CBT for Voices and Worries: Therapist's Manual

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Table of Contents

Introduction

History & Purpose of the Manuals

The original version of the *Cognitive Behavioral Therapy (CBT) for Voices and Worries: Veteran's Workbook* was developed by Yulia Landa, Psy.D., M.S. from the James J. Peters VA Medical Center and entitled, *Cognitive Behavioral Therapy for Paranoia.* The manual was subsequently adapted for outpatient VA use by Dimitri Perivoliotis, Ph.D. at the VA San Diego Healthcare System Psychosocial Rehabilitation & Recovery Center (PRRC), where it has been used successfully as a group CBT for psychosis (CBTp) manual since 2011. Therapists have also reported positive experiences using the manual to guide delivery of individual CBTp. The manual was revised in 2021 by Drs. Perivoliotis and Landa to make it more targeted toward individual therapy use, as part of a VISN 21 MIRECC CBTp training initiative led by Dr. Shirley Glynn.

The purpose of the *Veteran's Workbook* and this accompanying *Therapist's Manual* are to structure the delivery of high-fidelity CBTp with Veterans in the VA healthcare system who are experiencing current, distressing/impairing auditory hallucinations (voices) and/or delusional beliefs, especially paranoia. The *Veteran's Workbook* (which is often referred to simply as "the manual" below) is designed to be given to Veterans participating in the treatment and the *Therapist's Manual* is to guide therapists in delivering the treatment. The latter has been designed with the novice CBTp therapist in mind, and is intended to facilitate delivery of the treatment. Although these manuals were designed to support the delivery of full, formal, CBTp, they can also be used to guide CBT-informed interventions outside of formal therapy (e.g., a case manager may pull stress reduction strategies from Session 5 to help a Veteran who is distressed; a psychiatrist may use material from Session 9 to help understand a Veteran's thoughts and behaviors pertaining to medication use).

How to Use the Manuals

There is no one specific way to conduct CBTp. Psychosis is a complex phenomenon and patients can present with highly variable presentations of symptoms, functioning, cognitive abilities, insight levels, etc. Hence, these manuals are designed to be used flexibly. You can certainly follow the *Veteran's Workbook* session-by-session, but be prepared to make adaptations as necessary—e.g., some sessions may have to be extended into two or more visits, while others may be reviewed briefly or skipped altogether, depending on the Veteran's needs and abilities. However, to maximize learning and ensure good treatment fidelity, we recommend that beginning therapists try to follow the treatment session-by-session as much as possible and make adaptations as their competence builds.

These manuals are ideally to be used in the context of a comprehensive training package that includes a workshop and community of practice calls. Before using these manuals, we recommend therapists read *Cognitive Behavioral Therapy for Psychosis (CBTp): An Introductory Manual for Clinicians* by Yulia Landa, Psy.D., M.S., which serves as a foundational primer on CBTp and orients the reader to the basic strategies and interventions of CBTp.

Before each session with a Veteran, we recommend the therapist prepare by reading the corresponding section from both the *Veteran's Workbook* and this accompanying *Therapist's Manual.*

A Note on Language

This manual will typically use the word "Veteran" or "patient" to refer to the person participating in CBTp, and "therapist" to denote the provider. "Voices" refer to the specific kind of auditory hallucinations targeted by this intervention. The word "**worries**" was intentionally chosen to refer to persecutory beliefs/paranoia since the word "paranoia" can be stigmatizing and off-putting to some patients, especially those who have little to no insight into their psychosis. At times, the *Veteran's Workbook* refers to "suspicion" as a common type of worry. Have a conversation with the Veteran about what language is acceptable to them (see Session 1 in this manual for more guidance). Although the treatment we describe in this manual was designed to address voices and paranoia, it can be used for other distressing/impairing experiences associated with psychosis, such as depression, anxiety, and negative symptoms.

The words "thoughts" and "beliefs" are typically used interchangeably here and in the *Veteran's Workbook* for simplicity, but in CBT, these are technically two related but different concepts. **Thoughts** (also called "automatic thoughts") refer to how we construe or perceive a specific situation, while **beliefs** refer to ideas we have developed over time about ourselves, other people, and the world. The most central beliefs which we tend to hold rather deeply and consider absolute truths are called **core beliefs** (Beck 2020).

Recruiting Veterans

As explained in the training orientation and workshop, the therapist should select their beginning training cases carefully to help ensure they have a good training experience. The following are characteristics of good CBTp training cases (S. Glynn, personal communication, 2021):

- Veteran is diagnosed with a psychotic disorder.
- Veteran has a track record of regular attendance at the VA.
- Comorbid depression, anxiety, substance abuse (not dependence) are acceptable, including moderate depression with passive suicidal ideation, provided that the Veteran is not so distressed they cannot complete outside assignments.
- Veteran is experiencing distress associated with their psychotic symptoms.
- Veteran is interested in learning new ways of coping/dealing with their distress.
- There are no competing needs which would interfere with attendance at weekly sessions.
- For initial training cases, try not to pick a client with full delusional conviction; even a little doubt is helpful. Can assess with questions like, "How convinced are you that [delusional belief] is really happening, from 0-100%?"
- The therapist's and participant's schedules align so that there are no anticipated scheduling conflicts.
- Previous experience with CBTp is fine if the Veteran is still distressed.
- The therapist can use telehealth or in-person modalities.

- The Veteran can read and write English.

Once you have identified a potential Veteran for the therapy, you may have a phone call or meeting via telehealth or in-person to tell them a little more about the therapy. You can share the *CBT Fact Sheet* that was provided as part of the training and in the Appendix for them to read and learn more about CBT. Be mindful about the Veteran's insight level when describing the therapy. For example, if they have limited insight, it would be best to avoid clinical terms such as "symptoms" and certainly "psychosis" or "delusions."

Recovery Orientation & Context

CBTp should be delivered in a recovery-oriented manner, meaning it should be in the service of supporting the Veteran in living the life they want and as a tool to remove obstacles that are interfering with their vision of that life. Well-delivered CBTp includes various qualities that support its recovery orientation (Brabban et al. 2016; Beck et al. 2020), including:

- A collaborative approach between the therapist and the Veteran
- Giving the Veteran choices and eliciting and responding to their feedback
- Focusing on the Veteran's personal goals
- Recognizing and celebrating their personal strengths and talents
- Framing their difficulties as understandable reactions given their life context
- Helping the Veteran find meaning in their experiences
- Empowering the Veteran to understand and manage challenges

Accordingly, CBTp works quite well when delivered in the context of other recovery-oriented VA services, e.g., as part of programming at a Psychosocial Rehabilitation & Recovery Center (PRRC) or Mental Health Intensive Case Management (MHICM), in conjunction with psychosocial rehabilitation and related services for people with serious mental illness such as Social Skills Training, Wellness Recovery Action Planning, Supported Employment, Supported Education, Illness Management & Recovery, and peer support. An added benefit of delivering CBTp in the context of such services is that the other providers involved in the Veteran's care can help support the work of the therapist and provide additional information about the Veteran that can inform the therapist's assessment, case formulation, and treatment planning. Additional guidance for delivering CBTp in team-based settings that emphasize recovery can be found in Beck et al. 2020.

Course of Therapy

CBT is an open-ended therapy with a flexible number of sessions, but typically in the range of about 16-25 (Lincoln et al. 2016). The therapy outlined in this manual is 16 sessions, designed to be conducted once per week, with the exception of the final session, which is intended as a booster, offered 2-4 weeks after session 15. Depending on the Veteran's needs and your clinic's procedures, you may elect to provide a series of several booster sessions that are sufficiently spaced apart (e.g., by 1-month intervals or intervals starting at 2 weeks and increasing to 1 month).

As noted above, this therapy is designed to be delivered flexibly, so you might decide to spend more than one appointment on a given session in the manual. This is usually indicated if the therapist has to tend to a crisis during a session and needs more time to cover the material, or if the Veteran is struggling to learn or apply the material, due to factors such as cognitive impairment, negative symptoms, or thought disorder.

The therapy is designed in a logical order: a) psychoeducation; b) foundational information and skills pertaining to recovery goal setting, stress management, emotion regulation, and symptom management; c) cognitive restructuring of beliefs associated with voices and paranoia (cognitive module); d) wellness planning/relapse prevention, preparing the Veteran for maintaining their gains, and processing termination. However, you could alter the order depending on each Veteran's needs; e.g., it might make sense to start right with stress reduction (Session 5) or techniques for managing symptoms (Session 7) if the Veteran presents in a very distressed or symptomatic state. Use your clinical judgment about what would be most helpful to the Veteran and most likely to secure their engagement.

Engagement

Securing and maintaining the Veteran's engagement should be a high priority for the CBTp therapist (Beck et al. 2020). Factors including psychotic symptoms, low insight, and negative symptoms can all make engagement challenging. You can use a number of strategies to promote engagement, including:

- Show empathy for the Veteran's experience, no matter how unusual it may seem. This can sometimes be challenging when the Veteran is expressing a bizarre delusion. Ask yourself, "If this were really happening to them, how would I feel?" Imagine their belief were true, but actually affected you rather than the Veteran; how would you feel?
- Engage the Veteran in discussions about shared interests. You might take clues from things they are wearing (e.g., a shirt with a sports team), or if conducting the therapy via telehealth, objects in their home.
- Notice what topics result in the Veteran being at their best; e.g., when their affect brightens, their communication becomes clear, they do not seem as preoccupied with their psychosis. Such topics are often things the Veteran enjoys or is good at. Continue the conversation about these topics.
- Ask the Veteran for advice on something they are good at and that you can use some help with. For example, if you have a dying plant in your office and they are good with plants, how would they recommend you save this plant? If they were a cook in the military, what were some of their favorite recipes that you can try?
- Start the session with an engaging, non-clinical activity, like watching an entertaining YouTube clip or listening to a song.
- Hold the session outside of the office, or have a walking session.

Therapist Style

The therapeutic alliance is an important element of effective therapy, and is particularly important when working with people with psychosis. The following are what we have found to be characteristics of effective CBTp therapists:

- **Empathic, reinforcing, warm**: Show empathy for the Veteran's experience, be warm, kind, personable, and always supportive. Readily praise them for attempts to do the work of therapy (even for just showing up to sessions), for any accomplishments they make, and for their strengths.
- **Motivating and energizing**: It is important to balance being warm, kind, and gentle with being a source of motivation and energy for the Veteran. You should model hope and optimism for their ability to accomplish their goals and encourage them to try new skills and engage in new behaviors.
- **Relatively casual**: Although people vary in what works for them, an overly formal approach to therapy often does not work well with people with serious mental illness; it can be boring, intimidating, and lead to disengagement. A more casual approach tends to be more effective, while of course maintaining professional boundaries and ethics.
- **Collaborative:** You are working together as a team, side by side. You might have expertise in therapy, but the Veteran is an expert on their life and what works and does not work for them. When possible, give them choices.
- **Active:** You will be quite active in this therapy, which includes maintaining structure to the sessions, teaching skills, doing activities with the Veteran, collaborating with their support people, etc.
- **Flexible:** Use the approaches in this manual but do not feel overly beholden to it. Be ready to think outside the box when strategies do not work and mold the interventions so that they work for your Veteran. Don't be afraid to use your creativity and ingenuity.

Basic Structure of CBTp Sessions

The CBTp sessions in this manual all follow the same basic structure, outlined below.

1. **<u>Opening (approx. 5-10 mins)</u>:**

   a. **Agenda & check-in:**

   The therapist briefly outlines the content that he or she suggests to be covered in the session, using the *Veteran's Workbook* as a guide. Outlining the agenda helps the Veteran feel prepared for what will be discussed. Having an agenda and referring back to it can help to organize patients, especially if they tend to get off track due to thought disorder or other challenges. The agenda should be done in a collaborative fashion by asking the Veteran if they agree with your suggestions and what, if anything, they want to add.

   The therapist also asks how the Veteran has been since the last session. At the start of therapy, this can be a general mood check-in ("How have you been feeling since the last session?") As the therapy progresses, you can be more pointed by asking about specific issues addressed in therapy ("How have the voices been since we last met?" "How would you rate the voices/worries since the last session, from 0-10, where 0 means they didn't bother you at all and 10 means they were the worst ever?") The therapist must balance checking-in about the past week with allowing time for new content to be covered. The check-in should not be so open-ended and broad that it derails the session. If the Veteran presents a lot of information during

the check-in, use your clinical judgment to decide how much to go into this material. Of course, risk-related material (e.g., suicidal/homicidal ideation) must always be prioritized and could take over a session. For other pressing problems, it may be possible to collect a brief update, cover the new session content, and then revisit the problem with the new strategies/interventions covered during the session. E.g., "I'm sorry to hear that the voices have been so difficult this week. Today, we'll be talking about some strategies that could help. Would you be willing to talk about those for a bit, and then we can see how to apply them to your voices?"

b. Review of last session: The therapist briefly recaps the content from the last session. Asking the Veteran to recap ("Do you remember what the main points were from the last session?") is an ideal way to recap since it can assess their understanding/memory and encourage them to be more of an active participant in therapy.

c. Review of action plan: The therapist asks about the Veteran's experience with the action plan (homework) from the previous session ("The action plan was to write down your goals and begin to break them down into smaller steps. How did that go?") If the Veteran did not complete the action plan, inquire about the reasons, normalize their difficulties, and help the Veteran problem-solve. E.g., "What got in the way of practicing the stress reduction techniques?" "A lot of people have a hard time remembering to practice at first…do you have any ideas for ways to help you remember for next time?" Provide suggestions as needed, depending on the reason for non-completion (e.g., help them put reminders in their phone). Ideally in CBT, if a patient has not completed the homework, the therapist helps them to complete it in the session before moving on to new material. This helps relay the importance of homework completion and helps correct obstacles that are getting in the way.

2. <u>New material (approx. 30-35 mins)</u>: This is the main part of the session, when new material is discussed, using the *Veteran's Workbook* as a guide.

3. <u>Closing (approx. 10 mins)</u>:

a. **Take home points:** A brief review of the session always occurs at the end. When possible, it is best to ask the Veteran to provide the review ("What were the take-home points from today?" "What did you learn today?") However, you may have to provide the review for the Veteran in early sessions or when challenges such as cognitive impairment or negative symptoms are present.

b. **Action plan:** This is usually called "homework" in CBT but in this therapy, it's called an "Action Plan" since the word "homework" can be off-putting and trigger negative associations from school for some patients. "At home practice" is another useful term; any term that the Veteran prefers can be used. Ideal Action Plan items are those that the Veteran is willing and able to do well and that will help them translate session content into positive life changes. Each session in the manual has suggested Action Plan activities, but you should treat these as only as suggestions; the process should be collaborative. Ask the Veteran what they think of these

suggestions and if they have alternative ideas. Homework adherence can be a challenge when working with patients with serious mental illness. Below are some strategies you can use to facilitate adherence:

- Ask the Veteran how likely they are to complete the Action Plan, from 0-100%. If they report anything under 80% (or another agreed-upon number), work with them to revise the assignment so that its more feasible, or help them plan ahead to manage any obstacles they anticipate.
- If forgetting is an issue, help the Veteran devise a reminder system, e.g., programming a phone alarm, using sticky notes.
- If the Veteran has consented for their family or loved ones to be involved, explore recruiting their help in supporting the Veteran's Action Plan completion (e.g., reminding them, providing transportation).
- If other providers are involved in the Veteran's care, enlist their help as well.
- Reinforce completion of assignments by praising Veteran and asking what strategies they used to help them do the work.

c. **Feedback:** The therapist closes the session by briefly asking the Veteran for their feedback about the session. "How did you feel about our session today?" "Is there anything you wish we did differently today?" "I want to make sure these sessions are as helpful as possible for you, so I would love to hear both what you like and what you don't like about them."

Involving Natural Supports

It can be very helpful to involve supportive others, like family members, friends, partners, or other loved ones in the therapy. This should only be done with the Veteran's consent, and if they are able to identify appropriate people who are supportive and willing to be involved. This involvement can take various forms, such as:

- An early meeting to ask the support person's feedback and impressions about the Veteran's presenting problems, strengths, and any other relevant information, to inform your assessment and case formulation.
- Providing psychoeducation to the support person so that they can better understand the Veteran's experience and more effectively support them.
- Assistance from the support person in getting the Veteran to therapy sessions reliably.
- Eliciting the support person's help of the Veteran in completing therapy assignments and working on recovery goal steps.
- Sharing the Veteran's Recovery Plan, Wellness Plan, Coping Ahead Plan, and any other relevant material that they generate during the course of therapy so that they can better support the Veteran.
- Inviting the support person to a session at the end of therapy so they can share what growth they have seen in the Veteran and learn about how they can continue to support them after therapy is done.

Assessment & Case Formulation

The training workshop included guidance on assessment and case formulation. The following is intended as a brief summary.

Assessment Measures

A wide variety of assessment measures can be used to track Veterans' progress in CBTp. We recommend at least the following two measures, which are both self-report, brief, and can be accessed in Mental Health Assistant:

- The **Behavior and Symptom Identification Scale 24 (BASIS-24**; Cameron et al. 2007): A 24-item patient self-report questionnaire designed to measure symptoms and functional difficulties in the past week in individuals seeking mental health services. Each item is scored from 0-4, with 0 being less frequent symptoms or difficulty and 4 being more frequent symptoms or difficulty. An overall score as well as scores for 6 subscales are generated:
    - Depression and Functioning: Daily/role functioning and depression and anxiety symptoms
    - Interpersonal Relationships: Patient's perception of the quality of their relationships
    - Psychosis (items 14-17): 4 symptoms, including grandiose delusions (item 14), auditory and visual hallucinations (item 15), and paranoia (items 16-17)
    - Substance Abuse: Urges to drink or use drugs and problems stemming from use
    - Emotional Lability: Mood swings, racing thoughts, and feeling short-tempered
    - Self-Harm: Suicidal ideation
- The **Illness Management and Recovery Scale – Consumer version** (**IMRS** in Mental Health Assistant; Gingerich & Mueser, 2005): A 15–item patient self-report questionnaire measuring illness self-management and pursuit of recovery goals. Items are rated on a 1-5 scale, with higher scores indicating higher functioning. Many of the items refer to the period of the past 3 months.

Timing and Administration of Measures

The measures can be administered in Mental Health Assistant for ease of use and to facilitate tracking and chart documentation. If you do not have time to administer the entire BASIS-24 or doing so would be contraindicated (e.g., it would disengage the Veteran), you can administer the 4 psychosis items only, which are found in Mental Health Assistant as **BASIS-4**.

The measures should be administered at the beginning of therapy to establish a baseline, and then at regular intervals throughout to track change. Use your clinical judgment about what frequency is feasible for your Veteran, but once per month (about every 4 sessions) is a good rule of thumb. At minimum, there should be one mid-point assessment around session 8. Administer the measures one more time at the end of therapy.

Present the rationale for the measures to the Veteran to ensure their buy-in, as illustrated below.

Sample therapist language:

"We will be working together to help you solve problems you're facing, feel better, and meet your goals. We have found that it's very helpful to collect some measures along the way to track our work. Just like when you start a fitness routine at the gym, you might weigh yourself or measure your heart rate and the size of your muscles over time to track your progress, I recommend we do the same here. We use two questionnaires—one measures difficulties and symptoms like depression, anxiety, and voices, and the other measures how you're doing with your day to day life and your goals. I would like it for you to complete these at the beginning, along the way, and at the end of therapy. This way we can see if the therapy is working well and feel good about that, or if it's not, we will know that we have to adjust something to make it better. How does that sound?"

