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Published online: 07 Dec 2016.

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The importance of human relationships, ethics and recovery-orientated values in the delivery of CBT for people with psychosis

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ABSTRACT

Cognitive behavioural therapy for psychosis (CBTp) is, at times, perceived as a technical therapy that undervalues the importance of human relationships and the fundamental principles on which CBTp itself is based (such as collaboration, validation, optimism and recovery-orientated practice). As such, it can be dismissed by service users or practitioners as undesirable. It is also possible that delivering CBTp that does not adhere to these values can be unhelpful or harmful. We review the evidence regarding what service users want from mental health services and the ability of CBTp to meet these standards. Evidence from qualitative studies and randomised controlled trials suggests that CBTp should be delivered in a manner that is both acceptable to, and empowering of, service users. We suggest strategies that are likely to maximise the likelihood of successful implementation that is consistent with both values base and evidence base.

Cognitive behavioural therapy (CBT) is often viewed as a technical psychological intervention that prioritises techniques or strategies over relationships and values (Boyle, 2011; Proctor, 2003; Thomas & Longden, 2013), and forms part of a mechanistic paradigm that Radden (2008) characterises as "a repair manual" approach to mental health. However, Aaron Beck, the developer of CBT, was an analyst by training and clearly stated that a good therapeutic relationship was essential to the delivery of CBT. The emergence of an evidence base for CBT for people with psychosis (CBTp) relied on the adoption of drug trial methodology in order to establish credibility, overcome inherent resistance to offering psychological therapy to this client group, and persuade psychiatric services that it was safe, acceptable and effective. In turn, the utilisation of randomised controlled trials (RCTs) with blind assessments, psychiatric interviews as the outcome measures, and an emphasis on fidelity of delivery has resulted in the adoption of CBTp into clinical practice guidelines; for example, the National Institute of Clinical Excellence (NICE) in the UK recommends that all children and adults with psychosis are offered CBT that aims to reduce distress or improve quality of life. However, the use of symptoms as primary outcomes and the use of scientific terminology in the reporting of such clinical trials, has also led to an impression that CBT for psychosis devalues the therapeutic relationship and imposes therapist-led goals, values and frameworks on service users in a didactic, inflexible way. Proctor (2003, p. 15) characterises this dynamic of the CBT model as follows:

> The ethical principle which underlies the practice of CBT is beneficence. The therapist is believed to be in a better position to decide what the client needs than is the client; the authority of the therapist is justified by the principle of … paternalism. It is not clear at what point the client's autonomy is considered, particularly if the client does not agree with what the therapist believes to be best. The focus on "realism" can be used to discount or challenge the feelings or views of the client, who can then be accused of being prey to "cognitive distortions" … It could be claimed that the intention behind

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> CBT … is to increase the client's sense of agency and reduce the power of clients' personal histories of powerlessness. However, the means by which CBT attempts to achieve this is not consistent with the ends. It is difficult to argue that the aim of CBT is to increase the power of the client, by the therapist using "power-over" or their authority.

While it is possible that such practice occurs, we would argue that it not only fails to represent quality implementation of CBTp, but actively violates many of the model's core values and principles. We aim to review the evidence regarding what service users and people with lived experience of psychosis want, and then consider how the evidence regarding the values and principles of CBTp compares to this.

What do people with experience of psychosis want from services?

Two recent national surveys have asked service users what they want from services. The public consultation, which was conducted as part of the Independent Mental Health Taskforce to the NHS, heard the views of over 20,000 individuals. A key theme that emerged from service users was that "too often, care was 'done to' them rather than shaped with them and that health professionals did not systematically listen to them or take their concerns seriously" (2015, p. 10). Similarly, the Schizophrenia Commission (2012) in the UK reported that services users wanted to be listened to, to have their experiences validated, to be seen as a person and not just a set of symptoms, and to be given hope. This is consistent with studies of service user priorities and preferences; Byrne and Morrison (2014) used a Delphi methodology to establish consensus among service users with experience of psychosis, finding that the most highly valued treatment preferences were a desire for more information, choice and collaboration in treatment decision-making (suggesting common dissatisfaction in these domains). The items most frequently endorsed as unnecessary or undesirable were several aspects of routine practice, including the use of medical terminology and appointments at mental health centres. They concluded that services which recognise the idiosyncratic characteristics of people with psychosis and their valued goals and outcomes are likely to prove more acceptable and, therefore, effective. Similarly, Shumway et al. (2003) compared the treatment priorities of service providers, users, policy makers and family members; they found that across groups, participants valued social and functional improvements more than symptom reduction.

