**Cognitive Behavioral Therapy for Psychosis (CBTp)**

***What is the practice?***

Cognitive Behavioral Therapy for psychosis (CBTp) is a time-limited, solutions-focused, structured form of talk therapy that is indicated for individuals who experience distress or impairment related to psychotic or psychotic-like experiences (SAMHSA, 2021). CBTp is rooted in each individual’s personal recovery goals. Together with a therapist, individuals identify obstacles to those goals, with a specific and intentional focus on goal-interfering thoughts, feelings, and behaviors.

Framing psychotic and psychotic-like experiences as common, understandable, and treatable, CBTp aims to work collaboratively with clients to reduce distress, identify personally meaningful goals, and promote personal agency in one’s own recovery.

***What outcomes does this practice produce?***

CBTp has been found to be helpful in relieving psychotic and mood symptoms, reducing the risk or length of hospitalization, improving medication consistency, and maintaining treatment gains after the therapy ends. Effect sizes for CBTp on delusions and hallucinations tend to be similar to antipsychotic medications (McDonagh et al., 2017). This means that CBTp can and should be used alongside medication and preferably within the context of multidisciplinary care (APA, 2020; McDonagh et al., 2020).

***What is the evidence for this practice?***

CBTp has amassed more than 30 years of empirical evidence. The effectiveness and efficacy of CBTp have been examined across the illness spectrum, care continuum, therapeutic modalities, specific symptoms, and subpopulations (McDonagh et al., 2021; Turner et al., 2020; van der Gaag et al., 2013; Wykes et al., 2008). Findings generally support that CBTp helps individuals manage common psychotic symptoms, like **hallucinations** (perceptual disturbances), **delusions** (strongly held beliefs that are inconsistent with prevailing beliefs within the individual’s cultural groups and are resistant to disconfirmation), and **negative symptoms** (challenges with motivation and emotional expression). In addition, CBTp can provide relief from **depressed** and a**nxious mood states**, improve **sleep** and **activity** cycles, and support efforts to take **medications** regularly.

***How is this practice implemented?***

***In what contexts is this practice implemented (e.g., schools, clinical)?***In 2021, SAMHSA published a guide entitled ***Routine Administration of Cognitive Behavioral Therapy for Psychosis as the Standard of Care for Individuals Seeking Treatment for Psychosis: State of the Science and Implementation Considerations for Key Stakeholders***. In this document, SAMHSA advises that “CBTp should be implemented within our mental health systems, and CBTp-informed care at a minimum should be implemented in primary care, correctional and forensic settings, and educational settings” (SAMHSA, 2021,[[1]](#footnote-2)p6). Ideally, CBTp should be accessible across the care continuum and wherever individuals experiencing psychosis are served.

***What is the dosage of this practice (e.g., one-time training, six-week curriculum)?***  
Although there is a wide range of dosages for CBTp in clinical practice, CBTp is preferably administered in weekly 50-minute sessions over the course of 25 sessions (Lincoln, Jung, Wiesjahn, & Schlier, 2016). There is also strong evidence for symptom-specific protocols, which can often be conducted over a shorter duration (Lincoln, 2019).

***How is the practice delivered (e.g., online, in-person)?***   
Traditionally, CBTp has been conducted in-person in an office, on an inpatient unit, or out in the community. Recently, [CBTp has been delivered via telehealth](https://mhttcnetwork.org/centers/northwest-mhttc/product/clinical-innovations-telehealth-learning-series-telehealth-and) in both individual and group formats. In addition, smartphone applications that incorporate CBTp skills and concepts are increasingly available. To-date, only a handful of these mobile apps have been empirically tested. Users are encouraged to inquire with their mental health team about evidence-based digital health interventions that can support their care.