Score Interpretation and Measurement-Based Care Discussions

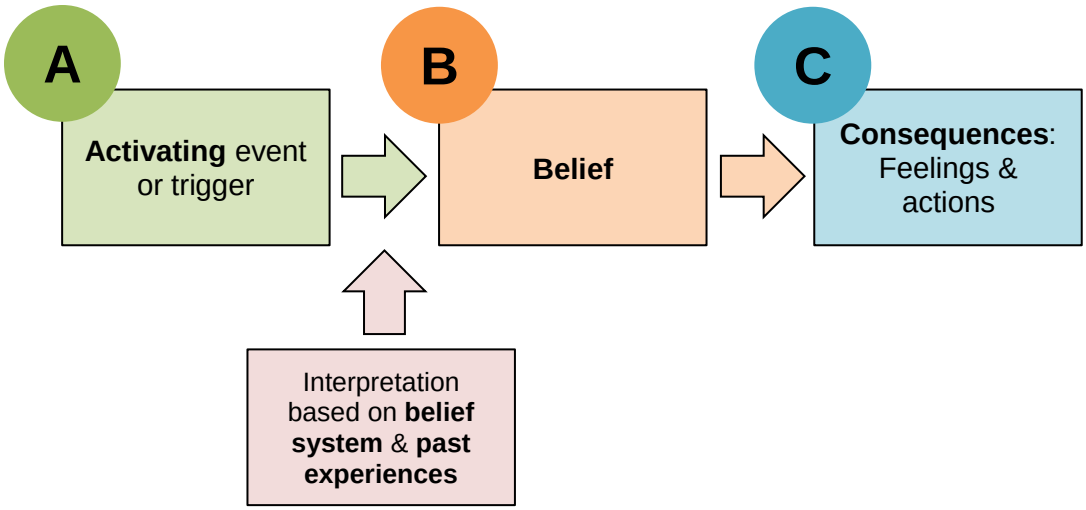
Ideally, you will share the results of each assessment with your Veteran, in a measurement-care (MBC) discussion. The VA has published a wealth of resources and education to guide clinicians in having MBC discussions, which can be found at the VA Mental Health MBC SharePoint, at https://dvagov.sharepoint.com/sites/VACOMentalHealth/MBC. Be mindful and sensitive to Veterans' insight levels when sharing results. For example, avoid using potentially disengaging clinical terms like "symptoms" or "psychosis" in patients who have no or limited insight and would find these terms offensive.

In the Appendix you will find more details about interpreting measures and two score tracking forms, one for your own use and two (one each for the BASIS-24 and IMRS) that can be shared with Veterans. Or you can use the Mental Health Assistant's tracking feature or a spreadsheet you keep on your computer to examine the Veteran's score history. Note the following when interpreting measure scores:

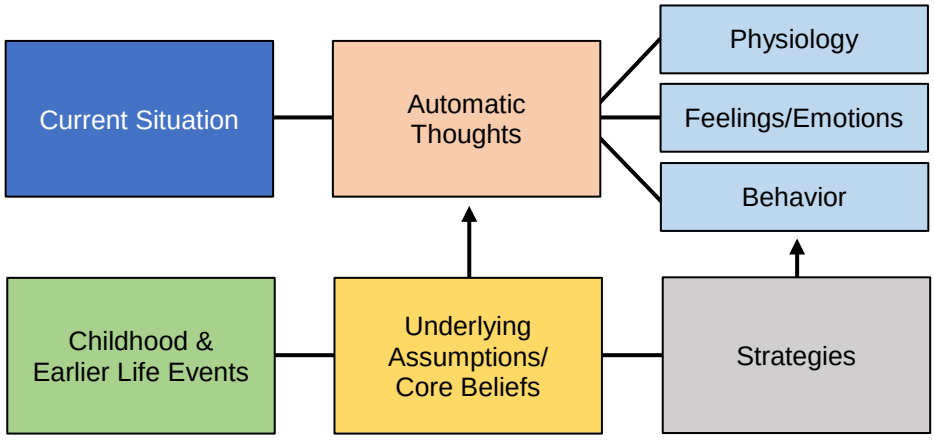
- BASIS-24:
  - Higher scores mean more frequent symptoms or difficulty, so *lower is better*.
  - See the Appendix for reference scores and normative data against which you can compare your Veteran's scores.
- IMRS:
  - Total score ranges from 15-75, or 14-70 if the Veteran does not take medications and therefore skips that item.
  - Higher scores mean higher functioning, so *higher is better*.
  - See the Appendix for reference scores against which you can compare your Veteran's scores.

Case Formulation

The main cognitive model used in this manual to explain the maintenance of distressing emotions and maladaptive behaviors that interfere with recovery is the **ABC model**, which is introduced in session 1 and further elaborated in sessions 8 and 9. You will teach the Veteran about this model and use it as a reference point from which to understand the experiences they share with you:



As you learn more about the Veteran through assessment, their presentation in sessions, and information collected from other providers and the Veteran's support people, you will assemble that information into a **historical case formulation** such as the following (from Peters & Kuipers, PICuP Clinic, Maudsley Hospital, London UK):



Blank formulation worksheets for both formulations, as well as another one specifically for voices are in the Appendix. At times during the therapy, you will need to share your formulation (or elements of it) with the Veteran to help them gain a better understanding of their psychosis and to ensure that your formulation is on track. Follow these guidelines when having formulation discussions with the Veteran:

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

Session 1: Introduction to CBT

Objectives

The primary goal of this session is to orient the Veteran to CBT, so they understand what this therapy is about and know what to expect in the sessions. Your stance should be engaging, warm, and gentle, but also upbeat, optimistic, and excited that the Veteran has chosen to engage in therapy. The content in this section does not include the typical treatment initiation procedures, like informed consent, attendance rules, confidentiality and its limits, and anything else required by your clinical setting, so factor time in for these as well. Along with those procedures, you will also:

- Start to get to know each other.
- Explain structure of sessions.
- Process reaction to starting CBT.
- Explain what CBT is and what will happen in sessions.
- Define voices and worries.
- Elicit Veteran's intention for therapy.

Material

1. Agenda:

   Remember to set this collaboratively by asking if the Veteran agrees with your suggested items and if they want to add anything (e.g., perhaps a significant life event occurred that they want to talk about, they may have questions, need help navigating VA healthcare, etc.)

2. Introductions:

   Engagement is paramount at the start of therapy, so it is helpful to have a casual icebreaker. The manual recommends the Veteran share one thing they like about themselves or that other people like about them. You can use this or any icebreaker, and you should share the same about yourself. Other possibilities include talking about common interests or recent events. Ideally topics that are likely to elicit a strong emotional response are avoided at this point; it should ideally be a casual, lighthearted interaction.

3. How was it coming here today?

   - Invite the Veteran to share how they felt about coming to the session. Normalize any possible positive or negative reactions. If the Veteran is presenting for help with voices, talk openly about how for some, those may say things about their choice to come into therapy.
   - It is important to model open, honest communication about psychosis from early in the therapy so the Veteran can hopefully do the same about their experiences.

- Give the Veteran plenty of praise for coming in. Consider directly conveying optimism by saying comments like, "I am really glad you're here…you came to the right place."

4. What is CBT?

   - Briefly explain the basic model of CBT using the prompts in the manual. There is no need to go into extended explanations, because they can be too academic and boring at this early juncture. The Veteran will learn the model with time.
   - Sample therapist language:

     "In CBT we collaboratively identify problems that might be troublesome for you. The Veteran has as much – if not more – decision-making power as the therapist. We look at how we think and our 'thinking habits'; we'll be asking ourselves again and again, 'how do we think about things?' If we have some difficulties, how do we react? What are our behaving habits? Is how we tend to behave realistic and helpful? Are there any other ways of thinking or reacting that could be more helpful? In short, we try new ways of thinking and behaving, and choose ones that work specifically for each of you, because what could work for you might not work for someone else. Questions?"
   - Introduce the ABC model. It is best to use a specific, simple example to illustrate the model; this can be the one in the manual but even better would be another real-life situation that the Veteran is experiencing at the moment, but ideally one that is not too emotionally laden at this point. You may even share one of your own simple and not too private examples to normalize that this model applies to everyone.
   - Sample therapist language:

     "According to CBT, a person's feelings and behaviors in a situation are based on how they make sense of the situation. We call this the ABC model. A is activating event, which is the situation or trigger. B is a belief, or an automatic thought—a quick thought we have in response to the situation. And C is the consequences—the feelings and actions we have based on how we made sense of A. For example…(reviews example in manual)."

     Alternative example: "*Let me give you an example: a girl—let's call her Mary—believes that she is boring and that others don't enjoy being around her; a good-looking guy asks Mary out on a date. What Mary is going to think and what she is going to do? Do you think she's going to go on the date?* (Veteran responds.) *How is Mary going to feel as a result of not going on the date?* (Examples: she's going to feel bad; she might make up an excuse to avoid going on the date.) *Now, what if Mary believes that people like her, and that once people get to know her they're going to like being around her, and then a nice man comes along and asks her out on a date; what is Mary going to do now?"*

5. What will we do in our sessions?

   - Explain the main elements of CBT using the prompts in the manual.
   - Emphasize that CBT involves learning, which means in order to get the most benefit, the Veteran will have to practice skills, techniques, and new ways of thinking between sessions.

- Sample therapist language:

  "So, what will do in these sessions? Sometimes we'll begin with a warm-up exercise, like we did today. Next, we'll briefly review what we learned last time and go over the Action Plan, if there was any. An Action Plan is basically homework from the last session—things you did after the session to practice what we learned. Veterans who review the material after session and do the Action Plan say they benefit a lot from it, so I would very much encourage completing the Action Plan each week. There will also be a lot of exercises to do in your manual, and I strongly encourage you to do them to gain a stronger grip on the material, which can be difficult at times. At the end of each session, we will summarize it with three questions: What were the take-home points from the session, meaning what did you gain from it and want to remember? How was the session for you? And, is there anything that you learned that you could practice during the week, as part of your new Action Plan? How does that sound? Any questions about that?"

6. Voices and worries

   - Here, you will define both concepts, but it can be more engaging to first ask the Veteran how they would define them; Veterans often have intriguing definitions, several of which are listed in the manual as examples.
   - Explain that different people use different words to describe these experiences, and ask the Veteran if they have specific preferences. E.g., a Veteran in a CBTp group once preferred to use the word "spirits" to describe her voices, and became angry when group facilitators would call them "voices." The facilitators apologized and the Veteran agreed with their suggestion to say "voices or spirits" moving forward.
   - Note that this section (and the whole manual) avoids the use of clinical terms like "hallucinations," "psychosis," "delusions," and "paranoia" because these can be loaded and stigmatizing, and can be especially problematic for patients with little to no insight (e.g., those with high-conviction delusions). If the Veteran uses any of these terms, do not take them at face value. Ask them what they mean by the term and how they feel about that term. It could be that they say "delusions" because providers have used that term, but in fact they don't believe they have delusions, and instead may relate to a different word. Agree to use whatever term the Veteran desires to describe their experience.

7. What is my intention for therapy?

   Ask the Veteran what they hope to gain from this therapy. This might be a problem or problems they want to resolve. There are several examples of past Veterans' answers in the manual. They are often readily able to provide an answer, but if they are not sure, assign this as the Action Plan.

8. Take-home points:

   If possible, ask the Veteran to state what they thought the take-home points were from the session, or what they learned from it. But if the Veteran seems to have difficulty or feels pressured, present them yourself. Remember to ask if they have any questions about the session.

9. Action plan & feedback:

   Suggestions include administering self-report measures like the recommended BASIS and IMRS, as described earlier in this manual, and having the Veteran continue to reflect on what their intentions are for therapy and write them in the manual, if they did not finish doing this during the session. End by eliciting feedback for the session.

Troubleshooting

- **Veteran is not fully engaged:** It is not uncommon for the Veteran to be somewhat quiet, shy, or tentative at the beginning of therapy. This can be due to a variety of reasons, e.g., active psychosis, mistrust of the therapist, nerves about meeting someone new, negative symptoms. Do not pressure the Veteran to share more than they are comfortable with. Therapist strategies that can help include: taking a warm, empathetic, and gentle approach; engaging the Veteran in light-hearted conversation about non-clinical topics of interest; and providing ample praise for any participation, or just for coming to the session.

- **Veteran is ambivalent about therapy:** Veterans' motivation for therapy may vary. It is not uncommon to find that they express ambivalence about treatment. Having a conversation about their life aspirations, recovery goals, or more simply, what they may want to change in their life, could be helpful here. This topic will be covered in greater detail in session 4, but you may choose to cover it sooner if indicated. Ask the Veteran what is getting in the way of their aspirations and explain how therapy can help. Instill hope and let them know that this kind of therapy has helped other Veterans with similar challenges. You might suggest that they commit to three sessions as a "trial" of the therapy and hold off on making a decision about whether or not to continue until after that.

Session 2: A Closer Look at Voices and Worries

Objectives

In this session, you will:

- Provide psychoeducation about voices and worries.
- Encourage Veteran to share about their personal experience with these symptoms.
- Give them an overview of what the therapy will look like and instill hope and enthusiasm that it be a positive and helpful experience for them.

Material

1. Agenda & check-in:

   Since it is early in the course of therapy, during the check-in, you may ask about how they felt after the first session and if they have any questions about therapy.

2. Getting to know each other:

   Talk with the Veteran about activities that you both like doing, or any other casual icebreaker topic.

3. Review:

   Briefly review the content of the previous session. A good strategy is to ask the Veteran what they remember from the last session to test their memory and comprehension and prompt engagement. Be prepared to summarize what they do not remember. Ask if they have any questions from the last session.

4. Review of Action Plan:

   - What did the Veteran decide will be their intention for therapy? Reinforce appropriate intentions and provide hope (e.g., “A lot of Veterans have that same intention of not being so controlled by their voices. You’ve come to the right place for that, because we will be talking about lots of methods to better manage voices that have worked for many other Veterans.”)
   - If the Veteran did not complete the Action Plan, ask “What got in the way?” and help them problem-solve accordingly. Ask them what their intention for therapy is, and ask them to write it down in the manual, at the end of Session 1.

5. How do voices and worries affect my life?

   - Explain that for many people, voices and worries have both negative and positive consequences. Ask them for personal examples of both; you can share the examples from the manual. For example, people sometimes say that they have some positive voices, or even negative voices can be helpful because they provide

companionship, warn the person about danger, or keep them structured by telling them to take showers, etc. Veterans also often state that paranoia can be helpful because it helps them avoid dangerous people or situations ("better safe than sorry"), so they don't get hurt (or hurt again).

- Try to also get specific examples of the negative consequences of voices and worries/paranoia for the Veteran as well, and normalize these ("It is very common for people to get so distracted and stressed from their worries that they avoid leaving the house and doing the things they want to do, like going to school, getting a job, and socializing with people. It makes sense, because these experiences can be frightening and stressful.")
- Next, instruct the Veteran to draw what their experience with voices and/or worries is like. This exercise is useful for Veterans who struggle to put their experiences into words and can often result in quite powerful images. Explain to the Veteran that there are no rules for this exercise; they can draw or write anything that comes to mind to describe their experiences. Usually about 5 minutes is enough for this exercise. After they are done, ask them to explain their drawing. Show curiosity and interest, and ask questions. Reinforce them for sharing such a private experience.

6. <u>What will I learn to manage my voices and worries</u>?
   - Explain that the therapy is divided into five sections, and then explain each one using the table in the manual. For each one, try to engage the Veteran by asking if they can relate to the relevant issues; e.g., for the Refocusing section, you may ask, "Do you ever find that when your voices or worries come up, you have a hard time thinking about anything else? This is a common reaction, and we will talk about techniques to shift your attention away from them, so you can feel better and focus your attention on what's really important to you."

7. <u>Take-home points</u>:

   Ask the Veteran what they learned from the session, or what they want to take from it.

8. <u>Action plan & feedback</u>:
   - The recommended Action Plan is for the Veteran to write down 3 ways their life might be better if they learn to reduce voices/worries (e.g., less stress/anxiety, better able to accomplish their goals) and 3 things that might make it hard to reduce them (e.g., coming to sessions regularly, fear/anxiety). As usual, this is only a suggestion; the assignment can be anything that you and the Veteran together decide is most helpful.
   - As always, remember to also ask how likely the Veteran is to complete the Action Plan, if they anticipate any problems with doing so, and if so, help them work around those problems (e.g., if they might forget, suggest putting a reminder in their phone or using a sticky note).

Troubleshooting

- **Veteran reports positive experiences of psychosis:** It is not uncommon for Veterans to report positive aspects to their psychosis. This appears to be most common regarding their voices; e.g., they may report having positive voices or voices that say both positive and negative comments. They may even worry that you are trying to "take away" these helpful voices. If this occurs, you can normalize that many people have mixed experiences, that are both positive and negative, and reassure the Veteran that this therapy is only aimed at helping people manage the negative aspects.

- **Veteran has difficulty describing their psychosis:** Proper screening should help ensure that Veterans who start the therapy are able to talk about their experiences with psychosis, but sometimes, especially at the beginning of therapy, they may be hesitant to do so. These are very private experiences and it can be difficult to share. Cognitive impairments and thought disorder may also interfere. Be patient and do not push too hard. You may take pressure off by asking questions like, "Many of the Veterans I've worked with have told me that worries make them anxious or depressed and prevent them from living the life they want; can you relate to that too?" You can also remind them that in order to get the most from the therapy, it will be important that they feel safe to talk about their experiences. Possible statements include: "I know this can be difficult stuff to talk about. I really commend your courage for coming here to talk with me." "This will be a safe space where you can share privately about what you're going through." "The more I understand your experience, the more I can possibly help." "Is there anything I can do to make you feel more comfortable sharing?"

Session 3: Managing Voices and Worries

Objectives

The overall goal of this session is to help the Veteran better understand their experience of voices and paranoia, realize they are not alone and that these are understandable experiences, and instill hope that they can learn to manage the experiences and live a good life despite them. Specifically, you will:

- Provide psychoeducation about voices and worries.
- Discuss famous people who have experienced voices/psychosis to help destigmatize the Veteran's experience and convey hope.

Material

1. Agenda & check-in:

   Review the agenda shown in the manual and ask the Veteran if they agree with it or want to add/change anything. Prioritize the agenda items if necessary.

2. Review:

   Briefly recap the main points of the last session, or ask the Veteran to do so.

3. Review of Action Plan:
   - Ask the Veteran if they thought of three ways their life might be better if they learned how to reduce voices/worries and three things that might get in the way of doing so. Reinforce the former and assist them with the latter.
   - If the Veteran did not complete the Action Plan, inquire about the reasons and help them problem-solve. It may help to provide possible options for both items, based on experiences from people who have completed CBTp in the past. Examples of possible benefits may include decreased depression and anxiety and an improved ability to engage in meaningful life goals like school, work, and relationships. Common obstacles include fear, avoidance, and memory/cognitive impairments.

4. What causes or worsens upsetting voices and worries (also known as triggers)?
   - This is a discussion of common triggers of psychosis. The information in this section is intended in part to normalize the experience of psychosis so that the Veteran does not feel as strange or different. To promote engagement, you may open by asking the Veteran what personal triggers they have experienced, and then supplement their answer with the list from the manual.
   - Explain that there are many possible triggers for voices and worries, and that anybody can experience them if certain conditions are present (e.g., sleep deprivation).

- Place special emphasis on the role of stress in experiencing voices and worries, especially when the person has a vulnerability to developing these symptoms. This is known as the **stress vulnerability model**.
- Sample therapist language:

  "We are all vulnerable to developing certain experiences, which could be physical or emotional. When we are under a lot of stress, we could start experiencing things like voices or worries. For example, if we have a genetic predisposition to hearing voices, having worries, or becoming depressed because someone else in our family had these too, environmental factors, such as stress or trauma, could trigger these experiences. Research shows that sensory deprivation, long-term isolation and/or sleep deprivation could lead to hearing voices or seeing things that are not there. Soldiers returning from war, for example, because of PTSD, might begin hearing voices that simply are not there or seeing scary things that do not exist. These people get frightened easily as a result of being exposed to very stressful and frightening things in combat. So even without genetic predispositions, like for soldiers, high stress could trigger these experiences. Having been abused could also contribute to them, as could extended periods of isolation. For example, a sensory deprivation box, a box that seals out sounds and sights, might be relaxing for 15 minutes but after a few hours anyone would start hearing and seeing things. When there are no other stimuli, the brain produces information by itself. Questions?"