These preferences and priorities are also consistent with the research on recovery from psychosis from a service user perspective. Research examining user-defined recovery (Pitt et al., 2007) has shown that people with psychosis clearly valued regaining a sense of self, rebuilding their lives and optimism about the future. In a Delphi study of nearly 400 people with psychosis that examined definitions of recovery, the highest level of consensus was reached for the statements "recovery is the achievement of a personally acceptable quality of life" and "recovery is feeling better about yourself". In turn, the CHIME framework for operationalising recovery, derived from a systematic review of 97 papers that explored conceptualisations of personal recovery from mental health problems, highlights the importance of the following themes: connectedness, hope, identity, meaning and empowerment/choice (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011). Likewise, research with 50 individuals who had recovered from distressing voice hearing experiences found that factors like acceptance, emotional reconstitution and meeting individuals who valued the voice hearer as a person as opposed to a patient, were consistently nominated as beneficial in the recovery journey (Romme, Escher, Dillon, Corstens, & Morris, 2009). In contrast, numerous aspects of statutory psychiatric provision were identified as actively harmful, including: the negative impact of hospitalisation, medication and diagnosis; refusal of staff to engage with the voice hearing experience; being treated as a "passive victim of pathology"; and psychosocial difficulties being disregarded in favour of focussing on the person's symptoms.

How does CBT for psychosis compare to these preferences, priorities and recovery values?

Evidence from qualitative studies and reviews

Three separate syntheses of qualitative research into experiences of receiving CBTp (Berry & Hayward, 2011; Holding, Gregg, & Haddock, 2016; Wood, Burke, & Morrison, 2013) identify aspects of CBTp that service users

consistently value, which reflect many of the user-defined preferences, priorities and values described above. It is also important to note that these reviews also identify challenges and difficult experiences of CBTp, which may reflect experiences when such core principles are violated; however, findings from all three suggest that CBTp is broadly seen as an acceptable, helpful and positive experience.

What does CBTp help with?

All studies reviewed by Wood et al. (2013) "endorsed the view that individual CBTp was successful in facilitating change for people who experience psychosis" (p. 291). Holding et al. (2016) identified the most common positive outcomes of therapy for psychosis (predominantly CBTp) as improvement in symptoms, including distressing beliefs, voices, mood, anxiety and self-concept. However, valued outcomes of CBTp identified by service users were not limited to specific reductions in psychotic experiences (Berry & Hayward, 2011; Holding et al., 2016; Wood et al., 2013), but also included developing acceptance of and ability to cope with such experiences. Improvements in social and occupational functioning were also consistently highlighted:

> … that gives me more confidence, more self-esteem, because I think I don't have to be … under the control of the Devil [voice] anymore. I can just try and be myself. (Hayward & Fuller, 2010, p. 369)

> It was helpful. It helped me with thinking clearly. I started going to work. It helped me to express my emotions. It helped me with catharsis. Now I don't argue or fight with my family members. (Naeem et al., 2014, p. 53)

The development of hope was also highlighted by two of the three reviews as a frequently valued outcome of CBTp (Holding et al., 2016; Wood et al., 2013), with Holding et al. describing the engendering of hope as a "dramatic outcome" for many therapy clients:

> The first time I came into contact with the mental health services I couldn't see anywhere forward, didn't want to be here, couldn't see the point of being here, now I've got things to aim for, it's like, okay, I've got things to aim for. (Kilbride et al., 2013, p. 98)

How does CBTp help?

