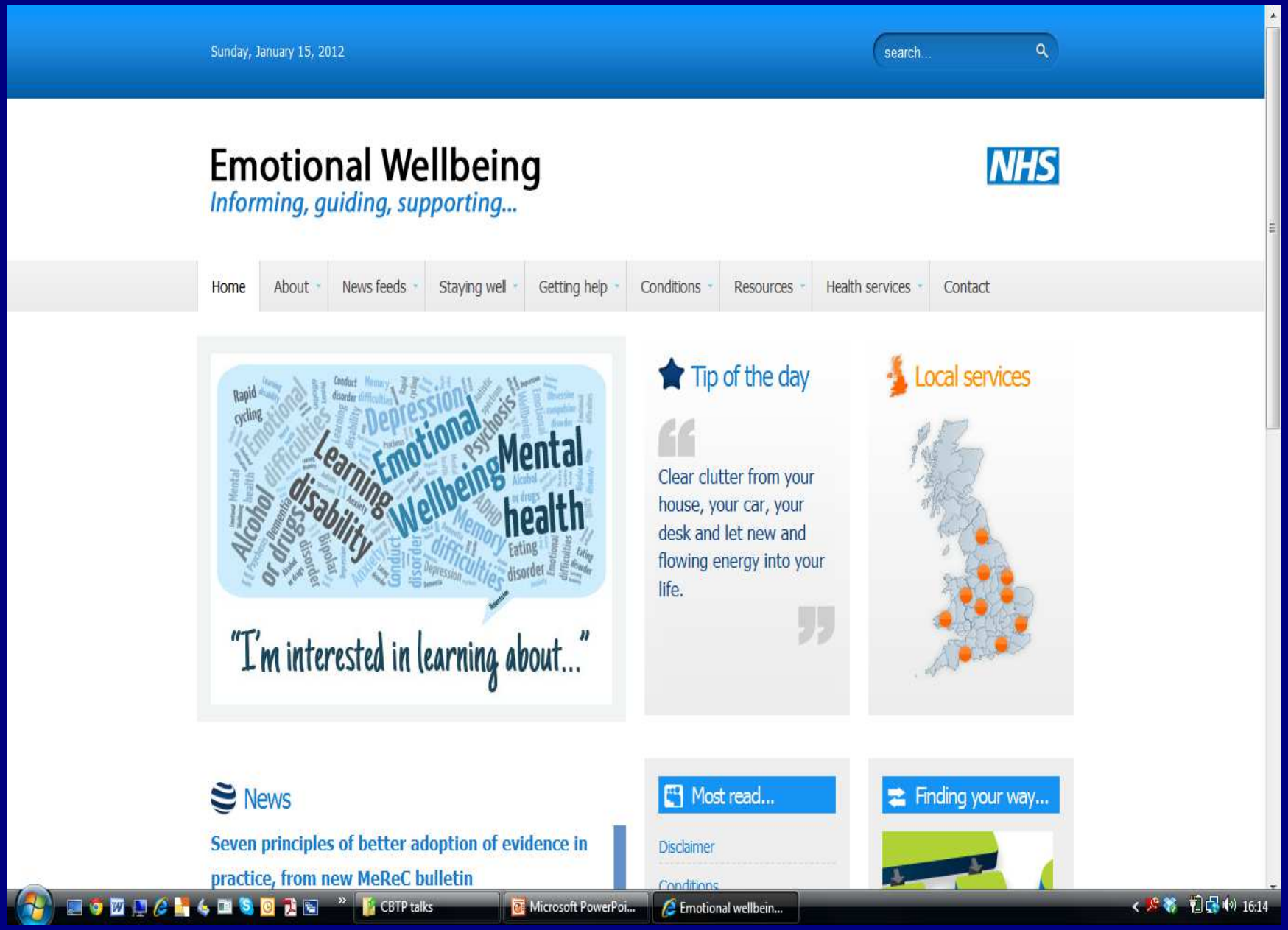
A self-help guide using Cognitive Behavioral Techniques
MARK HAYWARD, CLARA STRAUSS & DAVID KINGDON


BACK TO LIFE, BACK TO NORMALITY
Cognitive Therapy, Recovery and Psychosis



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Psychosocial Treatment - Psychosis

As we have done previously, we are using the term psychosis. Most relevant guidance described here continues to use the term 'schizophrenia'. General information on psychosocial treatments (meaning psychological and family work) is given first and then more specific information for professionals.

Information for service users and carers (NICE) on psychological treatment:

Psychological treatment

As well as medication you should be offered a psychological treatment called cognitive behavioural therapy (CBT for psychosis). This will involve meeting with a therapist on a one-to-one basis for at least 16 sessions. If you live with your family or are in close contact with them, you and your family should also be offered a psychological treatment called family intervention. Treatment should last for between 3 months and a year and include at least 10 sessions.

You may also be offered one of the arts therapies (e.g. art therapy), particularly if you have symptoms such as withdrawing from family and friends and losing interest in things that were once enjoyable. Therapy should usually take place in groups with people with similar problems.

Your therapist should make sure that you, and your family or carer if appropriate, are happy with how the psychological treatment is progressing. If you start psychological treatment during a hospital visit for an acute episode, it should continue once you have left hospital until you have completed the course.

There are other types of psychological treatment, such as counselling, supportive psychotherapy and social skills training. These are not thought to be as effective as CBT, family intervention and arts therapies for people with schizophrenia. However, your personal choice should be taken into account, especially if the other treatments are not available in your area and you wish to talk about your feelings, thoughts and symptoms.

You should not be offered a treatment called adherence therapy because there is not enough good evidence that it can help people with schizophrenia.

You should be offered social, group and physical activities (such as exercise) as part of your treatment programme, especially as you begin to get better. The activities should be recorded in your care plan.

Full details of the types of treatment and the supporting evidence is given in the NICE guideline on Schizophrenia (Chapter 8).

Books

Freeman, D. & others. Overcoming paranoia and suspicious thoughts. Robinson.

Gumley A. & others. Staying well after psychosis. Wiley-Blackwell.

Morrison A & others. Think you are crazy; think again. Routledge.

Mueser K. & others. The complete family guide to schizophrenia. Guilford.

Romme M. & others. Living with voices. 50 stories of recovery. PCCS books.

Turkington D. & others. Back to life; back to normality. Cambridge.

Leaflets

Psychosis leaflet - CBT

Psychosis leaflet - understanding voices

Psychosis leaflet - understanding how others think

Psychosis leaflets - getting motivated

CBT for psychosis - slides

Training

Conclusions

- CBT techniques continue to evolve in the treatment of psychosis
- Further dissemination requires increased availability of training and implementation of evidence-based care pathways (PbR-linked)