5. How can upsetting voices and worries be managed?
   - Here too, it can help to start with an open-ended question about what the Veteran has found helps to reduce or manage their voices and worries, and then reviewing the list in the manual.

6. Famous people who have experienced voices or worries:
   - This section contains stories of six people who have made significant accomplishments despite experiencing psychosis. Many of the people are famous and are likely to be known by Veterans, and all of their stories contain key teaching elements that are consistent with the spirit of this treatment—the people share about strategies they learned to manage their psychosis so they could continue doing what was important to them and what brought them joy and a sense of meaning.
   - You do not necessarily have to review all the stories in the session, and will likely not have the time to. Instead, you can ask the Veteran which of the people they know and review those, or you can select the stories you think would most resonate with your Veteran. You can have the Veteran read the story aloud, read it silently, or you can read it to them, whatever they prefer.
   - After reading a story, ask the Veteran if there was anything that they could relate to in the story, and if there is anything to be learned from it. Key parts that may be emphasized are underlined—e.g., Brian Wilson talks about using love to combat his negative voices, by kissing his wife and kids. Eleanor Longden speaks about learning to see her symptoms were actually "meaningful messages" from her mind connected to past trauma.
   - Encourage the Veteran to read the stories you do not review before the next session.

7. Take-home points:

   Ask the Veteran what they learned from the session, or what they want to take from it.

8. Action plan & feedback:

   - The recommended Action Plan is for the Veteran to finish reading the stories and write down 3 triggers of their voices/worries and 3 strategies, activities, or techniques that help to manage these symptoms. As usual, this is only a suggestion; the assignment can be anything that you and the Veteran together decide is most helpful.

Troubleshooting

- **Veteran reports that problematic behaviors reduce their psychosis.** Sometimes during the portion of the discussion about what helps reduce voices and worries, Veterans will cite avoidance, drinking, or drug use (especially cannabis), or other problematic coping strategies. It is important to not invalidate the Veteran by forcefully condemning the behavior. Instead, ask about how the behavior helps, and reflect that you can understand why they would use that behavior. Then ask if there is anything unhelpful about the behavior (i.e., the pros and cons). Veterans will often readily acknowledge the cons of such coping strategies. You can also explain that certain coping strategies work in the short-term (e.g., alcohol temporarily decreases anxiety) but can cause problems in the long-run (e.g., alcohol is a depressant and can lead to depressed mood and other difficulties in daily living). Explain that in this therapy, you will cover a lot of potentially new strategies that we have found to be helpful in both the short- *and* long-term.

  Cannabis use can be especially challenging to address since there is enormous variability in the types and potencies of cannabis available. There is some evidence that one component in cannabis, CBD, can have antipsychotic and anxiolytic effects, but the component that provides psychoactive effects, THC, has the opposite effects. Providing psychoeducation such as this in a non-judgmental manner can be helpful in addressing problematic coping strategies.

- **Veteran does not agree that their experience is due to mental illness.** Several of the first-person accounts cite schizophrenia and other serious mental illnesses. If you are working with a Veteran with little insight, you may find that they react negatively to these stories because they do not see their experience as coming from mental illness. Be careful to not try to force insight, since this could lead to disengagement. Instead, you may remind them that voices and worries can stem from a variety of experiences, as described in this session, not all of which are mental illness (e.g., sleep deprivation), and that a proportion of the population that is not diagnosed with a mental illness also has these experiences.

Session 4: The Healing Power of Goals

Objectives

The overall goal of this session is to instill the idea that working toward one's life aspirations and goals helps to counteract voices and worries, and can be therapeutic. Specifically, you will:

- Provide psychoeducation about goal-setting, particularly how it relates to psychosis.
- Help the Veteran complete a simple Recovery Plan, where they break down 1 long-term goal into 2 short-term goals and accompanying steps.

Material

1. Agenda & check-in:

   Review the agenda shown in the manual and ask the Veteran if they agree with it or want to add/change anything. Prioritize the agenda items if necessary.

2. Review:

   Briefly recap the main points of the last session, or ask the Veteran to do so.

3. Review of Action Plan:
   - Ask the Veteran if they read the rest of the first-person accounts, and what they thought of them. Could they relate to anything? What did they learn from them that they may incorporate into their own life?
   - Did the Veteran identify 3 things that trigger/worsen and help their voices and worries?
   - If the Veteran did not complete the Action Plan, inquire about the reasons and help them problem-solve.

4. Setting goals:
   - Explain the rationale for setting and working toward recovery goals.
   - Sample therapist language:

     "Today we will be talking about goals. When we say 'goals,' we mean living your life you want, in a way that gives you meaning, purpose, and connection. Goals can be things like having a friend or romantic partner, going to school, or working. What are some of the things you want in your life?" (Veteran answers; therapist reinforces any goals Veteran provides.) *"It's very common when people experience voices and worries for them to have a hard time working toward their goals. Many people think, 'The voices and worries have to go away before I work on my goals.' That is understandable, because these experiences can be difficult and stressful! Have you ever felt that way?* (Veteran answers; therapist reflects.) *But what we have found is*

that actually, working toward goals <u>despite</u> voices and worries can actually help reduce them and make them bother us less. Why might that be? (Veteran answers; therapist reinforces correct responses.) *Working toward goals that are important to you can help reduce voices and worries because the more time and energy you devote to the goals, the less you will be have for the voices and worries. Also, the sense of achievement and happiness that comes from working toward goals neutralizes the negative effect of voices and worries! For example, if you're having fun with a friend, you might be too busy and distracted to notice the voices, or the good feelings of spending time with your friend make the voices less bothersome."*

- Explain the concept of SMART goals using the material in the manual. It may help to give examples to illustrate the five SMART characteristics. For example, "Lose weight" (not specific, measurable, or time-bound) vs "lose 5 pounds within the next 2 months." When describing "Relevant," note that the Veteran's goals should be whatever they want for themselves, not necessarily what others (including their providers) may want for them.

5. <u>Exercise: Design a Recovery Plan:</u>
   - In this exercise, you will assist the Veteran in identifying a long-term goal and then breaking it down to 1 or 2 short-term goals, and then up to 3 steps for each. The short-term goals and steps should ideally follow the SMART model. If you are working with a Veteran in a PRRC, they may already have a Recovery Plan that you can reference here. The number of goals is kept intentionally small so the Veteran can focus their efforts on them and start to have a successful experience working toward these goals during therapy. Less is more here; no goal is too small.
   - Use your clinical judgment in deciding which goals to focus on. All of the goals do not necessarily have to be achieved within the course of therapy, but there should at least be several steps that can be accomplished during the course of therapy.
   - Below is a sample completed Recovery Plan.

My Recovery Plan		
Long-Term Goal: *Think about an exciting big picture goal you have.* Get a job that I like.		
Now break that goal down into up to 1-2 SMART **short-term goals** and small **steps** that you can take every day or every week toward those short-term goals.		
Short-Term Goal 1:	Figure out what kind of job I want.	**Target dates:** 12/1/21
Step a:	Make an appointment with a vocational rehabilitation counselor at the VA.	9/1/21
Step b:	Meet with the counselor and ask for help.	10/1/21
Step c:	Look at jobs on Craigslist twice per week.	Every week

Short-Term Goal 2:	Apply to at least 3 jobs.	**Target dates:** 3/1/22
Step a:	Write down my past work experience, with dates.	10/1/21
Step b:	Make a resume with the help of my voc rehab counselor.	11/1/22
Step c:	Select at least 3 jobs I want to apply for.	2/1/22

6. Take-home points:

   Ask the Veteran what they learned from the session, or what they want to take from it.

7. Action plan & feedback:

   - The recommended Action Plan is for the Veteran to identify one small step toward their goals that they will commit to working on in the coming week. You may ask the Veteran additionally to note any changes to their voices or worries as they work on this step. Working on goal steps should be a standing assignment for the rest of the treatment. As usual, this is only a suggestion; the assignment can be anything that you and the Veteran together decide is most helpful.

Troubleshooting

- **Eliciting a goal is difficult.** The Veteran may have difficulty identifying a goal for their Recovery Plan. This can be especially likely for those with negative symptoms and functional impairment. Sometimes the word "goal" itself can be triggering, because the Veteran may feel undue pressure from it. A few strategies can be helpful here:
  - One is to avoid the word "goals" and simply ask, "What would you like to be different in your life? Are there things you would like to have or be doing differently?" You can also substitute other similar or related words, like "aspirations" or "values."
  - If the Veteran is having difficulty identifying goals because of their symptoms, you may ask, "If we had a magic wand and all of this (voices, worries, other symptoms) went away tomorrow, what would your life look like? What would you be doing differently?"
  - You might also ask about past hopes and dreams they had, before their symptoms started.

- **Veteran provides an unrealistic goal.** Occasionally patients may provide unrealistic goals or goals based on a delusion, e.g., becoming a famous millionaire, saving the world as the Messiah. We of course would not want to collude with such goals, but at the same time, we must try to not invalidate them. You may ask, "What would be good about that?" to get a sense as to what function the goal serves, and then craft more realistic and adaptive goals that would serve this function. For example, being the Messiah might

be good because you can help many people. In this case, you might say, “So helping people and being respected are important to you, that is great. What are some small, practical ways you can start helping people right now?”

Session 5: Stress Reduction and Relaxation

Objectives

The overall goal of this session is to explain the relationship between stress and psychosis and teach the Veteran techniques to manage their stress and negative emotions. Specifically, you will:

- Provide psychoeducation about the bi-directional relationship between voices/worries and stress.
- Introduce several strategies that are aimed at reducing stress, decreasing negative emotion, and increasing positive emotion, and engage the Veteran in experiential practice of at least one of these so that they experience the benefits firsthand.

Material

1. Agenda & check-in:

   Review the agenda shown in the manual and ask the Veteran if they agree with it or want to add/change anything. Prioritize the agenda items if necessary.

2. Review:

   Briefly recap the main points of the last session, or ask the Veteran to do so.

3. Review of Action Plan:

   - Ask the Veteran about their progress working on a goal step. If they completed it, enthusiastically reinforce them and ask if they noticed any changes in their voices or worries during or after completing the goal step. Ask questions to draw out positive beliefs, such as, *"That is terrific that you went grocery shopping despite hearing voices! What does it mean about you that you were able to do that?"* (You may add, *"Could it mean that you have some control over the voices/you don't have to let the voices stop you from doing what's important to you?")*
   - If the Veteran did not complete the Action Plan, inquire about the reasons and troubleshoot. It could be that their goal step was too ambitious, they need a system to remind themselves about the homework, or negative beliefs got in the way.

4. Relationship between stress and voices and worries:

   - Explain the bi-directional relationship between stress and voices/worries; i.e., that the symptoms can cause stress, and stress can cause/worsen the symptoms. Ask the Veteran if they can relate to this cycle; i.e., do their voices/worries cause stress? Can they think of times when they were stressed and the voices/worries got worse?

5. How do you relax?

   - Ask the Veteran what they currently do to manage their stress, and reinforce positive behaviors.

6. Some other stress reduction techniques to try:

   - Explain that you would like to tell the Veteran about 4 techniques that have been shown to be effective in reducing stress and negative emotions, and increasing positive emotions, based on past Veterans' reports and research.
   - Briefly describe the 4 techniques and ask the Veteran which ones sound most appealing, so that you can practice them together during the session. You might also recommend (or avoid) specific techniques based on your clinical judgment of what might be best for the Veteran. We recommend always teaching Soothing Rhythm Breathing, as this is a simple yet effective emotion regulation technique, and then adding at least one more during this session. The table below summarizes each of their techniques and their indications, based on our experience.

Technique	**Clinical Indication**
Soothing Rhythm Breathing	▪ All-purpose, simple emotion regulation technique ▪ Limited attention span
Progressive Muscle Relaxation	▪ Physical tension ▪ Insomnia ▪ Limited attention span
Loving Kindness Meditation	▪ Negative affect ▪ Critical voices ▪ Negative symptoms ▪ Good imagination ability
Self-Compassion Break	▪ Negative affect ▪ Self-criticism/low self-esteem ▪ Critical voices

7. Exercise: Practice stress reduction techniques:

   - Before practicing the technique(s), ask the Veteran to rate their current stress level using the chart in the manual. This will serve as a baseline against which to compare their stress level after the practice.
   - Using the instructions in the manual, guide the Veteran through the selected exercises. Each one should take up to approximately 5 minutes.
   - After the exercises, ask the Veteran to re-rate their stress level. Compare this to their baseline stress and celebrate any reductions. Also process their reaction to the technique, both positive and negative. Reinforce any positive experiences and troubleshoot any negative ones (see Troubleshooting section below).
   - Sample therapist language:

     "Wow, that is great! Your stress level went down from a 7 to a 4; that's a 30% reduction. That's impressive, because this is the first time you've tried this technique.

What did you think of it?" (Veteran replies; therapist reinforces any positive effects and adds any observations, if applicable, e.g., *"You seem more relaxed to me too; your face looks more relaxed and your voice slowed down a little bit.") "Was there anything difficult about it?"* (Veteran replies and therapist helps troubleshoot.) *"Does this seem like a technique that could be helpful to you? Would you be willing to practice it at home?"*

8. Other stress reduction and relaxation techniques:
    - Ask the Veteran to mark which stress reduction and relaxation techniques they already use from the table in the manual, and reinforce that. Ask them also to mark the ones they would be willing to try.

9. Take-home points:

    Ask the Veteran what they learned from the session, or what they want to take from it.

10. Action plan & feedback:
    - In addition to continuing to work on goal steps, the recommended Action Plan is for the Veteran to practice stress reduction techniques every day, and note any change on their voices and worries using the chart in the manual. Instruct them to begin by practicing any new techniques during times that they are *not* very stressed, so they can get the hang of the technique, before starting to apply it during times of stress. Advise them to use stress reduction techniques as needed for the rest of the therapy and into their life after the treatment ends.
    - Recommend strategies to maximize their likelihood of practicing the techniques. These may include ritualizing the practice by doing it at the same time every day, e.g., upon waking up and at bedtime or in the shower, and using external aids like YouTube videos or smartphone apps (there is a link to the VA app store, which contains many excellent and free mental health apps, in their manual).
    - As usual, these are only suggestions; the assignment can be anything that you and the Veteran together decide is most helpful.

After this session is completed, you can always revisit it as needed. For example, if a Veteran comes to session in a highly distressed state, you can spend a few minutes practicing one of the techniques from this session to help regulate them. This serves two purposes of giving the Veteran more practice with the technique and helping the session to be more productive, since it is difficult to learn or think flexibly when we are highly emotional.

Troubleshooting

- **Veteran did not benefit from, or had a negative reaction to, a technique.** The stress reduction/emotion regulation techniques included in the manual were selected because of past success with Veterans in this treatment, and research findings, but not all of them work for all people. Sometimes Veterans will appear to not benefit from, or less commonly, have a negative reaction to a technique. When this happens, try not to rule out use of the technique right away. Inquire about what exactly happened and see if

additional training helps. Commonly encountered issues and possible solutions are listed below:

- If they had trouble concentrating during the practice or became distracted by voices, you might recommend shortening the exercise and/or selecting one that requires less cognitive effort; Progressive Muscle Relaxation tends to work quite well in these situations, whereas Loving Kindness Meditation and Self-Compassion break tend to require more cognitive effort.
- If they could not think of someone who made them happy in the Loving Kindness Meditation, let them know that this is not uncommon, and remind them that it can be a person, pet, deity, celebrity they haven't met etc., and help them find someone. If the exercise triggers significant negative emotions, process them and shift to other techniques instead.
- If they had difficulty sending compassion to themselves in the Self-Compassion break, normalize that this is common at first. They can begin by just acting it out, and it should improve with continued practice.
- If voices or paranoia interfered with the practice, normalize this and let them know that this may happen sometimes, but typically as people get better at practicing the technique, it happens less. It may be helpful to shorten the practice or select one that is simpler and less internally-focused, like Progressive Muscle Relaxation.

Session 6: Social Activities & Support

Objectives

The overall goal of this session is to explain the relationship between socializing and psychosis and encourage the Veteran to increase their socialization, in part as a means of managing their psychosis. Specifically, you will:

- Provide psychoeducation about the bi-directional relationship between voices/worries and social isolation.
- Help the Veteran generate ideas and plans for increasing their social activities.

Material

1. Agenda & check-in:

   Review the agenda shown in the manual and ask the Veteran if they agree with it or want to add/change anything. Prioritize the agenda items if necessary.

2. Review:

   Briefly recap the main points of the last session, or ask the Veteran to do so.

3. Review of Action Plan:
   - Ask the Veteran about their practice of stress reduction techniques. Enthusiastically reinforce any practice they did and ask about any impact they noticed on their voices and worries.
   - Ask if they experienced any problems, and if so, normalize and help them problem-solve. The most common problems tend to be forgetting to practice (help the Veteran devise a reminder system), and quickly giving up on a technique after doing it only once or twice because it didn't seem like it was working (explain that like any new skill, these take practice and often get more effective over time, but if a technique is truly not helping, they can switch to a different one).
   - If the Veteran did not complete the Action Plan at all, inquire about the reasons and help them problem-solve. Consider spending a few minutes starting this session with practice of one stress reduction technique they selected.

4. Reducing voices and worries by socializing:
   - Ask the Veteran to think of as many cons (first) and pros (second) to socializing, using the table in the manual.
   - Reinforce them for good answers and then supplement their responses with the benefits listed after the table.

- Explain the bi-directional relationship between voices/worries and social isolation; i.e., that when people experience voices/worries, they commonly will avoid other people (because they feel unsafe around them, the voices tell them to, etc.), and although this may reduce stress in the short-run, eventually if the person remains socially isolated, often the voices/worries worsen. Ask the Veteran if they can relate to any part of this cycle; you may ask for them to give specific examples.
- Explain that everyone is different in their need for socialization, with introverted people needing less than extroverted people. So, we use the term "social activities" quite broadly.
- Explain the rationale for why social activities can actually help with voices/worries, using the material in their manual. Ask if the Veteran can think of any additional reasons why socializing can be helpful against voices and worries.

5. Ideas for increasing socializing and social support:
   - Ask the Veteran to think of one or more people who they can spend time with, e.g., do recreational activities together. Have them write these people down in their manual. Be sure to select only people who the Veteran believes are positive, supportive, and would be willing to spend time with them. These do not necessarily have to be people the Veteran can turn to for support or help.
   - Help the Veteran complete the remaining sections, including noting social activities they are doing, find helpful, or would be willing to try in the coming week. You will notice that the Social Activities table lists activities ranging from low social intensity (e.g., connect with people on Facebook) to high (e.g., go to a party).
   - Ask the Veteran to think of and write down people in their life they can turn to for support, again, ensuring that these are positive sources of support.
   - Review the list of support organizations, focusing on the ones you would most recommend for your Veteran, and adding additional local resources.

6. Take-home points:

   Ask the Veteran what they learned from the session, or what they want to take from it.

7. Action plan & feedback:
   - The recommended Action Plan is for the Veteran to work on at least one goal step, continue using stress reduction techniques as needed, and do at least one social activity in the coming week, using the Social Activity Questionnaire at the end of the session to plan it and document the outcome. Work with the Veteran to select one achievable social activity, and have them rate their prediction of how much they think they will enjoy it and how well they think it will go. They will then re-rate these items right after the activity, and note if they noticed any changes in their voices/worries. The rationale for this assignment is that patients will often underestimate the pleasure to be derived from social situations and how well they are likely to go. The exercise serves as a test of these beliefs. Remember that they should also be working on goal steps every week. As usual, this is only a suggestion; the assignment can be anything that you and the Veteran together decide is most helpful.