Several "key ingredients" of CBTp were highlighted in all three reviews. The first consistently identified benefit of CBTp appears to be a change in understanding psychotic experiences; in particular, a shift towards understanding psychosis in the context of difficult or traumatic life experiences (Berry & Hayward, 2011; Holding et al., 2016; Wood et al., 2013). The collaborative development of an individual case formulation between therapist and client was consistently endorsed as an important process for facilitating this. Identifying and illustrating links between past and current experiences, and between experiences and thoughts, emotions and responses, helped CBTp clients to gain important new understanding or knowledge about their experiences:

> She was helping me to perceive things in a different way. (McGowan et al., 2005, p. 518)

> [therapist] doesn't start with hallucination, just telling me it's not real, whatever it is, he's, for example, starting with my er my behaviour in the past, my feelings, how outside events that could have caused me stress and could … I mean, previously, I've just had been, had no idea of how I could be hallucinating these things. (Messari & Hallam, 2003, p. 177)

> A better understanding I think of what was actually occurring and how I can pull myself away from feeling bad when certain events occur. (Morberg-Pain, Chadwick, & Abba, 2008, p. 133)

Another key aspect of service users' experience of CBTp was normalisation (Berry & Hayward, 2011; Holding et al., 2016; Wood et al., 2013). For some service users, the overall therapeutic process can be inherently normalising and act as a mechanism of change in itself (Wood et al., 2013). Through offering non-judgemental support and acceptance, CBTp also has the capacity to reduce experiences of shame or stigma that are often related to the experience of psychosis. Active normalising in CBTp can also be associated with the development of individual case formulations, and locating the development of psychosis within the context of an individual's life experience:

> [the therapist] is listening to my belief system, he's taking it seriously … he understands that it's, it's been built up understandably from a lot of evidence, a lot of factors and and so that makes me feel a bit better about having, having these beliefs … I don't have to feel that I'm stupid or just crazy or irrational, you know, in that, so that's made me feel better. (Messari & Hallam, 2003, p. 179)

Acceptance of psychotic experiences was another common process in CBTp (Berry & Hayward, 2011; Holding et al., 2016; Wood et al., 2013). For some, this involved a shift from feeling that symptoms of psychosis must be entirely absent in order to lead a positive or enjoyable life towards an acceptance that recovery is possible while psychotic experiences continue. For others, acceptance also involved a positive appreciation of the experiences themselves:

> I don't want to get rid of them [voices], I don't feel like they should ever really die or anything. (Hayward & Fuller, 2010, p. 369)

> I don't think it's [CBT] used to eliminate them altogether its knowing why you get the voices erm … how to deal with them basically. (Kilbride et al., 2013)

The importance of a collaborative relationship

Two of the three reviews identified the central role of the *therapeutic alliance* in CBTp. The therapeutic setting of CBTp in general tended to be seen as a safe, containing space which fostered trust, where people felt more able to be open about their experiences (Holding et al., 2016). The development of a collaborative therapeutic relationship within this setting was often identified by service users as an important aspect of CBTp (Wood et al., 2013)**.** Beneficial therapeutic relationships were seen to improve engagement and collaboration, and to promote esteem and equality:

> Interviewer: Do you feel there is a common cause between the two of you?
>
> Participant: Yeah
>
> I: What do you feel this cause is?
>
> P: To get one well, to get one to understand what one's done, to get one to understand what's been done about it … and for one not to be frightened, not to feel like one's alone … not to feel like all is lost. (Messari & Hallam, 2003, p. 177)

Many highlighted shared control of therapy as an integral part of their experience, and identified individualised, client-led agenda-setting as particularly important:

> It was very much a partnership between myself and the psychologist, it was really put to me as team work, which I thought was great. It wasn't that someone else has an agenda … it was centred around me which I'd not come across before in anything really in medicine or psychiatry (Kilbride et al., 2013, p. 93)

Along with the professional skills and knowledge that therapists bring to CBTp, service users have frequently described valued interpersonal qualities that therapists demonstrate, including genuineness, friendliness and caring; which help service users feel listened to, valued, understood and cared for (Holding et al., 2016; Wood et al., 2013). The ability to compassionately manage disclosures and discussions that service users themselves find most difficult has also been highlighted:

> She didn't, she wasn't really shocked or anything…it's nice to have someone who gets it, you know like [therapist], like when you, to not be shocked and to know why you're saying it and just, to feel normal. (Byrne & Morrison, 2013, p. 362)