***What infrastructure or readiness is needed to implement this practice (e.g., capacity for data analysis, individual full-time equivalent [FTE])?***  
The resources needed to deliver CBTp depend on the needs of the implementation setting. For instance, a psychosis specialty care team that serves a small census of patients with psychotic spectrum disorders may only need one or two trained mental health professionals to meet their needs. A large healthcare organization that serves inpatient, outpatient, and specialty care teams with a large census of qualifying patients may benefit from a CBTp stepped care service delivery model (Kopelovich et al., 2019; 2023). Stepped care service delivery models have been advanced as a means of addressing limited accessibility to treatments by providing the least intensive treatment indicated for a patient’s mental health needs and to monitor and adjust treatment as indicated by the client’s response.

Operationally, embedding CBTp within an organization requires thoughtful consideration of the referral and care pathways, how response to treatment will be dynamically assessed, reimbursement, care coordination with other service providers, and how to ensure that therapists can deliver the treatment as intended. In particular, adequate training and follow-along supervision and/or consultation are needed for practitioners to effectively provide CBTp. Culturally, CBTp is most suitable to Recovery-Oriented Systems of Care. As such, organizations that have adopted a recovery-advancing mission, vision, and culture will be well-poised to support CBTp services, which seek to empower clients, incorporate families, and prioritize the needs, preferences, strengths, and resources of the client.

***For which population(s) can this practice be implemented?***

***For which population(s) is this best or promising practice (BPP) intended? Has it been adapted for diverse groups? If so, which ones? For which populations is there evidence of effectiveness? With which specific populations has this practice been successfully implemented?***   
Although Cognitive Behavioral Therapy originated in the United States, it was first adapted for psychosis in the United Kingdom in the early 1990s. It has since been implemented in diverse countries and clinical settings. Cultural adaptations have helped to further personalize the intervention to the unique needs and preferences of individuals from different ethnocultural groups.

CBTp is helpful for individuals who are at high risk of developing psychosis, within an early phase of a psychotic disorder, or at later stages. In fact, some studies support the effectiveness of CBTp among individuals with medication-resistant psychosis, although individuals may require a longer course of treatment (McDonagh et al., 2021; Valmaggia et al., 2008).

***For which populations, if any, is this practice NOT a good fit?***Research suggests that individual characteristics, including severity of psychotic symptoms, do not significantly influence treatment outcomes (Turner et al., 2020). That said, CBTp requires that clients and clinicians are actively collaborating throughout CBTp. For that reason, individuals who experience psychosis but who are not ready, willing, or able to participate in talk therapy may wish to meet first with a practitioner who can help them explore areas of their life where assistance is preferred. For instance, clients with unmet housing needs or who are experiencing [severe formal thought disorder](https://www.hopkinsguides.com/hopkins/view/Johns_Hopkins_Psychiatry_Guide/787025/all/Thought_Disorder) will benefit from addressing these needs prior to embarking on weekly CBTp sessions. In addition, CBTp will facilitate examination of clients’ thoughts, feelings, and behaviors. Some clients with intellectual disability, neurocognitive impairments, or developmental disabilities may have difficulty with the learning, rehearsal, and retention required of CBTp. In these cases, clients may benefit from Cognitive Adaptation Training, which is a treatment designed to help individuals with psychotic disorders to compensate for cognitive deficits and improve key areas of functioning. Finally, individuals considering CBTp should be able to invest the time and energy in their CBTp treatment. This includes both weekly sessions and practicing skills and concepts between sessions.

***Who can implement this practice?***

***What expertise is needed to implement the practice?***

CBTp is ideally delivered by a licensed Doctoral- or Masters-level mental health professional (i.e., MD, PhD, PsyD, LICSW, LMHC) who has received general training in Cognitive Behavioral Therapy as well as specialized training in CBTp. That is because practitioners who are competent in CBTp must also be able to demonstrate competence in generic psychotherapy skills as well as competence in general CBT for common disorders of mood and anxiety.

Over the years, different CBTp protocols and delivery methods have been developed and tested that enable non-therapists to deliver CBTp group therapy, CBTp-informed care, brief and symptom-specific CBTp protocols, and to support guided CBTp self-help. Therefore, CBTp has evolved to become an expansive set of psychotherapeutic interventions that can be supported by a range of behavioral health and allied practitioners.

Clients with complex presentations or who present with significant risk factors for harm to themselves or others should ideally be referred to a CBTp expert therapist who has undergone extensive training in CBT and risk management practices.