Troubleshooting

- **Veteran expresses strong negative views about socializing.** It is fairly common for Veterans in this treatment, especially those with paranoia, to express strong negative beliefs about socializing. They may state that people are not to be trusted, and it is safer to be alone, particularly if they have a history of trauma. They may also report that their voices or paranoia worsen when around other people. If this occurs, normalize these beliefs as understandable reactions the Veteran's life experiences; you may frame this in a conversation about their case formulation. Ask them about any current or past social connection they have had, no matter how small, and if there was anything positive about that connection. Are there friends or family members they have lost touch with but would like to be closer? Veterans will sometimes mistakenly think the therapist is trying to push them to be hypersocial. Explain this is not the case, and that each person has to find the right level of social involvement for them. See if they would be willing to test out their beliefs by trying a low social intensity activity, like just sitting at the park or a café, being around people without interacting. Veterans will often feel safer around other Veterans, so you also suggest social opportunities for Veterans, e.g., support/therapy groups, peer support, or local organizations for Veterans. If possible and indicated, involve natural supports, such as friends or family members. These supports can help you and the Veteran problem-solve around socializing and support the Veteran in doing more of it (e.g., a Veteran and their spouse agreeing to doing at least one fun thing together in the coming week).

Session 7: Taking Power Away from Voices & Worries

Objectives

The overall goal of this session is to teach the Veteran that they can redirect their attention away from voices and worries as a means of better managing, and getting their power back from, these experiences. Specifically, you will:

- Provide psychoeducation about the different ways of relating to psychotic experiences, ranging from ignoring them to overly focusing on them.
- Educate the Veteran about various refocusing strategies and motivate them to try these on their own between sessions.

Material

1. Agenda & check-in:

   Review the agenda shown in the manual and ask the Veteran if they agree with it or want to add/change anything. Prioritize the agenda items if necessary.

2. Review:

   Briefly recap the main points of the last session, or ask the Veteran to do so.

3. Review of Action Plan:

   - Ask the Veteran about their experience completing the Action Plan, which was to engage in a social activity. How did their ratings of how much they enjoyed the activity and how well it went compare to what they had predicted? If the ratings were higher than they predicted, ask questions to draw out positive belief change, e.g., "*It looks like it went better than you thought it would and you enjoyed it more than you thought you would. What do you think that means?...Is there something we can learn from this?...Maybe doing social things is better than you think it will be?"*
   - Ask about any changes they noticed on their voices and worries during and right after the social activity, and ask similar questions to draw out belief change. Veterans often state that their voices or worries reduced during positive social activities or at least did not bother them as much, or that the mood lift they experienced from the social activity helped to reduce the negative impact of their symptoms afterward.
   - If the Veteran reports that the social activity went poorly, carefully review it to make sure that this is accurate vs. a misinterpretation due to negative beliefs or psychosis. If it did go poorly, help them process their reaction and see if the activity can be retooled and tried again, or if a different one would be more appropriate.
   - Remember to ask about and reinforce any progress they have had on using stress reduction techniques and working toward goal steps.
   - If the Veteran did not complete the Action Plan, inquire about the reasons and help them problem-solve. Common reasons include forgetting to do it, the social activity

chosen was too ambitious, and interference from negative beliefs and/or psychotic symptoms. You may find that they need a booster from the previous session on stress reduction strategies to be better prepared for social activities.

4. Attention to voices and worries:

   - Provide psychoeducation about the different kinds of responding to psychotic experiences, as outlined in the manual. These range from ignoring (or actively suppressing) the voices/paranoid thoughts on one end of the spectrum to overly fixating on them on the other. Ask the Veteran if they can relate to these different ways of responding, and what the outcome tends to be in each case. Typically, responding in the two extremes is tied to more distress and poorer outcomes. The main point to convey is that we have a choice in how we respond to these experiences, and that the most optimal method is typically in the middle—noticing the voice/worry/paranoia and then making a conscious decision to direct one's attention to what is most helpful to their wellbeing (e.g., to their values, aspirations, and goals).
   - Sample therapist language:

     "For example, a lot of times when people hear upsetting voices, their natural reaction will be to really focus on the voice. They might spend a lot of time and energy trying to make out what the voice is saying, listening for the next voice, or even fighting it by talking back to it or yelling at it. Often what happens next is that this makes them feel more stressed out and the voice gets worse. Then the person focuses on it more and feels even worse. They might stop going out, stop talking to people, and stop working toward what's important to them, and their goals. They lose their power to the voices. It's sort of like being pulled into quicksand. Can you relate to this at all?" (Veteran replies; therapist reflects and reinforces response.) *"Yes, this is a very common and understandable reaction, especially when faced with something scary! The good news though is that we have the ability to channel our focus and our energy to other things—more positive things that are helpful to us—so we can feel better and stay on track with what we want our life to be about. It's the difference between reacting vs. responding. Today we're going to talk about some strategies for doing this, to help you take your power back from the voices. We call these* ***refocusing techniques****."*

5. Refocusing techniques:

   - Ask the Veteran what activities or techniques they already use to refocus their energy and attention from psychotic symptoms, and strongly reinforce these. Have them mark any applicable techniques from the table, and mark any that they would be willing to try. Explain that typically, good refocusing techniques are things that take some degree of mental effort, which can help distract our mind. With voices in particular, many patients have found that using their voice (e.g., reading aloud or under one's breath, singing, humming) or listening to music to be effective. Explain that refocusing techniques can range from very simple, such as listening to music, to more elaborate, such as working toward one's goals.
   - Introduce the **Look Point Name Game** as a very simple refocusing technique that many patients have reportedly found helpful, particularly for voices. Walk the Veteran through the instructions and practice it with them; i.e., have them point and name

things in the room until they run out. You can make the activity more fun and richer by doing it outside. Explain that the technique can be modified for different settings—e.g., if the Veteran is experiencing voices on a bus and does not want to call attention to themselves, they can skip the pointing part and just name the objects under their breath.

6. Take-home points:

   Ask the Veteran what they learned from the session, or what they want to take from it.

7. Action plan & feedback:

   - The Action Plan is for the Veteran to work on at least one goal step, continue using stress reduction techniques as needed, and practice using refocusing techniques at least once per day and tracking the effect on their psychosis symptoms using the form provided at the end of the session in their manual. As usual, these are only suggestions; the assignment can be anything that you and the Veteran together decide is most helpful.

Session 8: Beliefs & Feelings

Objectives

This session is the first of the cognitive module of the manual, which spans much of the second half of the manual. The overall goal of this session is to introduce the concepts of feelings and beliefs and teaching the Veteran how to distinguish between the two. The information in this session serves as a foundation for subsequent sessions which primarily cover cognitive restructuring. Many patients struggle with understanding the difference between beliefs and feelings, or with being able to identify them, so it is important to train them on these basic skills before attempting to introduce cognitive restructuring methods. Specifically, you will:

- Re-introduce the ABC model.
- Explain what feelings are.
- Explain what beliefs are.

Material

1. Agenda & check-in:

   Review the agenda shown in the manual and ask the Veteran if they agree with it or want to add/change anything. Prioritize the agenda items if necessary.

2. Review:

   Briefly recap the main points of the last session, or ask the Veteran to do so.

3. Review of Action Plan:
   - Briefly check-in on and reinforce the Veteran's progress using stress reduction techniques and working on a goal step, and help them problem-solve around any obstacles.
   - Discuss their experience engaging in activities that refocus their attention away from voices and worries. Which ones did they try, and which worked best? Did they notice any changes in their voices, worries, or mood while or after working on a goal step?
   - If the Veteran did not complete the Action Plan, inquire about the reasons and help them problem-solve.

4. ABC of CBT:
   - Re-introduce the ABC model of CBT.
   - Sample therapist language:

     "The type of therapy we are doing, CBT, is based on the idea that what we believe affects how we feel and what we do. As you might remember from our first session, we call this the ABC model. A is an activating event, also called the antecedent; B is

a belief, also called an automatic thought – a quick thought we have in response to a given situation. Our feelings and behaviors are determined by this belief. Let's go back to that example we talked about before: *a girl – let's call her Mary – believes that she is boring and that others don't enjoy being around her; a good-looking guy asks Mary out on a date. What Mary is going to think and what she is going to do? Who thinks she's going to go on the date?"* (Veteran responds.) *"How is Mary going to feel as a result of not going on the date?"* (Examples: she's going to feel bad; she might make up an excuse to avoid going on the date.) *"Now, what if Mary believes that people like her, and that once people get to know her they're going to like being around her, and then a nice man comes along and asks her out on a date: what is Mary going to do now?" This is a good example of the ABC model. Over the next few sessions, we will be going deeper into this concept and seeing how it applies to you, especially your voices/worries."*

5. <u>What are feelings?</u>
    - Define feelings using the material in their manual. The key idea here is that feelings (or emotions) are often experienced in the body and can be described in one word. Ask the Veteran if they experienced any of the feelings on the **Feelings Wheel** recently or currently, and ask where they experienced them in their body. You can self-disclose where you tend to experience your emotions (e.g., anxiety in tight shoulders).
    - Point out that certain basic emotions like sadness can have a variety of associated emotions, like hurt, guilty, lonely, etc., and that we often experience more than one emotion at the same time.
    - Explain that the skill of identifying one's difficult emotions has been shown to actually reduce those emotions (Dr. Dan Siegel's (2012) "Name it to tame it" concept.)

6. <u>What are beliefs?</u>
    - Define beliefs using the material in their manual. The key idea here is that beliefs can be experienced as words, images, or memories that go through our minds and usually can be expressed in full sentences. As Brené Brown says, they are "stories we tell ourselves." If the Veteran reported some recently or currently experienced emotions above, ask them what beliefs may have been connected to those emotions.
    - As noted at the beginning of this manual, the Veteran's Workbook uses the terms "belief" and "thought" interchangeably to avoid confusion, but in CBT, there is a difference. Thoughts (also called "automatic thoughts") refer to how we construe or perceive a specific situation, while beliefs refer to ideas we have developed over time about ourselves, other people, and the world. The most central beliefs which we tend to hold rather deeply and consider absolute truths are called core beliefs (Beck 2020). The CBT concept of beliefs/core beliefs will be introduced in Session 9.

7. <u>Take-home points</u>:

    Ask the Veteran what they learned from the session, or what they want to take from it.

8. Action plan & feedback:
    - The Action Plan is for the Veteran to work on at least one goal step, continue using stress reduction techniques as needed and to log their feelings and associated beliefs/thoughts in the coming week, using the worksheet at the end of the session. This assignment can be more difficult than it appears, as it requires a fair amount of awareness and self-reflection. Instruct the Veteran to keep an eye out for any significant emotions that come up during the week, and use those as flags for completing the exercise. Another good strategy is for them to turn to the log at the end of each day and reflect on what came up for them that day. As usual, this is only a suggestion; the assignment can be anything that you and the Veteran together decide is most helpful.

Troubleshooting

- **Veteran has difficulty identifying specific emotions.** Some patients will have difficulty identifying their emotions. Referring to the Feelings Wheel can help, or focusing on just broad emotions (inner ring of the Feeling Wheel) rather than more fine-grained ones (outer ring). If even that is too difficult, you might use a simple distinction of “good” vs “bad” or a rating scale of 0-10 where 0 is worst feeling ever and 10 is best feeling ever.

- **Veteran conflates emotions with beliefs.** Differentiating emotions and beliefs is not always easy. One example is hopelessness, which one can argue represents both a belief (that there is no hope in the future) and some associated emotions (e.g., sadness). “Rejection” is actually a thought (“I’ve been rejected”) that leads to feelings such as hurt and sadness. Veterans often cite “paranoia” as an emotion, but really that too can be unpacked into specific beliefs (e.g., “Someone is following me”) and emotions (e.g., anxiety, anger). Normalize for the Veteran that distinguishing between emotions and beliefs can be tricky, and ask questions to help disentangle the two.

Session 9: How Beliefs Affect Feelings & Actions

Objectives

The overall goal of this session is to teach the Veteran about the power of belief; that different ways of thinking about the same situation can lead to significantly different emotional and behavioral reactions, and these in turn can positively or negative influence progress toward their goals. This session continues to form the foundation for cognitive restructuring, which will formally be introduced in subsequent sessions. Specifically, you will:

- Review the ABC model.
- Show several examples that bring the model to life and highlight the effect of beliefs.
- Introduce the idea that how we think about a situation is influenced by our belief systems and past experiences, and illustrate this with examples.

Material

1. Agenda & check-in:

   Review the agenda shown in the manual and ask the Veteran if they agree with it or want to add/change anything. Prioritize the agenda items if necessary.

2. Review:

   Briefly recap the main points of the last session, or ask the Veteran to do so.

3. Review of Action Plan:

   - Briefly check-in on and reinforce the Veteran's progress working on goal steps and managing stress, and help them problem-solve around any obstacles.
   - Review the Veteran's practice of tracking feelings and beliefs. Ask if they noticed any patterns in the kinds of feelings and beliefs that came up, and if they notice a connection between the two. Share any observations you have as well (e.g., a tendency toward anxiety) and reinforce any beliefs that were adaptive, connected to positive emotions, or progress toward goals.
   - If the Veteran did not complete the Action Plan, inquire about the reasons and help problem-solve. It could be that they had difficulty noticing their feelings and thoughts (in which case you can review the tips presented in the last session) or they need a system to remind themselves about the Action Plan. You can also try to identify any emotions and beliefs from the past week on the spot; e.g., if they did a goal step, ask what they thought about, and how they felt about, doing that. You can also do the same to investigate feelings and beliefs around not doing any goal steps.

4. How beliefs affect feelings and actions:

   - Re-introduce the ABC model of CBT using the figure in their manual (see previous session for sample therapist language).
   - Walk the Veteran through the figures in the next section that show how different beliefs can greatly influence our feelings and actions, and can either help us or hinder us as we work toward our goals. Have them guess what goes in the blank boxes, and ask them to write down their responses in their workbook.
   - Sample therapist language for second example:

     "Let's take a look at another example. Sometimes our thinking can make us feel suspicious. Let's say a person who has the goal of taking walks for exercise is walking outside and sees a man on the street wearing a business suit. They have the belief, 'He's the FBI and is after me.' This belief might lead to him feeling afraid and going home. What is a different man the thought can have when he sees the other man in the suit, so that he feels OK and keeps walking?" (If Veteran needs help…) *"What are some other reasons there might be a man on the street wearing a suit? What kind of people other than mafia wear suits?"* (If Veteran cannot think of an alternative thought…) *"What if he had the thought, 'Oh this guy must work in an office, he has nothing to do with me…I've done nothing wrong.' How might he feel then? Would he continue with his walk?"*

   - Introduce the idea that our beliefs do not come from nowhere, but rather are influenced by our belief systems and past experiences and guide the Veteran through the two examples before asking if they can think of a personal example. This section corresponds to the CBT concept of **core beliefs**—our most central beliefs about ourselves, other people, and the world which we tend to hold rather deeply and consider absolute truths. These beliefs tend to be shaped by early experiences as well as traumas.
   - Sample therapist language:

     "How do beliefs contribute to worries like suspicion? For example, a person has a negative belief about himself–let's say he thinks he's ugly, maybe because he was bullied about his looks when he was younger. So when somebody looks at him, he thinks that the person thinks he's ugly. And then he thinks that other people think he's ugly, too. As a result, how is he going to feel?" (Veteran responds.) *"Bad. And what is he going to do?"* (Veteran responds.) *"Withdraw. And how are feeling bad and withdrawing going to affect his belief about himself? It will be reinforced, meaning this will keep the belief going. Let's look at a different example: let's say this person has a different belief–that he's beautiful. Same situation, same activating event; if somebody looks at this person, what is he going to think?"* (Veteran responds.) *"Something good. And how is he going to feel?"* (Veteran responds.) "*Happy. And how are these thoughts and feelings going to affect his belief? It will be reinforced. So, when we believe something we're going to interpret things in a certain way according to this belief, which reinforces these beliefs."*

     "What are some beliefs you have about yourself, other people, and the world that might feed into your worries or how you relate to your voices? What beliefs do you have or think you can develop, that could protect you from worries and voices; something positive, something that makes you feel secure?"

5. Take-home points:

   Ask the Veteran what they learned from the session, or what they want to take from it.

6. Action plan & feedback:

   - The recommended Action Plan is for the Veteran to work on at least one goal step, continue using stress reduction techniques as needed, and practice applying the ABC method to personal situations, either those that arise in the coming week or from the past. As usual, these are only suggestions; the assignment can be anything that you and the Veteran together decide is most helpful.

Troubleshooting

- **Veteran displays rigid negative thinking.** Veterans will sometimes have difficulty generating alternative adaptive beliefs in the exercises in this session; e.g., in the voices example, they may say that there is no way to not fear their voices and stay home to avoid triggering them, because they are so distressing and negative. This is fairly common in this early stage of the cognitive module of the therapy. Do not force the Veteran to change their beliefs, and think about how this fits with the case formulation. Show empathy and use Socratic questioning (see the *Introductory Manual*) to try to elicit more adaptive beliefs, e.g., *"I know your voices have been incredibly difficult for you. I can see why you would be afraid and want to avoid triggering them at all costs. I wonder, has there ever been a time when you were able to stick to your plans despite the voices? Have you ever done something that brought them down, even a little bit?"* If such line of questioning fails, you can also gently float alternative beliefs after expressing empathy; e.g., *"We have found that with time and practice, many of our Veterans have been able to shift their beliefs about the voices so that they don't see them quite as powerful, and so they see themselves as having some control. When they learn to have thoughts like, 'Even though the voice feels powerful, it's not completely powerful, and I can still control it somewhat,' they feel less afraid and will be more able to do what they want with their life despite the voice."*

- **Veteran has difficulty identifying belief systems.** Veterans may struggle with identifying their belief systems/core beliefs in the latter part of the session. This is to be expected, as we are often not fully conscious of these beliefs. You can simply explain the concept, show examples, and ask gentle questions to see if you can elicit them, but do not push. It is fine to just plant the seeds for now. With time over the course of the next few sessions, patterns will likely emerge in the Veteran's thinking that will clue you into what these beliefs (as well as the past experiences that led to their development) might be, and you should note these on your case formulation. For Veterans who hear voices, the content of the voices can be hypothesized to reflect their core beliefs (e.g., a Veteran hearing a voice telling her she is a failure and loser may on some level think this way about herself).

Session 10: Catching Thoughts

Objectives

The overall goal of this session is to introduce the 3 Cs method of cognitive restructuring. Specifically, you will:

- Introduce the 3 Cs by explaining its rationales and each of the steps.
- Teach the Veteran how to implement the first C (Catch it), which means catching their thoughts.
- Practice Catch it with the Veteran.

Material

1. Agenda & check-in:

   Review the agenda shown in the manual and ask the Veteran if they agree with it or want to add/change anything. Prioritize the agenda items if necessary.

2. Review:

   Briefly recap the main points of the last session, or ask the Veteran to do so.

3. Review of Action Plan:

   - Briefly check-in on and reinforce the Veteran's progress working on goal steps and managing stress, and help them problem-solve around any obstacles.
   - Ask if they were able to apply the ABC method to any personal situations and reinforce any work they did on this.
   - If the Veteran did not complete the Action Plan, inquire about the reasons and help problem-solve.

4. Managing your thinking with 3 Cs:

   - Introduce the 3 Cs and explain the rationale for this technique using the material in the *Veteran's Workbook*. The main point to convey is that this is an effective method of managing one's own thinking, and managing thinking can lead to feeling better and being more able to work toward our goals.