Challenges and difficulties in CBTp

Both of the most recent reviews of service user experiences also highlight challenges and difficulties associated with CBTp (Holding et al., 2016; Wood et al., 2013). Service users' expectations about CBTp tend to be positive, but negative and ambivalent expectations have also been identified. Service users may mistrust mental health services generally, may doubt the usefulness of talking therapy, or believe that a different treatment would be more helpful (e.g. medication). Some people do not feel distressed

by "psychotic" phenomena and, therefore, are not seeking help; others may worry that talking therapy could increase distress (Holding et al., 2016). Exploring frightening experiences or painful memories often requires substantial courage and commitment, and service users may have to tolerate anxiety, embarrassment, exacerbations in distress or a decrease in mood as a result of CBTp:

> There were times when I spoke to [therapist], you know, and it's, you know, I was speaking about things from the past, and you know it brings it all back to you again, and there was times I left the session and you know my mood felt a bit low, but that's just because, you know bringing shit from the past, it's like a reminder. (Byrne & Morrison, 2013, p. 365)

> I think the worst thing is getting upset and being left with it once they've gone. (Kilbride et al., 2013, p. 97)

Such accounts of CBTp consistently suggest that negative emotional or psychological impacts of therapy tend to be temporary rather than sustained, and are most often accepted as a necessary part of the therapeutic process. Nonetheless, there is potential for therapy to confer more serious negative consequences, and most of these studies have not been successful in interviewing, for example, individuals who disengaged with therapy entirely.

Holding et al. (2016) also highlight the potential for disappointment if service users feel that their expectations for CBTp go unmet, or that they feel stuck, with little or no perceived change in their wellbeing. It can also be problematic if there are difficulties in the development of a collaborative relationship or mutually agreed goals:

> Couldn't see the relevance, I'm not sure why it was important, she just asked me to do it. (Dunn, Morrison, & Bentall, 2002, p. 366).

Finally, therapy endings can be difficult for clients, particularly when they have had a positive experience (Holding et al., 2016). For all of these reasons, it is important that engagement in CBTp is an informed choice.

Evidence from a Delphi study examining expert consensus about aspects of CBT for psychosis

Morrison and Barratt (2010) employed a Delphi process to elicit and quantify the opinions of a group of expert CBT clinicians working in the UK. The study aimed to determine the extent of expert consensus on the essential principles, and structural and functional elements of CBTp. Consensus was established in relation to values, principles and relationship factors that are relevant to the consideration of how CBTp compares to the preferences and priorities of people with psychosis (see Table 1). It is clear that the agreed principles and values emphasise the importance of factors such as a good therapeutic relationship, collaborative team working, respect, choice and optimism, which overlap significantly with what service users report wanting from services.

Evidence from clinical trials, guidelines and protocols

There is also evidence, from clinical trials and treatment protocols, that is relevant to whether or not CBTp is consistent with the preferences and priorities of service users and recovery orientated values. For example, Goldsmith, Lewis, Dunn, and Bentall (2015) demonstrated the importance of having a good collaborative working relationship characterised by warmth, empathy and respect. They showed that a good therapeutic alliance was associated with positive outcomes in CBTp, whereas a poor therapeutic alliance is actively detrimental. The NICE guidelines for both children and young people (CG155: NICE, 2013) and adults (CG178: NICE, 2014) with psychosis state that CBTp should last for at least 16 sessions, demonstrating the importance of therapy that includes time to establish a good therapeutic relationship. It also emphasises the importance of a recovery orientation that emphasises valued outcomes (distress reduction or improved quality of life), rather than symptom reduction only. CBTp should also inspire hope (since it is goal-directed and future-orientated) and promote choice and collaboration (since it emphasises shared goals and collaborative empiricism). The use of individualised

Table 1. Consensus statements on the essential principles, and structural and functional elements of CBTp from a therapist perspective.