The North American CBT for Psychosis Network (NACBTpN) published CBTp competence standards for both high-fidelity CBTp as well as for CBTp-informed care. These can be accessed from their website: <https://www.nacbtp.org/resources>

***What specific training or certification is required to implement the practice?***

Training to competence in CBTp or CBTp-informed care requires more than didactic training. Providers offering CBTp have engaged in training, supervision, and/or consultation to acquire in-depth knowledge of cognitive behavioral techniques for psychosis, have learned how to deliver these skills competently to a range of clients experiencing psychosis, and regularly engage self-reflective practices to ensure both ethical and effective treatment delivery. In addition to multimodal didactic training, skill development approaches including role play with peers, live and video-based demonstrations, and opportunities for practice and proximal feedback should be incorporated into the training program.

CBTp training should be facilitated by a qualified entity (i.e., Intermediary/Purveyor Organizations (IPOs) and/or experienced, independent trainers). IPOs actively work to implement a practice with fidelity and good effect; whereas intermediaries develop, implement, and support multiple best practice programs or services, and build capacity within an organization to sustain such programs (Proctor et al., 2009). Agencies that are interested in implementing CBTp are directed to Section 5 of the Position Statement on the Routine Administration of CBT for Psychosis, published by the [National Association of State Mental Health Program Directors](https://www.nasmhpd.org/sites/default/files/CBTp_Position_Statement_NASMHPD.pdf) (Kopelovich, Basco-Ramirez, Stacy, & Sivec, 2021).

***What costs are associated with delivering this practice?***

The costs associated with delivering CBTp depend on several factors. The most common costs associated with delivering CBTp come from training staff, paying staff salaries, reserving space for sessions, and miscellaneous materials. Multiple independent international studies and meta-analyses have demonstrated that administering CBTp is cost-comparable to administering standard care while yielding improved results for patients (Konings et al., 2022, Shields et al., 2019, van der Gaag et al., 2011). Cost-analyses conducted in North America have also found CBTp to be cost-effective (Health Quality Ontario, 2018, Washington State Institute for Public Policy, 2019). A recent analysis in Washington State concluded that the net cost of CBTp was $1,532; benefits minus net costs were estimated at $13,586 per participant (2018 US dollars; WSIPP, 2019).

***What costs and commitments are associated with becoming trained in this practice?***

***What is the cost associated with becoming trained?***

Costs associated with CBTp training vary depending on the intensity and scope of the training. Training practitioners to competence requires a financial commitment that can enable a breadth of training activities, including workshop training, longitudinal case-based consultation, and performance-based feedback. Training that is part of a broader effort to implement CBTp within a practice setting will be more time- and cost-intensive but will aim to embed CBTp services within the care setting. Once implemented, the training and technical assistance required should be gradually reduced over a period of 1-3 years.

For those who are interested in an introductory training, both the Northwest MHTTC ([Cognitive Behavioral Therapy for Psychosis {CBTp} ePrimer](https://mhttcnetwork.org/centers/northwest-mhttc/product/cognitive-behavioral-therapy-psychosis-cbtp-eprimer)) and SMI Adviser ([What is Cognitive-Behavioral Therapy for Psychosis {CBTp})](https://smiadviser.org/knowledge_post/what-is-cognitive-behavioral-therapy-for-psychosis-cbtp) offer free informational trainings.

***What is the time commitment associated with completing training?***  
Based on a recent point prevalence estimate (Kopelovich, 2022), the mean CBTp training workshop in the U.S. and Canada is 2.5 days. Some CBTp trainers require the CBTp e-Primer or another CBTp online distance learning course as a prerequisite to participating in a CBTp workshop. These online courses can range from 1 to 36 hours. Finally, many trainers also require longitudinal consultation or supervision, which can range from weeks to 1-2 years.