     Sample therapist language:

     "We've seen how powerful our thinking can be. How we make sense of a situation can really affect how we feel and what we do. Today I want to tell you about a technique that has been shown to really help in managing our thinking, called the 3 Cs. The 3 Cs works in a few ways. First, when we are emotional or feel under threat, like often happens with voices or worries, our thinking tends to go very fast. We tend to stick to one quick explanation and run with it. But because we are emotional and

thinking so fast, we are more likely to make mistakes. The 3 Cs slows down our thinking to make sure we are thinking clearly and accurately. The 3 Cs also helps us to see if our thinking is helpful to us—meaning, is it helping us to feel better and move forward with our life, or is it making us feel worse and holding us back? The 3 parts of the 3 Cs are Catch it, Check it, and Change it. 'It' means your belief or thought. So, Catch your thought, then Check it to see if it's accurate and helpful, and if it's not accurate or helpful, then you Change it to make it more balanced and helpful. We will be practicing the 3 Cs over the next few sessions."

5. Catch It:
    - Walk the Veteran through the two tables of common thoughts people have about suspicious worries (paranoia) and voices. Ask them to mark the ones they have had, and praise them for catching these thoughts. Ask if they see a difference between the thoughts in the left vs right columns. Those in the left tend to be associated with negative emotions and difficulty working toward goals, whereas those in the right are the opposite (i.e., more recovery-promoting). Provide empathy for thoughts the Veteran endorsed in the left column and praise them for any in the right, and say that the 3Cs can help to adjust our thinking so that it is more like the right-column.

6. When to catch it?:
    - Knowing when to even start the 3Cs can be tricky, especially at first. Review the table in this section that explains the four situations in which we should use the 3Cs. Ask them if they can relate to those kinds of situations to help prepare them for at-home practice.

7. Exercise: Practice Catching Thoughts:
    - Assist the Veteran in practicing Catch it using the form provided in their manual. It's best here to select a relatively low emotion/low complexity situation. Perhaps the Veteran shared about a recent event earlier in the session from which you could elicit (catch) a thought. If not, you could ask them to share a recent situation, using the preceding section as a guide; e.g., *"Can you think of a recent time when one of these four things happened to you? When you felt a difficult emotion, couldn't stop thinking about something that's upsetting you or interfering with your life, felt stuck in doing something that's important to you, or you were doing something that you probably shouldn't have been doing?"* If the Veteran provides multiple examples, pick the least emotionally charged and complex one for this exercise.
    - Have them fill out the worksheet, section by section. Some guidelines:
        - **Situation**: Should be a brief statement of "just the facts." Simply what was happening, where, and when. No beliefs or emotions should go here.
        - **Feelings**: What the Veteran was feeling at the time. It is common to have multiple emotions here, sometimes even conflicting ones.
        - **Actions**: What the Veteran did *or did not do* (e.g., avoidance) in the situation.
        - **Catch it**: One key thought the Veteran had in the situation. Often, we have multiple thoughts in a given situation. Try to help the Veteran locate the key one that most influenced their emotion and behavior above. Avoid getting too

obsessive about this part; it's fine to write down a number of thoughts. The main goal today is to get them used to the skill of identifying thoughts.

8. Take-home points:

   Ask the Veteran what they learned from the session, or what they want to take from it.

9. Action plan & feedback:

   - The recommended Action Plan is for the Veteran to work on at least one goal step, continue using stress reduction techniques as needed, and practice catching thoughts using the worksheets provided at the end of this session in their manual. As usual, this is only a suggestion; the assignment can be anything that you and the Veteran together decide is most helpful.

Troubleshooting

- **Veteran does not provide recent situations with which to practice Catch it.** Occasionally you may find that a Veteran is not able to tell you about a recent situation from which you can catch a thought. This is especially likely to occur with people with negative symptoms or cognitive impairment. You might ask what they thought about coming in to session today (they must have had some thought about having to or wanting to come in, otherwise they would not have), or you might demonstrate Catch it using one of your own (not overly personal) experiences. Alternatively, you might use a generic example (e.g., someone sees a friend across the street but the friend does not acknowledge them and keeps walking; what thought might they have?) The situation also does not have to be negative or distressing; they can share about a recent time they felt good or had a successful experience working toward a goal, and you can try to catch a thought there.

- **Veteran shares high-conviction delusional beliefs.** You may also get the opposite reaction, in which the Veteran shares rather intensely held beliefs, like paranoid delusions. That is fine, because we are not challenging the belief in any way. For now, all we want is for them to get in the habit of learning to identify their beliefs and the emotions and behaviors that stem from them. Delusions are often presented as a cluster of beliefs (e.g., the voices I hear at night are my neighbors talking about me; they're tracking everything I'm doing; they're plotting to get me evicted.) As noted above, it is best if you can steer the Veteran toward selecting the *one key thought* that was most tied to their emotional and behavioral reaction in that specific situation.

3 Cs adapted with permission from the publisher from: Granholm, E. L., McQuaid, J. R., & Holden, J. L. (2016). *Cognitive-behavioral social skills training for schizophrenia: A practical treatment guide.* Guilford Publications.

Session 11: Checking Thoughts

Objectives

The overall goal of this session is to introduce the second step of the 3 Cs, which involves checking thoughts for accuracy and helpfulness. Specifically, you will:

- Explain the rationale for the Check it step and teach the Veteran how to implement it—looking at evidence for and against the thought, determining if a thinking habit is occurring, and determining if the thought is helpful or unhelpful regarding the Veteran's wellbeing and goals.
- Explain common thinking habits and help the Veteran practice spotting them.
- Guide the Veteran through a practice of the first two Cs: Catch it and Check it.

Material

1. Agenda & check-in:

   Review the agenda shown in the manual and ask the Veteran if they agree with it or want to add/change anything. Prioritize the agenda items if necessary.

2. Review:

   Briefly recap the main points of the last session, or ask the Veteran to do so.

3. Review of Action Plan:
   - Briefly check-in on and reinforce the Veteran's progress working on goal steps and managing stress, and help them problem-solve around any obstacles.
   - If Veteran was able to practice Catching thoughts, review what they wrote down on the worksheets. Reinforce any work they did, and help them resolve any confusion.
   - If the Veteran did not complete the Action Plan, inquire about the reasons and help them problem-solve. The most common problem with this assignment is that the Veteran forgot to do it, or did not know when to catch thoughts, so it could be helpful to discuss a plan for remembering to do the Action Plan and/or review the list of four situations in which the 3 Cs should be used, from the last session. Depending on time and your patient's needs, you could guide them in briefly doing the homework on the spot by catching a thought that came up in the past week, or you can bypass this since the present session will entail more 3 Cs practice.

4. CHECK IT: 3 ways of checking thoughts:
   - Explain the rationale for the 3 Cs using the material in the *Veteran's Workbook*.

- Explain the three key questions that are asked when Checking a thought—1) What is the evidence for/against it; 2) Could it be a thinking habit; and 3) Is the thought helpful?

5. Thinking habits:
   - Introduce the concept of **thinking habits**, which are formally known as cognitive distortions or reasoning biases in CBT. Emphasize that these are normal shortcuts in thinking that everybody does, and do serve a purpose, however we tend to overuse them when we are highly stressed of feel threatened, which can lead to misinterpretations, negative emotions, and trouble working toward our goals. If indicated, you may add that there is research showing that people who experience the worry of suspiciousness (i.e., paranoia) tend to use Jumping to Conclusions more than those who do not, so it is particularly important to be careful about that one.
   - Explain each of the thinking habits. If necessary and time permitting, you could include a quick example of each one (see table below). Ask the Veteran if they can relate to the thinking habits, and which one is their "favorite," i.e., the one they find themselves using the most. Normalize the thinking habits by sharing your favorite one as well.

Thinking Habit	Description	Example
Jumping to Conclusions	Coming to a conclusion (usually a negative one) without enough evidence	Your doctor leaves you a voicemail asking you to call them back and you assume they have terrible news.
Mind Reading	Thinking that you know what others are thinking	Walking into a room and believing that the people there are judging you, even though they didn't say or do anything.
Fortunetelling	Predicting that things will go badly in the future	Telling yourself, "Why bother working on my goals? It will go badly."
Personalizing	Thinking that something is all about you when really, it's not	Someone at the store is laughing and you think it must be about you.
Emotional Reasoning	Making decisions that are based only on feelings rather than facts	You wake up feeling anxious and think, "something bad is going to happen today."
Externalizing	Thinking that internal thoughts & feelings are really coming from outside	Hearing a voice and being convinced it is because someone is transmitting it into your brain.

Selective Abstraction	Focusing on a detail taken out of context; not looking at the whole picture	Thinking that your voices are totally uncontrollable and all-powerful and forgetting that there have been times where you did manage to control them or they proved to not be so powerful.
Missing the Positives	Not noticing the good parts of a situation, or not giving yourself credit for positive things you or others do	Doing really well on most parts of a task but focusing only on the part you didn't do well on, and beating yourself up about it
Intentionalizing	Thinking that others are doing things on purpose to harm you	Your friend hasn't replied to your text message yet and you think they're doing it on purpose to disrespect you.

6. Exercise: Spotting Thinking Habits:
    - Ask the Veteran to complete this exercise with you by reading each of the nine scenarios and having them guess which thinking habit is taking place. There can be more than one answer, and technically jumping to conclusions (JTC) is a broad thinking habit and all of the others are specific versions of JTC.
    - The answers to the exercise are: 1) JTC, MR; 2) JTC, ER; 3) JTC, SE, MP; 4) JTC, MR, P, I. 5) JTC, E; 6) JTC, I, MR; 7) JTC, ER; 8) JTC, P, MR; 9) JTC, SE.

7. Catch it & Check it examples:
    - Walk the Veteran through the one or both of the Catch it, Check it examples, depending on what is relevant for them; the first one is about suspicion/paranoia and the second one is about voices. Answer any questions they may have.

8. Exercise: Practice the 3 Cs!
    - Help the Veteran practice the Catch it and Check it steps by selecting a recent situation in which they experienced voices or worries. Walk them through each step, just like last session, except this time adding the Check it step, which will include the following substeps, each of which include sample therapist language:
        - **Identify evidence for the thought:** Ask the Veteran to list as much evidence as they can. These should be facts. It might be helpful to tell them to envision that they are in court, and have to present only solid facts that could possibly be taken as evidence. If they get stuck, you can suggest some. Usually Veterans are easily able to supply "evidence" that seemingly supports negative or unhelpful beliefs they have about their voices and/or delusional beliefs.
        - **Identify evidence against the thought:** Do the same, except for evidence against the thought. Encourage Veterans to brainstorm and list as many pieces of evidence against the thought as possible, even if they don't believe

them. Veterans are more likely to struggle with this part, so you may have to help them with Socratic questioning, e.g.: *"So you came up with a few possible pieces of evidence that the person had a mean look on their face because they were trying to intimidate you. Can you think of any possible reasons that the look wasn't about you? Why else might someone have a mean look on their face? Did you know this person? Did you do anything that would justify them trying to be mean to you?"* If this isn't sufficient, you could also float possibilities, e.g., *"It doesn't sound like you did anything wrong that would justify them trying to intimidate you; can we put that down as evidence against?"*

- **Is the thought totally accurate?:** Ask the Veteran to reflect on the analysis you just did and decide whether the thought now appears accurate or not, e.g.: *"Now that we have analyzed the evidence for and against the thought, do you think it's totally accurate? This doesn't have to be a 100% yes/no answer, because it's not always easy to say for sure. Think of it like a needle on a car gauge. Is it more on the 'yes' side or more on the 'no' side?"*
- **Are there thinking habits?** Ask the Veteran if any thinking habits might be taking place. Float any that they may miss.
- **Is the thought helpful for your feelings and goals?** Finally, this is a check of how adaptive the thought is. Does the Veteran think that the thought is serving them well or could it be hurting them? You may ask, *"Now that we've looked at how accurate the thought is, we also want to look at how helpful it is. What do you think, does the thought, ____ help you to feel better and motivate you to move toward your goals, or does it make you feel worse and get in the way of your goals?"* This too does not have to be a black or white choice; is it more helpful or more unhelpful?

9. Take-home points:

   Ask the Veteran what they learned from the session, or what they want to take from it.

10. Action plan & feedback:

    - The recommended Action Plan is for the Veteran to work on at least one goal step, continue using stress reduction techniques as needed, and practice catching and checking thoughts related to their psychosis using the worksheets provided at the end of this session in their manual. As usual, this is only a suggestion; the assignment can be anything that you and the Veteran together decide is most helpful.

Troubleshooting

- **Veteran presents a cluster of beliefs.** As described in the previous session, we usually have multiple beliefs/thoughts in a given situation. If your Veteran presents a situation that has a lot of beliefs associated with it, try to strategically select the one that they will most likely be able to "check" so that the 3 Cs exercise is productive. This usually means selecting a belief that is quite relevant to the situation, but that is not held with 100% conviction or has extremely high affect attached to it. In other words, go for the lowest

hanging fruit. For example, a Veteran once described a chronic, high-conviction (i.e., he believed it 100%) and distressing delusional belief about having an alien implant, but he had a number of associated beliefs that he held with less conviction and emotion. The therapist selected one of these ("There is nobody I can talk to about this," which he believed around 70%) as a target for cognitive restructuring in early sessions. As time went on in therapy, they moved toward the more intensely-held beliefs. Another possibility in such situations is to target the recovery-inrfering beliefs associated with the firmly held-delusion or negative beliefs about voices; e.g., "I can't go to school because of the voices," "I shouldn't leave the house because I might get hurt."

- **Veteran has difficulty objectively "checking" a belief.** The 3 Cs can be a challenging skill to implement at first, especially if the Veteran presents firmly-held beliefs that have a high degree of emotion attached to them, e.g., high-conviction, distressing delusional beliefs or strong maladaptive beliefs about their voices. This tends to be most challenging in those with low insight and high degree of cognitive rigidity. Do not forcefully challenge such beliefs. Stay calm and objective, and simply walk them through the Catch it and Check it steps, using Socratic questioning and gently floating suggestions as indicated. Even just identifying some possible evidence against such beliefs can be helpful; it is like planting seeds that could eventually lead to cognitive shifts down the line. These shifts rarely happen suddenly all at once. It is often the case with such beliefs that the "helpfulness" question is key. Even Veterans who may not be able to acknowledge that their belief is inaccurate are usually able to admit that the belief is not helpful, or that fixating on the belief is not helpful. This is a good place to be at this stage and is good preparation for the last C, Change it, that will be covered in the next session. If indicated, you can feel free to give them a "sneak peak" of the next session by helping them to adjust the belief so that it is more accurate and more helpful, and let them know that you will be covering this in more detail in the next session.

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Session 12: Jumping to Conclusions & Changing Thoughts

Objectives

The overall goal of this session is to discuss the jumping to conclusions thinking habit and ways to avoid it in more detail and introduce the third and final step of the 3 Cs, which entails changing inaccurate or unhelpful thoughts. Specifically, you will:

- Explain jumping to conclusions in more detail.
- Present and practice the method of avoiding it by generating alternative explanations.
- Provide instruction on the Change it step of the 3 Cs.
- Guide the Veteran through a practice of the entire 3 Cs.

Material

1. Agenda & check-in:

   Review the agenda shown in the manual and ask the Veteran if they agree with it or want to add/change anything. Prioritize the agenda items if necessary.

2. Review:

   Briefly recap the main points of the last session, or ask the Veteran to do so.

3. Review of Action Plan:
   - Briefly check-in on and reinforce the Veteran's progress working on goal steps and managing stress, and help them problem-solve around any obstacles.
   - If Veteran was able to practice catching and checking thoughts, review what they wrote down on the worksheets. Reinforce any work they did, and help them resolve any confusion.
   - If the Veteran did not complete the Action Plan, inquire about the reasons and problem-solve. The most common problem with this assignment is that the Veteran forgot to do it, or did not know when to use the 3 Cs, so it could be helpful to discuss a plan for remembering to do the Action Plan and/or review the list of four situations in which the 3 Cs should be used, from session 10. Depending on time and your patient's needs, you could guide them in doing the homework on the spot by catching and checking a thought that came up in the past week, or you could bypass this since the present session will entail more 3 Cs practice.

4. What is jumping to conclusions?
   - The jumping to conclusions reasoning bias (thinking habit) is important in psychosis because it believed to be a maintenance factor for paranoia. Research has shown that people with paranoia use a jumping to conclusions bias more than those without.

In this section, you will explain jumping to conclusions in more detail, using the material in the *Veteran's Workbook*. Ask the Veteran if they can relate to this habit and ask about a time that they think they might have used it. If comfortable, you can share one of your own non-overly personal examples to normalize that everyone can jump to conclusions, especially when stressed.

5. How to avoid jumping to conclusions:
    - Present the method of avoiding jumping to conclusions by looking for alternative explanations, which involves asking oneself three key questions: 1) What are other possible explanations for what happened? 2) What is the most likely explanation? 3) What is the BEST explanation—the one that would help my feelings and goals the most?
    - Sample therapist language:

      "One strategy for preventing jumping to conclusions is looking for alternative explanations for events. You should begin to get into the habit of asking yourself these three questions, especially when feeling worried about being harmed (or suspicious, paranoid, etc. depending on Veteran's preferred term)*. Studies show that many people who struggle with these kinds of worries make decisions based on little evidence and thus jump to conclusions about what happened. Coming up with alternative explanations and then selecting the most likely and best one is a great way to prevent this."*

6. Exercise: What Could Have Happened?
    - Engage the Veteran in this exercise using their manual. The rationale for the exercise is to get them in the habit of generating alternative explanations to potentially paranoia-inducing incidents. Encourage the Veteran to brainstorm as many explanations as they can, even ones they don't really believe, and praise them for doing so.
    - If the Veteran gives only non-paranoid explanations you might ask them, *"If Joe/Mary were feeling really worried/suspicious/paranoid* (use whatever term is preferable to the Veteran) *that day, what other explanations might he/she come up with?"*
    - Explain that these situations, much like life itself often is, are pretty ambiguous, so it's hard to decide which explanation is the correct one without obtaining more information. This concept will be covered more in the next session.

7. Change it: Changing inaccurate/unhelpful thoughts:
    - Introduce the final step of the 3 Cs, changing thoughts, which is done when the Check it step shows that a thought is inaccurate and/or unhelpful. Tell the Veteran that the goal is to change the original thought to a new one that is more accurate and balanced, yet they believe—we do not want to Pollyanna or sugar-coat things. The new thought should be realistic and balanced.
    - The table in the Veteran's Workbook outlines four questions the Veteran can ask themselves to help come up with a corrected thought:
        - Are there any alternative explanations for what happened?

- If someone I cared about had this thought, how would I tell him or her to change it?
- How can I think about this situation differently so that I feel better?
- How can I think about this situation differently so that I keep working toward my goals and have the life that I want?

8. Exercise: Practice the 3 Cs!
   - Help the Veteran practice the entire 3 Cs by selecting a recent situation in which they experienced voices or worries. Walk them through each step, just like last session, except this time adding the Change it step, if the thought they identify turns out to be not completely accurate, or unhelpful.
   - Changing a thought can be quite difficult, especially if the person holds on to it with a lot of conviction or has had the thought for a long time. So be prepared to assist the Veteran with this step. Try not to force them into an entirely new thought that you impose and that they do not believe. Work with them to find an acceptable thought that they buy into. Often this will be a tweak or edit of the original thought instead of an entirely new one; the following table illustrates moderately changed thoughts that might result from the 3 Cs.

Original Thought	**Changed Thought**
I have to do what the voices say or else they'll hurt me.	I don't always have to obey the voices. They have been wrong sometimes.
I can never get a job because of the voices.	Although the voices are really hard, I'm learning ways of managing them. I can do small things now to prepare myself for someday getting a job.
He gave me that look because he thinks he's better than me.	I can't know for sure that is why he was giving me that look. It's possible that he was upset about something that had nothing to do with me.