Factor	Consensus statements from the Delphi study (Morrison & Barratt, 2010)
Values that should be endorsed by the CBT practitioner	Therapists should believe that many people experience psychotic-like symptoms without feeling distressed by them
	Therapists should have a good understanding of recovery from psychosis
	Therapists ought to believe that delusions can be quite understandable
	Therapists should believe that it is not the hallucination or the delusion per se that is clinically relevant but the amount of distress or disability associated with it
	Therapists ought to believe that hallucinations or thought disorder can happen to anyone if they are very stressed
	Therapists ought to view most symptoms of psychosis as quite common in the normal population
Values that should NOT be endorsed by the CBTp practitioner	Therapists should believe that clients with psychosis are very different to clients with other mental health difficulties
	Therapists should believe that there is a clear boundary between being mentally unwell and mentally healthy
Relationship considerations that should be adhered to when delivering CBTp	The client should be engaged in the therapeutic relationship
	CBT should require consistent collaboration throughout the sessions
	CBT should be implemented using a collaborative approach
	Interventions should be informed by client feedback
	Normalising of psychotic symptoms should be used to reduce stigma and improve engagement
	The client should be allowed and encouraged to express positive and negative reactions regarding therapy
	Collaborative feedback should be used to engage the client
	CBT should take into account the clients' perspective and "world view"
	Account always needs to be taken of presenting symptomatology, past experiences of services, and cultural/family issues in engagement
Principles that should be upheld in the delivery of CBT	CBT should aim to reduce distress and improve quality of life
	CBT sessions should always be accommodated to the client's needs and speed of learning
	CBT should aim to reduce distress and prevent future distress
	CBT should aim to elicit hope in recovery
	CBT should consult the client regarding the terminology used to explain their experience
	Session structure and content should be decided jointly between client and therapist
	The client should be given a chance to explain his or her own model first
	The client should make choices and take appropriate responsibility for the CBT sessions
	CBT should assist the maintenance of a client's capacity to make informed decisions about their lives
	The client and therapist should jointly agree a problem list
	Appropriate flexibility needs to be given in constructing agendas, targets and problem lists according to client's capacities, inclinations and motivations
	Guided discovery should be used to help the client gain understanding
	Agreed short and long-term goals should underpin the intervention
	CBT for psychosis should be founded upon the principles of evidence-based practice and value-based practice
	The client should be encouraged to prioritise the items on the agenda

case formulation should enable a person to feel listened to and understood, while validating their experiences and providing hope for positive change (Chadwick et al., 2003; Morberg-Pain et al., 2008). The most common approach to ensuring fidelity to the treatment protocols within CBTp trials is to ensure regular supervision of the therapists utilising the assessment and rating of audio- or video-recordings of therapy sessions using the Cognitive Therapy Scale-Revised (Blackburn et al., 2001). This incorporates elements including the formal assessment of collaboration, two-way feedback, appropriate pacing for the individual client and the interpersonal effectiveness of the therapist. Failure on any of these items would lead to the conclusion that the CBTp was not competently delivered. All of these components are viewed as necessary (but not sufficient) to achieving the goals of the service user. People with psychosis need to be aware of this, in order to be able to complain if they receive something described as CBTp that does not incorporate these essential components. Similarly, would-be practitioners and commissioners of services also need to be aware of this so they can accurately assess competency in clinical practice and the acceptability and appropriateness of services.

Top 10 tips to ensure ethical and competent delivery of CBTp

Below we outline some considerations for promoting and preserving relationships, ethics and recovery-orientated values within the delivery of CBTp:

(1) *Be collaborative*: Establish a shared goal and a sense of working in partnership towards achieving this.

(2) *Use everyday language*: Technical terminology which is inaccessible, professionally-led, or otherwise alienating to service users should be avoided (e.g. negative automatic thought, schema, formulation). Unless it is the client's preference, we also recommend avoiding medical language (e.g. disorder, mental illness, relapse, symptoms) as well as employing normalising, non-medical terms to discuss the person's experiences (e.g. hearing voices or unusual beliefs, as opposed to hallucinations or delusions).

(3) *Acknowledge historical context*: CBTp should acknowledge the damaging impact of adverse life experiences, and should not to minimise such painful experiences by focusing exclusively on the present; Boyle (2011, p. 33) states "it is increasingly common to refer to cognitive accounts as theories of problem *maintenance* so that questions about early adverse experiences may no longer be asked, far less answered".

(4) *Evaluate appraisals and beliefs (rather than challenge them)*: Rather than implying the therapist has a superior knowledge and awareness, it is important to explore what a client's beliefs might mean to them with genuine curiosity and to support them to make sense of their experiences in their own terms.

(5) *Be cautious with the stress-vulnerability model*: While many clients find this hypothesis to be a helpful way of conceptualising their experiences, it can also be misapplied. Specifically, therapists should not imply that avoidance of all stress is necessary for wellbeing as this is incompatible with recovery goals like work and relationships. Nor should the model suggest that only the "vulnerable" are affected by stress.