9. Take-home points:

   Ask the Veteran what they learned from the session, or what they want to take from it.

10. Action plan & feedback:
    - The recommended Action Plan is for the Veteran to work on at least one goal step, continue using stress reduction techniques as needed, and practice catching, checking, and changing thoughts related to their psychosis using the 3 Cs worksheets provided at the end of this session in their manual. As usual, these are only suggestions; the assignment can be anything that you and the Veteran together decide is most helpful.

Troubleshooting

- **Veteran has difficulty changing a belief.** It can be difficult for anyone to change their beliefs, especially if they are firmly-held for a long time with a high degree of emotion attached to them. In patients with psychosis this can especially be difficult with chronic, high-conviction, distressing delusional beliefs or strong maladaptive beliefs about voices, in particular in those with low insight and high degree of cognitive rigidity. As explained above, do not forcibly impose a belief that the Veteran does not buy into, and try the strategies we previously described. If you become really stuck, one possible solution is to pivot away from changing the belief and adding something to it to support the Veteran's recovery. For example, in the example from above, if the Veteran is unwilling or unable to change the thought, "He gave me that look because he thinks he's better than me," you might suggest they add something to the thought to minimize its damaging effect on their wellbeing and recovery, e.g., "Even thought he might think he's better than me, I don't have to let that get to me because I have several good qualities. My family loves me and I want to be a good dad to my daughter. Maybe he's just jealous!"

- **Veteran presents non-psychosis examples.** Sometimes you may find that Veterans present examples that are not directly related to their psychotic symptoms. For example, they might do the 3 Cs homework on situations involving anger, depression, or anxiety. Although any practice is good practice, and the 3 Cs is a broad-purpose wellness tool that should be used for any kind of thinking, if the Veteran is presenting for the treatment of psychosis, you will want to apply the skill directly to psychotic symptoms for optimal benefit. It could be that the Veteran is hesitant or embarrassed to share about their psychotic symptoms. These are after all, very private experiences, and patients sometimes are ashamed of them. Point out your observation in a gentle manner and express curiosity as to why they have not been talking about their voices or worries directly. You may normalize their potential hesitation as a common occurrence, ask if there is anything you can do to make it more comfortable for them to share, and reassure them that nothing is "too much" and that what they share will remain confidential with the exception of the rare situations that would require a break of confidentiality.

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Session 13: Being Your Own Detective

Objectives

The overall goal of this session is to discuss an additional strategy for avoiding jumping to conclusions. Specifically, you will:

- Teach the Veteran how to avoid jumping to conclusions in a situation by selecting the most likely explanation, a skill we call "being your own detective."
- Guide the Veteran through practice of this skill.
- Summarize all the techniques they have learned for jumping to conclusions.

Material

1. Agenda & check-in:

   Review the agenda shown in the manual and ask the Veteran if they agree with it or want to add/change anything. Prioritize the agenda items if necessary.

2. Review:

   Briefly recap the main points of the last session, or ask the Veteran to do so.

3. Review of Action Plan:
   - Briefly check-in on and reinforce the Veteran's progress working on goal steps and managing stress, and help them problem-solve around any obstacles.
   - If Veteran was able to practice the 3 Cs, review what they wrote down on the worksheets. Reinforce any work they did, and help them resolve any confusion.
   - If the Veteran did not complete the Action Plan, inquire about the reasons and problem-solve. Common problems with this assignment are that the Veteran forgot to do it, or did not know when to use the 3 Cs, so it could be helpful to discuss a plan for remembering to do the Action Plan and/or review the list of four situations in which the 3 Cs should be used, from session 10. Depending on time and your patient's needs, you could guide them in doing the homework on the spot by completing one 3 Cs worksheet on a recent event involving voices or paranoia/worries.

4. Avoid jumping to conclusions by gathering more information:
   - Explain the final skill for avoiding jumping to conclusions using the information in the *Veteran's Workbook.* This technique is called "Being Your Own Detective" and entails identifying multiple possible explanations, then ruling out the least likely, identifying the possible ones, and finally identifying the most likely explanations based on the evidence.

- Sample therapist language:

  "Last session we talked about how coming up with alternative explanations to an event that is worrying us and then selecting the most likely explanation is a great way to avoid jumping to conclusions. But how do you decide which explanation is most likely? The process of doing this is called Being Your Own Detective, and it involves these three steps (reads steps from table)…*If you're very emotional, it might be hard to do this, so might need to say to yourself, 'I'm too emotional at the moment, and it might not be the best time to make decisions.' Research shows that when the emotional center of our brain is very active, it suppresses the cognitive-rational part of our brain. So, you can take a break, do a stress reduction activity, and come back to it later."*

5. Exercise: Practice Choosing the Most Likely Explanation:
   - To practice this skill, have the Veteran examine each of the two photos in the manual and try to decide which of the given explanations can be ruled out, which ones are possible, and which one is the most likely. These photos were intentionally chosen because they are ambiguous and can be interpreted in a paranoid manner.
   - Ask questions such as, "How can you tell that explanation is unlikely? What do you see in the picture that hints that?" Assist the Veteran as needed and praise them for their efforts, especially when they show flexible thinking and pick up on important details in the photo (e.g., that the man in the first photo is wearing what appears to be a team sport shirt, suggesting he may be running a marathon).
   - Ask the Veteran to generate any additional explanations that are not shown in the manual. You might also ask them to suggest which of the explanations someone who is feeling well might select vs. someone who is feeling suspicious/worried or hearing threatening voices.
   - Sample therapist language:

     "As you can see, much like life itself often is, it is not entirely clear what's happening in these pictures so it's hard to decide which explanation is the correct one without obtaining more information. All we can do is make an educated guess based on all of the available evidence. As in life, we would need to gather more information to make a more solid guess, but this isn't always possible, so we do the best we can. When we are torn between a couple of explanations, we can decide to choose the one that is the most helpful to us—the one that will make us feel better and help us live the life we want, and work on our goals."

6. Summary of how to avoid jumping to conclusions:
   Summarize the strategies of the last couple of sessions using the table in the *Veteran's Workbook.*

7. Take-home points:

   Ask the Veteran what they learned from the session, or what they want to take from it.

8. Action plan & feedback:
    - The recommended Action Plan is for the Veteran to work on at least one goal step, continue using stress reduction techniques as needed, and practice catching, checking, and changing thoughts related to their psychosis using the 3 Cs worksheets provided at the end of this session in their manual. As usual, these are only suggestions; the assignment can be anything that you and the Veteran together decide is most helpful.

Troubleshooting

- **Veteran chooses negative explanations in the exercise.** The goal of the exercise is to help the Veteran practice the skills of examining all available information and thinking flexibly about the situation. Although there is no way to rule out suspicious or paranoid explanations for both photos (e.g., that the women in the second one are talking about the man), you can encourage the Veteran to think more slowly about their explanation. You may ask, "*What tells you that they are talking about him? What additional information would we need to know for sure? They do look like they're talking; could it be about something else? Do we know they're saying bad things about him, or could it be good things?"* The Veteran may state that their explanation comes from their own experiences of rejection or judgment, in which case express you can express empathy, use this as a teaching opportunity, and refer to your case formulation. E.g., *"I am so sorry you experienced that; it must have been so difficult. I can see why you would think that they're talking about him. Like we talked about a few sessions ago, our beliefs are shaped by our past experiences. If you had not had those experiences, do you think you might interpret this picture differently?"* You can also reinforce the idea that we ultimately have a choice about how we interpret ambiguous situations, e.g., *"If this were happening to you, how would you feel if you believed that the women were talking about you?* (Veteran responds they would feel anxious or angry.) *And would it help you to go about your day and work toward your goals?* (Veteran says no.) *Although we can't know for sure what the women are talking about, you ultimately can choose what you think. Which of these other explanations can you tell yourself instead, so that you feel better and are able to go about your day?"* The Veteran may still stick to the negative interpretation, and that is ok. This work takes time and is about planting seeds of doubt.

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Session 14: Being Your Own Scientist

Objectives

This is the final session in the cognitive module. The overall goal of this session is to teach the Veteran the skill of using behavioral experiments to test beliefs. Behavioral experiments are activities designed to test the validity of a belief and are a powerful CBT technique. In this therapy, we call them "Being Your Own Scientist." Specifically, you will:

- Explain the steps of designing, conducting, and interpreting a behavioral experiment and review examples of experiments to test beliefs regarding suspicion and voices.
- Practice the skill using hypothetical character examples.
- Help the Veteran design an experiment to test one of their own beliefs about voices or worries.

Material

1. Agenda & check-in:

   Review the agenda shown in the manual and ask the Veteran if they agree with it or want to add/change anything. Prioritize the agenda items if necessary.

2. Review:

   Briefly recap the main points of the last session, or ask the Veteran to do so.

3. Review of Action Plan:
   - Briefly check-in on and reinforce the Veteran's progress working on goal steps and managing stress, and help them problem-solve around any obstacles.
   - If Veteran was able to practice the 3 Cs, review what they wrote down on the worksheets. Reinforce any work they did, and help them resolve any confusion. Did they use any of the strategies for avoiding jumping to conclusions? Which ones?
   - If the Veteran did not complete the Action Plan, inquire about the reasons and help them problem-solve. Common problems with this assignment are that the Veteran forgot to do it, or did not know when to use the 3 Cs, so it could be helpful to discuss a plan for remembering to do the Action Plan and/or review the list of four situations in which the 3 Cs should be used, from session 10. Depending on time and your patient's needs, you could guide them in doing the homework on the spot by completing one 3 Cs worksheet on a recent event involving voices or paranoia/worries.

4. Testing your beliefs with experiments: Being your own scientist:
   - Introduce the skill using the material in the *Veteran's Workbook.*

- Sample therapist language:

  "We've looked at how you can check beliefs by being your own detective. Today we will be talking about another powerful way to check your beliefs—by being your own scientist. This means that when something happens and we have a belief about it that causes us to feel worried, anxious, or any other negative feeling, we can test out the belief to make sure it's correct. We can also use this method when we're just not sure what's going on, and we want to test out our best guess. We call this being your own scientist because it involves designing an experiment to test your belief. There are 5 steps (shows table in manual). *First, you will state the specific belief you're going to test out. Second, you design an experiment to test this belief. That means, something you will do to see if the belief is accurate or not. Third, you agree beforehand on how you will make sense of what happens in the experiment—meaning, how you will interpret the results. Fourth, you conduct the experiment and note what happens. And finally, you interpret your results! You decide what the results mean for your original belief. Let's take a look at a couple of examples of how this is done."* (Proceeds to review examples in manual).

5. Exercise: Design Experiments:
   - Behavioral experiments can be a challenging concept. To help ensure the Veteran understands, do this activity with them using the fictional characters of Joe and Mary. Have the Veteran read each situation, and then help them design an experiment to test the belief. Provide assistance as needed.
   - For the Joe example, a good experiment would be for him to send himself a letter, or have a family member or loved one do so, and see if it arrives. If it does, it would mean that nobody is stealing his mail.
   - For the Mary example, a good experiment would be for her to rate her voices on a scale of 0-10 while she is inside, and then go outside for a few minutes and rate them again. Note here, we would need to know what exactly Mary means by "the voices will get really bad?" What intensity does the Veteran think the voices would have to be to show that her belief was accurate?
   - Finally, help the Veteran design an experiment for a belief they have about their voices or that is related to their paranoia (i.e., steps 1-3 in the Being Your Own Scientist process). Carefully go through each of the three steps, keeping the following guidelines in mind:
     - **State the belief you're going to test.** The Veteran should be very clear and specific about the one belief to be tested.
     - **Design your experiment to test your belief.** What would be a good way of them finding out what they need to know to determine whether or not the belief is true? What exact information is needed and how will this be collected?
     - **Agree on what the conclusion of the experiment will mean.** This is a critical step. It means that the Veteran must clearly agree beforehand on how the results are to be interpreted. For example, if the Veteran were testing the same belief about their mail being stolen like Joe, they might agree that if the mail does arrive, then their mail is not being stolen; there must be another explanation for why they have not seen it (e.g., it was addressed incorrectly, there is a delay, or it did arrive and they lost it).

6. Take-home points:

   Ask the Veteran what they learned from the session, or what they want to take from it.

7. Action plan & feedback:

   - The recommended Action Plan is for the Veteran to work on at least one goal step, continue using stress reduction techniques and the 3 Cs as needed, and conduct their behavioral experiment and record the results and implication for their original belief (steps 4 and 5) in their manual. As usual, these are only suggestions; the assignment can be anything that you and the Veteran together decide is most helpful.

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Session 15: Putting it All Together & Planning for the Future

Objectives

This is the penultimate session. After this session, we recommend that the therapist titrate off to the next session; e.g., if the frequency has been weekly until now, the next session should be scheduled for 2 weeks – 1 month, depending on your clinical judgment and the Veteran's preference. Session 16 is the last session with formal manual content and can be the last one, or you may elect to provide a series of several booster sessions that are sufficiently spaced apart (e.g., by 1-month intervals or intervals starting at 2 weeks and increasing to 1 month), again depending on clinical judgment and Veteran preference as well as clinic procedures.

This session and the next one introduces the concept of the Veteran being now ready to be their own therapist, which means they will now be using the skills they learned in CBT without your support. Of course, you should still connect the Veteran to any appropriate referrals, if indicated, such as peer support, group therapy at the VA, and community referrals for support, socialization, recreation, avenues for recovery pursuits, etc.

If the Veteran's family or loved ones were involved in therapy, this is an excellent session to invite them to, since they could provide important post-treatment support to the Veteran.

The overall goal of this session is to review the skills that the Veteran has learned over the course of the therapy and prepare for termination. Specifically, you will:

- Review the 5 general topics of the therapy.
- Optimistically convey the idea that the Veteran is now almost ready to be their own therapist.
- Help the Veteran complete a Wellness Plan and a Coping Ahead plan as tools to help them maintain their gains and prevent and manage relapse.
- Process their emotional reactions to ending therapy.

Material

1. <u>Agenda & check-in</u>:

   Review the agenda shown in the manual and ask the Veteran if they agree with it or want to add/change anything. Prioritize the agenda items if necessary.

2. <u>Review:</u>

   Briefly recap the main points of the last session, or ask the Veteran to do so.

3. Review of Action Plan:
    - Briefly check-in on and reinforce the Veteran's progress working on goal steps, managing stress, and using the 3 Cs, and help them problem-solve around any obstacles.
    - Did the Veteran conduct their behavioral experiment? If so, what were the results and what are the implications for the belief they tested? Specific questions you can ask to get at the latter may include:
        - What does this outcome mean for your original belief?
        - How much do you believe that belief now, from 0-100%?
        - How much did your original predictions come true or not come true?
        - Based on how the experiment went, what is the most realistic and helpful view of the situation now?
    - Note that sometimes patients will hang on to a maladaptive or delusional belief even after a behavioral experiment disconfirms it. They might morph the original belief to adjust for the experiment's results. E.g., in the previous example of testing the belief that mail was being stolen, the person might say, "Well they knew I was testing them, so they let the letter I sent through. They're still stealing the rest." This is to be expected with firmly held delusions. Use gentle Socratic questioning to encourage the Veteran to think of a different explanation that would fit with the results of the experiment, but do not push. You may have planted seeds of doubt that you can build upon with time. And as we have stated before, you can always redirect to the recovery implications of their belief—even if they stay convinced that their mail is being stolen, how can they continue to work on their goals despite that?
    - If the Veteran did not complete the Action Plan, inquire about the reasons and help them problem-solve. Common problems with this assignment are that the Veteran forgot to do it, the experiment was too complex, or they were too frightened or anxious about conducting it. Work with the Veteran to address the obstacle (e.g., reminders, re-design the experiment) and see if they would be willing to try again, or if possible, do it with you or a friend or other loved one.

4. Reviewing what we have learned:
    - Summarize the 5 different categories of strategies for managing voices and worries that were covered during therapy, using the table in the *Veteran's Workbook* as a guide.

5. Being your own therapist: Designing a Wellness Plan and Coping Ahead Plan:
    - Here, you will prepare the Veteran for taking what they have learned in therapy into their life without your assistance, i.e., being their own therapist.
    - Remind the Veteran that there is one (or more, depending on your treatment plan) sessions left, but that you will be taking a break before getting to the final session(s).
    - Try to take an optimistic and hopeful approach here, focusing on the Veteran's strengths, what they have learned in therapy, and the improvements they have made.

- Emphasize that like any skill, these skills will require regular practice to keep sharp.
- Introduce the Wellness Plan and Coping Ahead Plan as tools to help them be their own therapist.
- See if the Veteran would be willing to share these plans with natural supports, e.g., family, friends, loved ones, or with other clinicians involved in their care (e.g., case manager, psychiatrist, recovery coach) and do what you can to help them share the plans with these people, if necessary.

6. Exercise: Complete a Wellness Plan and Coping Ahead Plan:
   - The **Wellness Plan** contains activities and strategies, drawn from the 5 categories covered in this therapy, that the Veteran should do on a regular basis to stay well. As you go through each section, remind the Veteran of the strategies covered there if necessary and ask them which were their favorite, or the most helpful. Have them write these down so they can remember to keep practicing them.
   - The **Coping Ahead Plan** is meant to help the Veteran prepare for any obstacles and problems that might come up, such as a worsening of voices/worries/paranoia or anything else that might interfere with their recovery. Have them write down each potential problem on the left and then strategies they can use from those covered in therapy to address each one, being as specific as possible.

7. Feelings about ending therapy:
   - Like ending any relationship, people often struggle with ending therapy, especially if they have formed a strong alliance with the therapist and/or the therapy has been lengthy. People with psychosis often have attachment issues that can get triggered during therapy termination, so it is important to handle it carefully and sensitively.
   - This section prompts the therapist to check-in with the Veteran on how they are feeling about therapy coming to a close. A few common reactions are listed in the manual that might make it easier for the Veteran to share, if open-ended questions are not working.
   - You can frame any reaction they are having with the ABC model. What are they feeling (e.g., scared, anxious, angry)? How is this showing up in their behavior (e.g., isolating, cancelling/coming late to session)? And what belief are they having that can explain these reactions (e.g., “Without therapy, I’ll end up in the hospital or homeless again;” “You’re leaving me just like everyone else has.”)
   - Normalize any reaction, express empathy, and ask if there is anything the Veteran has learned in CBT that could be used to help them take care of themselves right now. For example, they might apply the 3 Cs to address negative beliefs, or use Self-Compassion Break to send themselves some compassion when the difficult emotions come up. It can also be helpful to provide a warm hand-off to any referrals, provide reassurance that you will be available for future booster sessions if necessary, and/or any other support that is applicable in your work setting.

8. Tips for being your own therapist:
    - The table at the end of the session summarizes the many ways the Veteran can be their own therapist. Review it together and ask the Veteran to check their favorite ones.

9. Take-home points:

    Ask the Veteran what they learned from the session, or what they want to take from it.

10. Action plan & feedback:
    - The recommended Action Plan is for the Veteran to practice all of the relevant skills they learned in therapy, as needed, and to complete (if they didn't in the session today) and follow their Wellness Plan and Coping Ahead Plan. You can add any other items to the Action Plan that the Veteran thinks would be helpful.