(6) *Validate the client's experience*: A central element of CBTp delivery is the collaborative development of a formulation that provides a rationale for why individuals are experiencing their current problems. A cognitive formulation provides a vehicle to validate a person's thoughts, emotions and behaviours, demonstrating that these are understandable and neither "madness" nor symptoms of illness.

(7) *Deliver hope*: CBTp should focus on the individual's personal goals as the intended outcomes; identifying and working to achieve them delivers an intrinsic message that they are achievable, which should convey hope.

(8) *Offer informed choice*: Make it clear that therapy is optional, and requires hard work and dedicated input from the client. Acknowledge not everyone will want it.

(9) *Ensure adequate training*: Delivering high quality CBTp is difficult and should not be attempted without extensive and specialist training.

(10) *Ensure access to quality supervision*: Ongoing support and supervision should be continuously available to practitioners.

Conclusion

There is consistent evidence that mental health services do not always meet the needs of service users. The aspects of service delivery most valued by service users map closely onto the "CHIME" factors (Connectedness, Hope, Identity, Meaning and Empowerment) identified as central to personal recovery (Leamy et al., 2011). Although such crucial factors are often perceived as absent from statutory services, service users who have benefitted from CBTp often mention them as having been particularly beneficial. In this regard, active listening promotes a sense of connectedness; focusing on personal goals can encourage hope; recognising personal strengths and talents is important for the development of a healthy identity; formulating a person's difficulties as understandable within the individual's life context can help a person find meaning in their experiences. Finally, CBTp can empower service users by helping them to understand and manage their difficulties. In short, CBTp delivered with fidelity to the model (including the principles and values outlined here), should be entirely consistent with what service users want.

Despite this, anecdotal accounts suggest some service users appear to have experienced CBTp as an overly simplistic and technical approach, rather than collaborative and empowering, focused on demonstrating that they have "faulty thinking" with blunt attempts made to "correct" this or eliminate symptoms using a set of prescribed techniques. The therapy they describe bares no resemblance to the form of CBTp delivered in RCTs by skilled therapists, but appears an erroneous corruption. Exposure to poor quality therapy will result in service users being less likely to benefit and more likely to experience unwanted effects, which could lead to dismissal of the therapeutic approach as opposed to questioning therapist competence. In addition, even within trials, it is clear that not everyone benefits from CBTp, and there are a variety of difficulties that could be improved (Thomas, 2015). However, in order to maximise the likelihood of replicating the outcomes of the trials that have resulted in the recommendations for access to CBTp in treatment guidelines, fidelity to the model is required. If what is delivered is missing crucial ingredients and delivered without fidelity, then it is unlikely to produce the same outcomes, resulting in an ineffective or, worse, harmful intervention.

Qualitative research embedded within trials demonstrates that, when service users are exposed to high quality CBTp delivered by competent trial therapists, they have high satisfaction and experience it as recovery-orientated, collaborative and validating. Therefore, a strategic approach to regulate the delivery of CBTp is required in order to protect service users. The competencies that are perceived as essential for the delivery of CBTp are contained within the competence framework for delivering CBTp (Roth & Pilling, 2013), which was derived from therapy manuals of the RCTs that provided the evidence base. Specific CBTp competencies are in addition to the generic CBT skills required for working with anxiety and depression and it is evident that to acquire such wide ranging knowledge and skills, therapists will require extensive training and supervision. In the UK, there is work underway to regulate therapists by introducing accredited CBTp training to ensure those delivering CBTp have sufficient training and supervision to practice competently, which should help to address the problem of rogue therapists providing unsatisfactory, sub-standard therapy. Informing service users about what to expect if receiving CBTp, which would highlight discrepancies between what should happen and what is being offered, may also increase quality of therapy. Many "What is CBTp" booklets neglect the underlying context of being listened to, collaboration, helping a person to make sense of experiences, offering hope and being recovery-orientated, which can also be true of presentations on the basics of CBTp; if CBTp is to be implemented successfully, it is important to emphasise the underlying values as well as specific therapy techniques.

Author contributions

All authors contributed to the conceptualisation and writing of the manuscript.

Disclosure statement

AB and APM deliver training workshops and have written texts on the topic of CBT for psychosis, for which they receive fees. All authors conduct funded research on CBT for psychosis.

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