Troubleshooting

- **Veteran expresses hesitation or has strong negative reactions about termination.** Usually, even Veterans who have benefited substantially from the therapy will still face some remaining challenges when it ends (e.g., voices might have gotten more manageable but are still present and at times spike; paranoia has eased but the Veteran may still have a lingering concern). This is not unusual, especially in those with chronic illness and lower levels of functioning. The Veteran may state that they are not ready to end therapy because these problems remain. CBT is an time-limited therapy with a flexible number of sessions, but typically in the range of about 16-25 (Lincoln et al. 2016). Depending on your clinic's policies, your availability, and your clinical judgment, you may extend the therapy beyond 16 sessions, but at some point, it must end. The Veteran may still have struggles, and that is to be expected and normal. After all, life is full of struggles! But hopefully by now they have shown some growth and progress that you can highlight and reinforce that, and instill hope that they are ready to manage these difficulties without your support. And, as noted above, help them process and manage their reaction using CBT methods and offer booster sessions ("tune-ups") if needed in the future, if possible. As noted above, difficult emotions can be triggered by therapy termination, including fear, anxiety, and even anger toward the therapist. These can sometimes be conceptualized as attachment reactions, in which case addressing them through an attachment lens can be helpful. The following is a list of additional methods that could ease a difficult termination:
    - Connect the Veteran's emotional response to past interpersonal experiences (e.g., rejection, trauma, loss), using your case formulation. Normalize their present experience as an "echo" of the past.
    - Disclose your own emotional reactions to ending the therapy; e.g., that it is difficult for you too.
    - Share what you have enjoyed about working with the Veteran, what traits you like most about them (e.g., their resilience, sense of humor, creativity), and how you think these will serve them well in their path toward recovery.

- Openly share signs of progress and growth you have seen in the Veteran.
- Invite family members or loved ones to this or subsequent closing sessions to ask what positive changes they have noticed in the Veteran (they will often cite things that the Veteran has not noticed), what challenges seem to remain, and to involve them in the wellness planning/coping ahead process.
- Write a letter for the Veteran summarizing the above and giving them advice for how you hope they continue to build on the work you have done together.
- Offer a small token gift (e.g., a stone or card) that will serve as a reminder of your work together, that they can look at and hold when they're having a tough time, or to recall positive emotions and memories of your relationship.

Session 16: Celebrating Your Achievements & Saying Goodbye

Objectives

This is the final formal session of the therapy, but as noted previously, you may elect to offer a few additional booster sessions after this one. The overall goal of this session is to encourage and help the Veteran implement what they have learned in therapy without your regular support, and to process their reaction to termination. Specifically, you will:

- Process their reaction to ending therapy.
- Help them reflect on what they have learned and accomplished in therapy.

Material

1. Agenda & check-in:

   Review the agenda shown in the manual and ask the Veteran if they agree with it or want to add/change anything. Prioritize the agenda items if necessary.

2. Review:

   Briefly recap the main points of the last session, or ask the Veteran to do so.

3. Review of Action Plan:
   - How was it for the Veteran to go a longer period of time without therapy?
   - Were they able to follow their Wellness Plan? Did they need to activate their Coping Ahead Plan to address any problems that came up? Provide help if any difficulties emerged; edit the plans as needed.

4. Thoughts and feelings about ending therapy:
   - Just as in the previous session, inquire about how the Veteran is feeling about ending therapy.
   - If the Veteran has had difficult reactions (like anxiety), were they able to use any CBT methods to address them (like soothing rhythm breathing)? Frame any reactions with the ABC model if possible, and help the Veteran identify CBT methods for responding to these reactions and taking care of themselves.

5. Reflecting on our time together:
   - This exercise asks the Veteran to reflect on the two most important things they have learned in CBT and the two biggest accomplishments they have made in therapy. If they are not able to identify these, you can point out what you have noticed and see if they agree. Ask them to write these down in their manual.

- Next, you will share two strengths that you recognize in the Veteran and two hopes or wishes you have for them as they move on without your support. Write these down in the Veteran's manual.
- Continue to process the Veteran's reaction to termination for the rest of the session. Try to take an optimistic and hopeful tone, again emphasizing their strengths and growth. But at the same time recognizing the challenges that remain and conveying your confidence in them for managing these on their own, with the help of referrals you might place for them. If their family or loved ones were involved in the therapy, remind them to continue to lean on them for support as well. Provide the Veteran with a list of any referrals if you haven not done so already, and if possible and relevant, explain how you will help to ensure that the transition takes place, so that they feel supported.
- Congratulate and thank the Veteran for their hard work, and ask for any feedback they have for you, as they reflect on the course of therapy.

6. Take-home points:

   Ask the Veteran what they learned from the session, or what they want to take from it.

7. Action plan & feedback:
   - The recommended Action Plan is for the Veteran to practice all of the relevant skills they learned in therapy, as needed, and to continue following their Wellness Plan and Coping Ahead Plan. You can add any other items to the Action Plan that the Veteran thinks would be helpful.

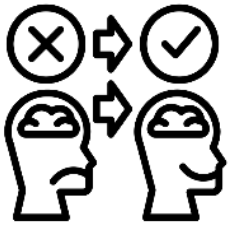
Troubleshooting

Please see the preceding session for common problems that may manifest in closing sessions.

Appendix

Cognitive Behavioral Therapy (CBT) Fact Sheet

What is CBT?



Cognitive Behavioral Therapy (CBT) is a type of talk therapy that supports peoples' mental health recovery. In CBT, a person talks to a trained therapist about worries and problems to try to understand them better, learn new, more helpful ways of making sense of them, and take action to change their life for the better. CBT works by breaking a person's problems down to their feelings, thoughts, and actions. For example, when somebody is *feeling* low, it may be because they are *thinking* badly about themselves. As a result, they might have a hard time *doing* things in their life, like their interests, goals, and relationships. CBT can help the person break out of this negative cycle and feel better by thinking and acting in new, more helpful ways.

How can CBT help me?

Many people find it helpful to talk with somebody when they have troubling experiences that make them feel depressed, anxious, scared, or confused. CBT can help by giving them a safe space to talk about these experiences and to learn ways to reduce them, cope with them better, and live the life they want. Many Veterans have completed CBT and have told us that it was a helpful tool for their recovery. CBT has been shown by research to be effective for a variety of problems including depression, anxiety, PTSD, bipolar disorder, psychosis/schizophrenia, substance use, and chronic pain.

What happens in CBT?

CBT usually starts with an assessment so that the therapist can better understand you, including your vision about what you want your life to be about, as well as the problems and obstacles that are getting in the way of achieving that. You will then work together as a team to help solve these problems and remove the obstacles. The therapy usually involves:

- Breaking down your life goals into smaller steps
- Doing activities to help you feel better, more productive, and connected to other people
- Talking about how your difficult experiences began and how they're affecting your life now
- Discussing how you are making sense of these experiences and trying out new perspectives
- Practicing new methods for reducing and coping with the difficult experiences

What kinds of things does CBT help?

CBT has been used effectively for a variety of problems, including the following:

Voices

Sometimes people can hear someone, or a number of people, speaking or shouting, but nobody else seems to hear them. "Voices" like these can be very upsetting: they may say abusive things about the person or tell them to do unpleasant things. CBT can help them better understand why these voices are happening and what to do about them. Understanding them is important in reducing the fear and anxiety they cause. CBT also teaches people a variety of techniques which can help them to better cope with the voices and maybe even to reduce them. This can give people a better sense of control over the voices, so that they can do what they want with their life and not let the voices keep them down anymore.

Worries

CBT can also help with worries that cause stress and get in the way of life; for example, when people believe they are being followed or plotted against or that someone or something is interfering with their brain or body. On the surface these worries may seem reasonable, but it could be that the worries have gotten out of proportion or things have been taken too personally. It might be possible with CBT to look at the situation differently and get a new perspective. It may be that there is a different explanation that is less upsetting and less stressful. For example, anxiety can cause all sorts of strange feelings like numbness or tingling, pain or breathing problems, but these can sometimes be misinterpreted as electric shocks or physical attacks by an outside force.

Depression and anxiety

CBT works on depression and anxiety by helping the person discover unhelpful and unbalanced ways of thinking, like thinking they are a bad person (in depression) or that terrible things are going to happen and they won't be able to handle it (in anxiety). The therapy helps them correct their thinking so that they feel better, but also encourages them to try doing things to help their mood. For example, a person with depression might schedule daily activities that give them joy and a sense of accomplishment, and someone with anxiety might practice breathing techniques to reduce their anxiety and break large, scary tasks into small steps so they're easier to accomplish.

What will I need to do?

To get the most out of CBT, you are expected to:

- Attend weekly sessions with a therapist that last about 45-50 minutes for about 16 weeks.
- Complete questionnaires at the beginning of therapy, periodically during therapy, and at the end, to see how you are doing and if the therapy is working.
- Complete between-session practice (also called "action plans" or homework) each week. This is very important, because people who practice between CBT sessions get more out of the therapy and improve faster.
- Be on time to your sessions and notify your therapist beforehand if you have to cancel or reschedule.
- Give your therapist honest feedback about how the therapy is going.

What will my therapist do?

You and your therapist will be working together as a team in CBT. Your therapist will:

- Customize the therapy so that it meets your specific needs.
- Provide the best quality CBT possible.
- Make every effort to be on time to your sessions and let you know beforehand if they have to cancel or reschedule.
- Have their work overseen by a clinical supervisor (if your therapist is a trainee).
- Give you honest feedback about how the therapy is going.

Are there any risks?

CBT is a very safe treatment. Like with any therapy, since you will be talking about difficult personal experiences, some difficult feelings may come up. Your therapist will support you through this process. Although CBT has been shown to be effective for many people, it does not work for everyone, so there is a chance that you may not benefit from it. If this happens, your therapist will suggest other treatment options with you and will offer to help connect you to them.

Do I need medication too?

Most studies which have shown CBT to be effective for things like voices and the worries described above have used it in combination with mental health medications. Sometimes people will accept medication but not CBT, and sometimes CBT but not medications—but it seems that the combination is best. There is however some new research showing that CBT can still be effective in people who refuse medications.

Dimitri Perivoliotis, Ph.D., 2021

CBTp Assessment Tracker

Veteran: _____ Start Date: _____

Date	BASIS-24 Symptoms							IMRS Functioning
	Depression & Functioning	Interpersonal Problems	Psychosis	Alcohol/Drug Use	Emotional Lability	Self-Harm	Overall	

BASIS-24: Lower scores are better; **IMRS**: Higher scores are better

Veteran's Score Tracker

Veteran: _____ Start Date: _____

BASIS-24

This questionnaire measures how you're doing with different kinds of symptoms and problems. Each symptom/problem area is scored from 0 – 4. Lower scores mean you're doing better.

Symptom/Problem Area	**Date:**	**Date:**	**Date:**	**Date:**	**Date:**	**Date:**
Depression, anxiety, and getting along with day-to-day life						
Quality of your relationships						
Voices, visions, worries, and strong beliefs						
Alcohol and drug use						
Mood swings, racing thoughts, and temper						
Thoughts about hurting yourself or suicide						
Total (0-4)						

0	1	2	3	4
No Problems				Most Serious Problems

IMRS

This questionnaire measures how you're managing your mental health and wellness and how you're doing with your recovery goals. The total score goes from 15-75 if you're taking medications or 14-70 if you're not. Higher scores mean you're doing better.

Date:						
Total Score:						

14/15	20	25	30	35	40	45	50	55	60	65	70	75
Having a Very Hard Time												Doing Great

Interpreting Measures

Behavior and Symptom Identification Scale 24 (BASIS-24)

24-item self-report measure of the Veteran's symptoms and functional difficulties, found in Mental Health Assistant. Each item is scored from 0-4. Average scores are calculated for 6 subscales and a total score. *Higher scores reflect more serious symptoms or difficulty.* Reference scores from published studies are provided below for comparison.

Table 1 displays median scores on the BASIS-24 from Cameron et al. 2007, which can be used to compare Veterans' scores. In that study, the samples were administered the BASIS-24 at two timepoints to establish its reliability and sensitivity to change; only medians from the first timepoint (baseline) are displayed.

Table 1. BASIS-24 Domains and Reference Scores

Scale	Veteran's Score	Reference Scores		
		Psychiatric Inpatients[1]	Community Mental Health[1]	General Population[1]
Depression & functioning: Daily/role functioning and depression and anxiety symptoms		3.00	2.33	0.67
Interpersonal problems: Patient's perception of the quality of their relationships		2.20	1.80	0.60
Psychotic symptoms: Grandiose delusions, auditory and visual hallucinations, paranoia		1.25	0.50	0
Alcohol/drug use: Urges to drink or use drugs and problems stemming from use		0.75	0.25	0
Emotional lability: Mood swings, racing thoughts, and feeling short-tempered		2.17	1.33	1.33
Self-harm: Suicidal ideation		1.50	0	0
Total score Average of all items		2.08	1.45	0.54

[1] Average BASIS-24 scores from 331 psychiatric inpatients (28% with psychotic disorders), 165 outpatients from community mental health centers (mostly mood disorders, 3% with psychotic disorders), and 630 people from the general population, baseline data only (Cameron et al., 2007).

Table 2 displays BASIS-24 total scores for the inpatient and general population samples from Cameron et al. 2007, along with their corresponding percentile scores; this table can be used for comparison purposes when administering the BASIS-24 to inpatients.

Table 2. BASIS-24 Total Score Normative Data for Inpatients vs General Population (from Cameron et al., 2007)

Percentile[2]	Inpatient Sample	General Population Sample	Percentile[2]	Inpatient Sample	General Population Sample
1	0.29	0.00	**33**	1.42	0.36
2	0.36	0.04	**34**	1.43	0.38
3	0.41	0.04	**35**	1.45	0.38
4	0.50	0.04	**36**	1.46	0.42
5	0.54	0.08	**37**	1.48	0.42
6	0.57	0.08	**38**	1.50	0.42
7	0.65	0.10	**39**	1.52	0.43
8	0.70	0.13	**40**	1.54	0.43
9	0.74	0.13	**41**	1.57	0.43
10	0.75	0.17	**42**	1.58	0.46
11	0.79	0.17	**43**	1.61	0.46
12	0.83	0.17	**44**	1.61	0.48
13	0.88	0.17	**45**	1.63	0.48
14	0.92	0.21	**46**	1.65	0.48
15	0.96	0.21	**47**	1.67	0.50
16	0.96	0.21	**48**	1.71	0.52
17	1.00	0.21	**49**	1.74	0.52
18	1.04	0.25	**50**	1.74	0.52
19	1.08	0.25	**51**	1.75	0.54
20	1.13	0.25	**52**	1.78	0.58
21	1.13	0.25	**53**	1.79	0.58
22	1.17	0.29	**54**	1.82	0.58
23	1.21	0.29	**55**	1.83	0.63
24	1.21	0.29	**56**	1.88	0.63
25	1.25	0.29	**57**	1.91	0.63
26	1.25	0.30	**58**	1.92	0.63
27	1.27	0.30	**59**	1.96	0.67
28	1.29	0.30	**60**	1.96	0.67
29	1.30	0.30	**61**	2.00	0.67
30	1.33	0.33	**62**	2.00	0.71
31	1.35	0.33	**63**	2.04	0.71
32	1.41	0.36	**64**	2.04	0.71

Percentile[2]	Inpatient Sample	General Population Sample	Percentile[2]	Inpatient Sample	General Population Sample
65	2.08	0.74	**84**	2.50	1.08
66	2.08	0.74	**85**	2.54	1.09
67	2.13	0.75	**86**	2.60	1.13
68	2.14	0.75	**87**	2.63	1.17
69	2.17	0.78	**88**	2.68	1.21
70	2.17	0.78	**89**	2.74	1.25
71	2.21	0.79	**90**	2.75	1.29
72	2.21	0.83	**91**	2.82	1.33
73	2.22	0.83	**92**	2.86	1.33
74	2.25	0.87	**93**	2.89	1.46
75	2.27	0.87	**94**	2.92	1.54
76	2.29	0.88	**95**	3.00	1.63
77	2.30	0.91	**96**	3.09	1.75
78	2.33	0.92	**97**	3.17	2.00
79	2.38	0.96	**98**	3.25	2.17
80	2.39	1.00	**99**	3.30	2.50
81	2.43	1.00	**>99**	3.46	2.88
82	2.46	1.04			
83	2.48	1.04			

[2] **Percentile scores** = Percentage of people in the comparison group of the reference study (inpatient sample or general population sample from Cameron et al. 2007) with a score lower than the patient completing the measure. E.g., an inpatient scoring 2.13 on the BASIS-24 would be at the 67th percentile, meaning 67% of inpatients in the reference study scored lower (better) than him/her and 33% scored higher (worse).

Illness Management & Recovery Scale – Consumer Version (IMRS)

15-item self-report measure of the Veteran's perceived ability to manage their illness and pursue their recovery goals, found in Mental Health Assistant as IMRS. Many of the items refer to the period of the past 3 months. Items are rated on a 1-5 scale. If all items are completed, the range is 15 – 75. If the Veteran is not taking meds and skips item 13, the range is 14 – 70. *Higher scores indicating better functioning.* Norms are not available but reference scores from published studies are provided in Table 3 below for comparison.

Table 3. IMRS Reference Scores

	Veteran's Score	Reference Scores		
		Day Treatment SMI[1]	ACT teams SMI[2]	Assorted community SMI[3]
Total score (sum of all items)		54.0	50.4	51.0 – 52.5

[1] 57 people with SMI in American outpatient day treatment program; 90% schizophrenia-spectrum disorders, 10% mood disorders. Baseline data only, estimated from item means. (Salyers et al., 2007)

[2] 101 people with serious mental illness (81% psychotic disorders) in American high-fidelity assertive community treatment teams. Baseline data only. (Monroe-DeVita et al., 2018).

[3] 197 people with unspecified severe mental illness in 6 assorted American community mental health center settings (clubhouses, day treatment, case management, assertive community treatment teams). Baseline data only, estimated from item means. (Salyers et al., 2009)

Additional Possible Measures

The following measures are not available on Mental Health Assistant but may be used in CBTp to assess the Veteran's voices and paranoia in more detail, if indicated.

Beliefs About Voices Questionnaire-Revised (BAVQ-R) (Chadwick et al., 2000; Strauss et al., 2018): A 29-item self-report measure of patients' beliefs, emotions and behavior about auditory hallucinations. It can be administered in a conversational manner during therapy sessions to learn more about the Veteran's relationship with their voices.

Revised Green et al. Paranoid Thoughts Scale (R-GPTS) (Green et al., 2008; Freeman et al., 2019): An 18-item self-report measure or paranoia. Severity cutoff scores are provided.

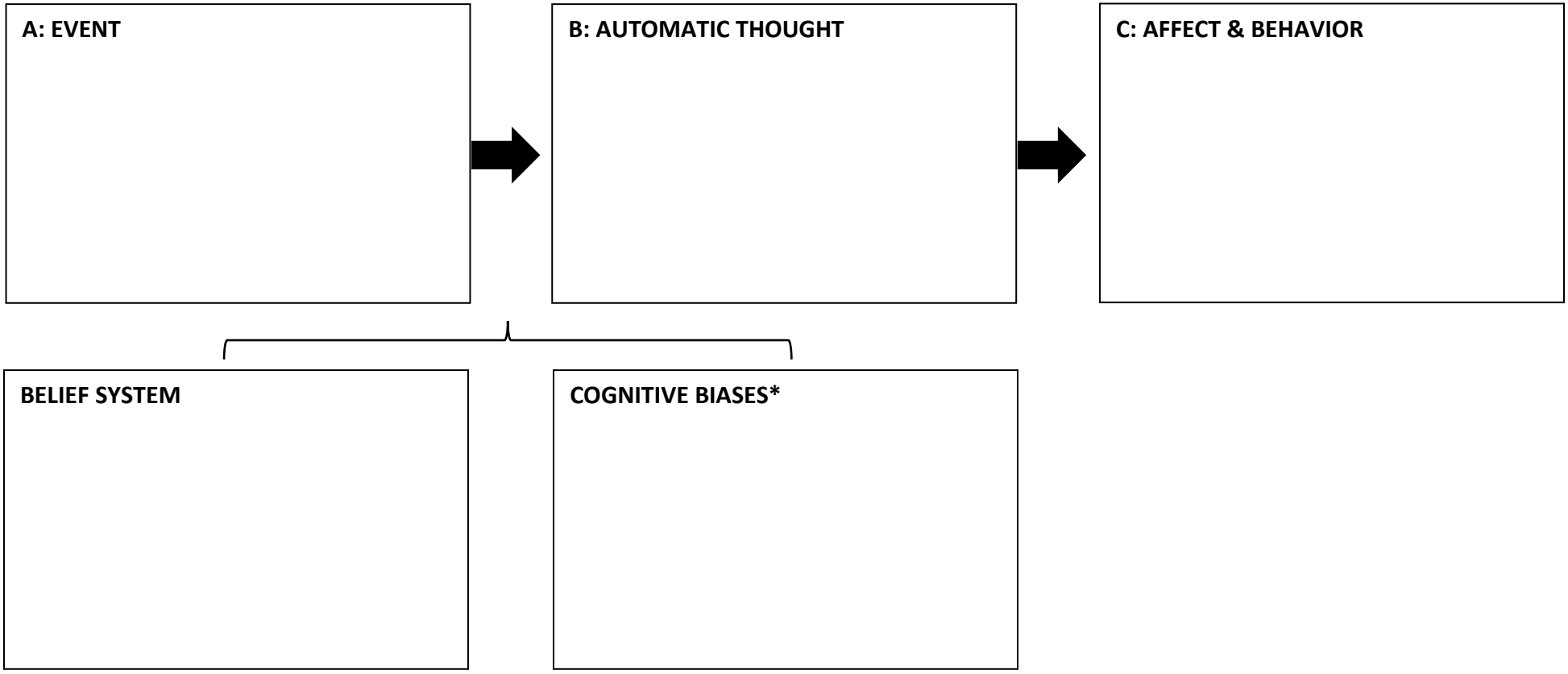
These measures, along with a spreadsheet that can be used to automatically score them, can be accessed by double-clicking the icons below.


Beliefs about Voices Quest. (BAVQ


Revised Green et al. Paranoid Thoughts

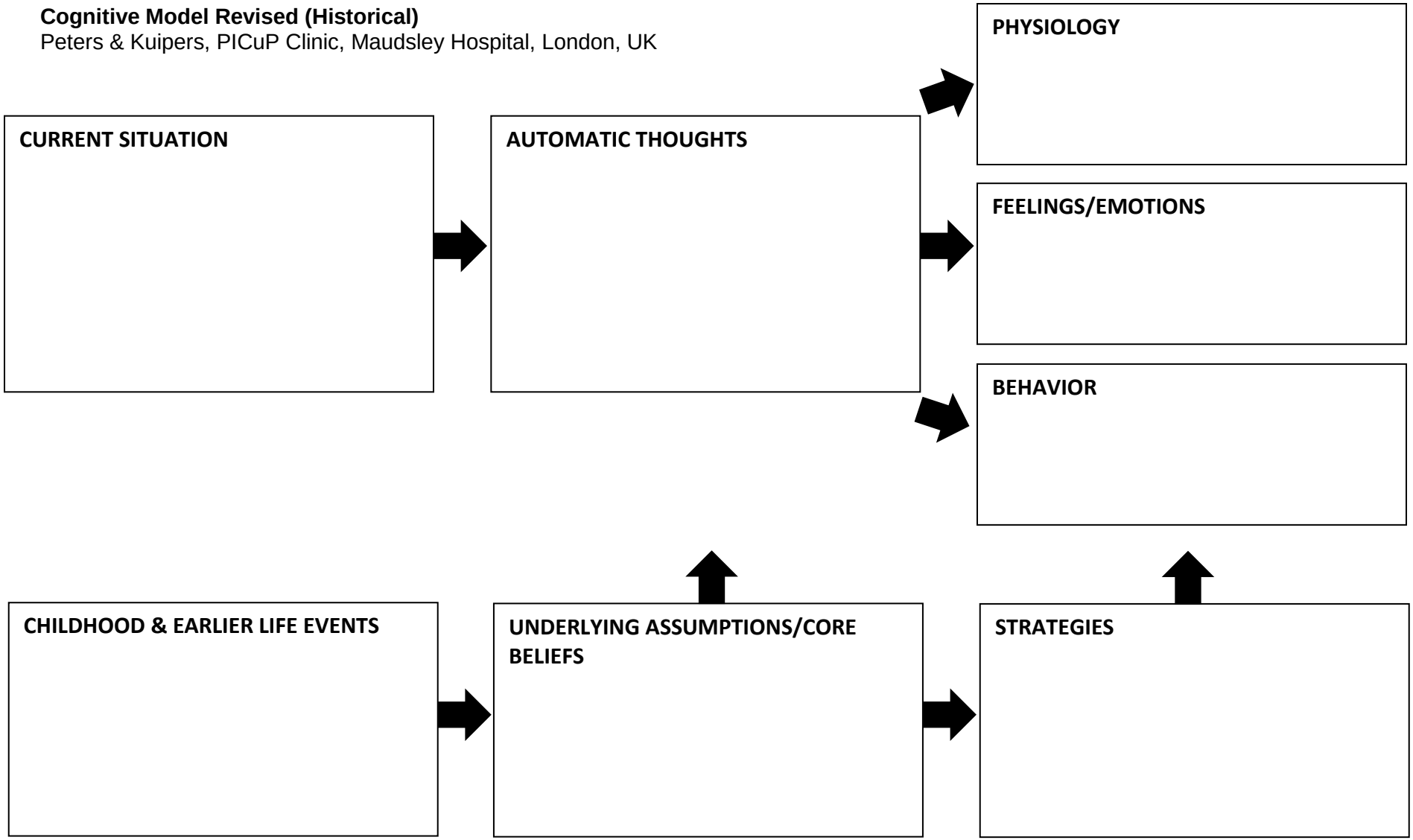

R-BAVQ & R-GPTS Scorer.xlsx

ABC of the Belief

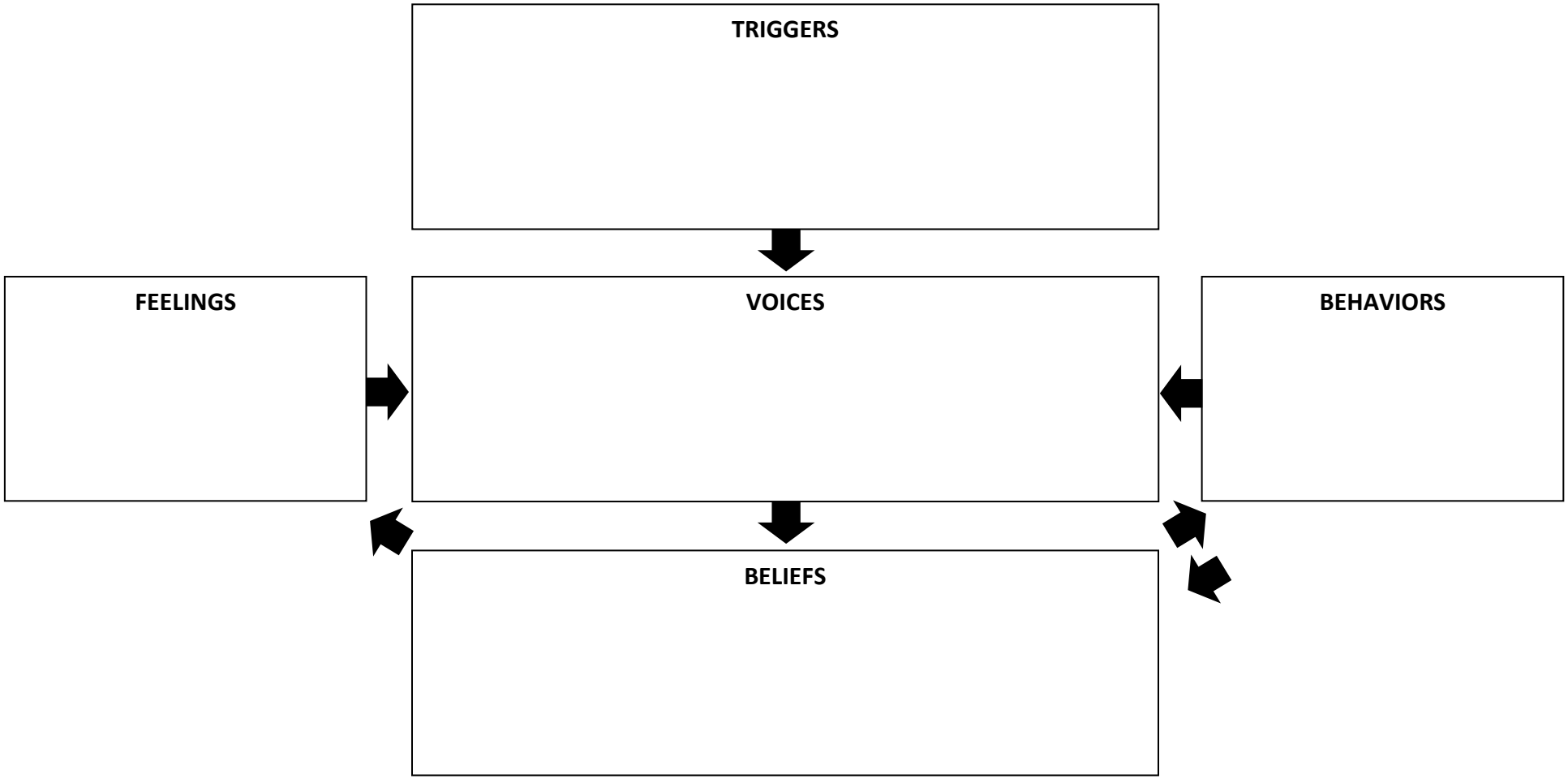


***Cognitive Biases:** Jumping to conclusions, all-or-nothing thinking, mind reading, fortune telling, emotional reasoning, personalizing, intentionalizing, selective abstraction, discounting the positive

Cognitive Model Revised (Historical)
Peters & Kuipers, PICuP Clinic, Maudsley Hospital, London, UK



Formulation of the Maintenance of Voices



Sample Progress Note Template

Clinic: ____
Visit type: Individual Psychotherapy
Provider: ____
Visit Date & Time: |TODAY'S DATE| @ ____
Visit Duration (minutes): __

Type of Psychotherapy: Cognitive Behavioral Therapy for Psychosis (CBTp)
Session #: __

S:

Veteran attended a session of CBTp, an evidence-based practice. The goals of this psychotherapy are to teach Veterans skills to manage psychosis, reduce the distress associated with it, take steps toward their recovery goals, and improve functioning. The manual "Cognitive Behavioral Therapy for Voices and Worries: Veteran's Workbook" was followed. The following occurred in this session:

<u>Manual Session 1: Introduction to CBT</u>
_ Explained structure of sessions
_ Discussed Veteran's reaction to starting therapy
_ Explained what CBT is and introduced the cognitive model
_ Explained typical structure of sessions
_ Provided psychoeducation about voices and worries
_ Discussed Veteran's intention for therapy
_ Action Plan: Veteran agreed to complete measures and write down goals for therapy

<u>Manual Session 2: A Closer Look at Voices & Worries</u>
_ Reviewed action plan from last session
_ Discussed impact of psychosis on Veteran's life
_ Provided overview of strategies that will be covered in CBTp
_ Action Plan: Veteran agreed to write 3 ways their life might be better if they learned to manage psychosis and 3 things that may interfere with doing so

<u>Manual Session 3: Managing Voices & Worries</u>
_ Reviewed action plan from last session
_ Discussed vulnerability factors/triggers and protective factors for psychosis
_ Reviewed first person accounts of famous/successful people with psychosis
_ Action Plan: Veteran agreed to write about their own triggers and protective factors/effective coping strategies for psychosis

<u>Manual Session 4: The Healing Power of Goals</u>
_ Reviewed action plan from last session
_ Reviewed homework from last session
_ Provided education about the importance and therapeutic potential of setting personal goals
_ Explained the SMART goal process
_ Helped Veteran begin to design a Recovery Plan containing their own goals and goal steps
_ Action Plan: Veteran agreed to take one small step toward one of their goals

<u>Manual Session 5: Stress Reduction & Relaxation</u>
_ Reviewed action plan from last session
_ Provided education about relationship between stress and psychosis
_ Discussed Veteran's current stress reduction/relaxation strategies
_ Introduced and practiced following techniques: Soothing rhythm breathing; Progressive muscle relaxation; loving kindness meditation; self-compassion break

_ Action Plan: Veteran agreed to take at least 1 step toward their goals, practice stress reduction techniques daily, and track any changes in their psychosis

Manual Session 6: Social Activities & Support
_ Reviewed action plan from last session
_ Discussed pros and cons of socializing
_ Provided education about relationship between social isolation and psychosis
_ Brainstormed on ways Veteran can increase social support and socialization
_ Reviewed several sources of support in the community (e.g., NAMI, Hearing Voices Network, AA/NA)
_ Action Plan: Veteran agreed to take at least 1 step toward their goals and engage in one social activity and track its outcomes

Manual Session 7: Taking Power Away from Voices & Worries
_ Reviewed action plan from last session
_ Provided education about ways of responding to voices and worries
_ Provided education on refocusing techniques as a way to cope with voices and worries
_ Introduced the Look Point Name Game and practiced it with Veteran
_ Action Plan: Veteran agreed to practice refocusing techniques daily, track their impact on voices/worries, and keep practicing strategies covered in previous sessions

Manual Session 8: Thoughts & Feelings
_ Reviewed action plan from last session
_ Introduced the ABC model of CBT
_ Provided education on what feelings are
_ Provided education on what beliefs are
_ Explained how feelings and beliefs are different
_ Action Plan: Veteran agreed to log feelings and beliefs they have until next session and keep practicing strategies covered in previous sessions

Manual Session 9: How Beliefs Affect Feelings & Actions
_ Reviewed action plan from last session
_ Explained how beliefs affect feelings and actions
_ Guided Veteran through exercises to practice identifying link between beliefs, feelings, and actions
_ Discussed how our belief systems and past experiences influence our thinking
_ Action Plan: Veteran agreed to practice applying the ABC method to their own personal situations and keep practicing strategies covered in previous sessions

Manual Session 10: Catching Thoughts
_ Reviewed action plan from last session
_ Introduced 3 Cs method for managing thinking
_ Explained the 1st C, “Catch it,” and thoughts the Veteran typically has about voices and worries
_ Explained 4 situations in which using the 3Cs can be helpful
_ Guided Veteran in completing an exercise to practice the Catch it skill
_ Action Plan: Veteran agreed to practice catching thoughts and keep practicing strategies covered in previous sessions

Manual Session 11: Checking Thoughts
_ Reviewed action plan from last session
_ Explained the 2nd C of the 3Cs method of managing thinking, “Check it”
_ Discussed common thinking habits and helped Veteran complete a practice exercise about them
_ Reviewed examples of completing Catch it and Check it when experiencing voices or suspicion
_ Guided Veteran in completing an exercise to practice the Catch it and Check it skills
_ Action Plan: Veteran agreed to practice catching and checking thoughts and keep practicing strategies covered in previous sessions

Manual Session 12: Changing Thoughts & Avoiding Jumping to Conclusions

_ Reviewed action plan from last session
_ Discussed the Jumping to Conclusions (JTC) thinking habit
_ Discussed method of avoiding JTC by looking for alternative explanations
_ Guided Veteran in completing an exercise to practice generating alternative explanations
_ Introduced the 3rd C of the 3Cs method of managing thinking, "Change it"
_ Guided Veteran in completing an exercise to practice the 3 Cs
_ Action Plan: Veteran agreed to practice the 3Cs in situations involving voices/worries and keep practicing strategies covered in previous sessions

Manual Session 13: Being Your Own Detective
_ Reviewed action plan from last session
_ Introduced method of avoiding Jumping to Conclusions (JTC) by choosing the most likely explanation
_ Guided Veteran in completing an exercise to practice selecting the most likely explanation
_ Action Plan: Veteran agreed to practice the 3Cs in situations involving voices/worries and keep practicing strategies covered in previous sessions

Manual Session 14: Being Your Own Scientist
_ Reviewed action plan from last session
_ Introduced method of testing beliefs with (behavioral) experiments; i.e., "being your own scientist"
_ Guided Veteran in completing an exercise to practice designing experiments to test beliefs
_ Helped Veteran design an experiment to test a belief they have about voices or worries
_ Action Plan: Veteran agreed to complete the experiment designed in session, track the outcomes, and keep practicing strategies covered in previous sessions

Manual Session 15: Putting it All Together and Planning for the Future
_ Reviewed action plan from last session
_ Reviewed the 5 main strategies for managing voices and worries that were covered in this course of CBT
_ Introduced the Wellness Plan and Coping Ahead Plan as tools to help Veteran become their own therapist
_ Helped Veteran to begin designing their Wellness Plan
_ Helped Veteran to begin designing their Coping Ahead Plan
_ Processed Veteran's thoughts and feelings about ending therapy
_ Reviewed suggested tips to help Veteran be their own therapist
_ Action Plan: Veteran agreed to complete and follow their Wellness Plan and Coping Ahead Plan, and keep practicing strategies covered in previous sessions
_ Planned for timing of final session

Manual Session 16: Celebrating Your Achievements and Saying Goodbye
_ Reviewed action plan from last session
_ Processed Veteran's thoughts and feelings about ending therapy
_ Helped Veteran identify what they learned in CBT, what accomplishments they've made, what strengths their therapist sees in them, and what hopes or wishes their therapist has for them
_ Advised Veteran to keep practicing techniques covered in this therapy, including working toward their recovery goals and following their Wellness Plan and Coping Ahead Plan
_ Planned for any booster session(s), if applicable

O:

Alertness: [] Alert [] Drowsy [] Lethargic [] Stuporous
Eye Contact: [] Good [] Poor [] Variable [] Not observable
Attitude: [] Cooperative [] Other:
Mood: [] Euthymic [] Irritable [] Elevated [] Anxious [] Depressed
Affect: [] Full [] Constricted [] Flat [] Appropriate [] Inappropriate [] Labile [] Not observable
Speech: [] WNL [] Rapid [] Slow [] Slurred [] Impoverished [] Incoherent [] Other:
Thought Process: [] Clear & coherent [] Goal-directed [] Tangential [] Circumstantial [] Other:

Thought Content: [] WNL [] Ideas of reference [] Obsessions
Delusions: [] None Reported [] Paranoid [] Control [] Somatic [] Thought insertion [] Grandiose [] Referential [] Bizarre [] Erotomanic
Hallucinations: [] None reported [] Auditory [] Visual [] Tactile [] Olfactory [] Gustatory
Memory/Concentration: [] Grossly intact [] Inattentive [] Other:
Insight: [] Good [] Fair [] Poor
Judgment: [] Good [] Fair [] Poor

SUICIDAL IDEATION:
[] When directly asked, Veteran denied SI.
[] When directly asked, Veteran reported SI. ____
[] No indication of SI. Direct assessment was not clinically indicated, as ____

[] Veteran was provided with the Veterans' Crisis Line number (800-273-8255, press 1) and other crisis resources (VA ED, 911).

HOMICIDAL IDEATION:
[] When directly asked, Veteran denied HI.
[] When directly asked, Veteran reported HI.
[] No indication of HI.

A:

Veteran completed the following self-report measures. Scores were discussed in relation to the Veteran's individual goals and objectives for recovery.

Behavior & Symptom Identification Scale 24 (BASIS-24; all subscales & total score range from 0-4; lower = less severe symptoms/difficulty):
Depression & functioning: __
Interpersonal Problems: __
Psychotic Symptoms: __
Alcohol/Drug Use: __
Emotional Lability: __
Self-Harm: __
Total Score: __

Illness Management & Recovery Scale – Consumer Version (IMRS) total score: __ (ranges from 14-75; higher = better functioning/recovery)

Previous Scores:
….

DSM-5 DIAGNOSES (PER CHART):

|ACTIVE PROBLEMS|

P:

Veteran will return to clinic for continued CBTp, on __.

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Graphics

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