***Are there recognized providers of training in this practice?***

Trainings are offered both virtually and in-person by trainers across the U.S. and Canada. A list of training offerings can be found on the North America CBT for Psychosis Network website: <https://www.nacbtp.org/trainings>

In addition, the [Northwest MHTTC](https://mhttcnetwork.org/centers/northwest-mhttc/) offers CBTp as an evidence-based practice (EBP) for psychosis, which is that center’s area of focus for the [MHTTC Network](https://mhttcnetwork.org/centers/global-mhttc/mhttc-areas-focus). Organizations interested in CBTp training or implementation may contact the North America CBT for Psychosis Network at membership@nacbtp.org.  
 offers CBTp as an evidence-based practice (EBP) for psychosis, which is that center’s area of focus for the [MHTTC Network](https://mhttcnetwork.org/centers/global-mhttc/mhttc-areas-focus). Organizations interested in CBTp training or implementation may contact the North America CBT for Psychosis Network at membership@nacbtp.org.

***Does the practice have an associated fidelity assessment?***

Fidelity assessment is a structured form of feedback regarding a clinician’s adherence to CBTp principles and protocols as well as their CBTp competencies. CBTp fidelity reviews, in which a CBTp trainer provides scores and written feedback on a CBTp session using a psychometrically-validated rating scale, is considered by most to be the gold standard fidelity assessment. Alternate forms of fidelity assessment, such as a structured behavioral rehearsal with simulated patients, are also emerging as valid and reliable fidelity assessment options. Most CBTp trainers in the U.S. require that clinicians who are learning to deliver CBTp receive at least one CBTp fidelity review during their initial training (Kopelovich et al., 2022). CBTp therapists are encouraged to receive regular fidelity reviews thereafter to support high-quality CBTp delivery over time.

***What resources or references are useful for understanding/implementing the practice? Where should you go for more information?***

* New learners are encouraged to complete the 3-hour self-guided e-Primer on CBTp produced by the Northwest MHTTC: <https://mhttcnetwork.org/centers/northwest-mhttc/product/cognitive-behavioral-therapy-psychosis-cbtp-eprimer>
* North America CBT for Psychosis Network is a professional network of practitioners, students, researchers, and trainers invested in enhancing access to CBTp in North America: <https://www.nacbtp.org>
* The University of Washington, Stanford University, Northeast Ohio Medical University each offer a range of CBTp training and implementation options:
  + <https://uwspiritlab.org/cognitive-behavioral-therapy-for-psychosis-cbtp/>
  + <https://med.stanford.edu/psychiatry/education/training/cbtp.html>
  + <https://www.neomed.edu/bestcenter/practices/cognitive-behavioral/>
* Administrators are encouraged to review the [SAMHSA (2021)](https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-03-09-001.pdf) and [NASMHPD (2021)](https://www.nasmhpd.org/sites/default/files/CBTp_Position_Statement_NASMHPD.pdf) for guidance on the value of implementing CBTp, laying the groundwork for practice transformation, empirically-supported approaches to CBTp training, and policy considerations.

***References***

American Psychiatric Association (2020). Practice Guideline for the Treatment of Patients with Schizophrenia, Third Edition. <https://doi.org/10.1176/appi.books.9780890424841>

Hardy, K., Meyer-Kalos, P., Adams, C., Elliott-Remes, R., & Gingerich, S. (2021). Brief report describing the integration of two psychotherapy evidence-based practices within coordinated specialty care services for early psychosis. *Psychological Services,* 18(2), 164.

Health Quality Ontario. Cognitive Behavioural Therapy for Psychosis: A Health Technology Assessment. Ont. Health Technol. Assess. Ser. 18, 1–141 (2018)

Konings, S., Berkhof, M., Visser, E., Mierau, J.O., Feenstra, T., Bruggeman, R. EE678 Cost Effectiveness of Cognitive Behavioural Therapy for Psychosis Through Reduced Hospitalisation, Value in Health, Volume 25, Issue 12, Supplement, 2022, Page S190, ISSN 1098-3015, https://doi.org/10.1016/j.jval.2022.09.917.

Kopelovich, S. L., Strachan, E., Sivec, H., & Kreider, V. (2019). Stepped Care as an Implementation and Service Delivery Model for Cognitive Behavioral Therapy for Psychosis. *Community Mental Health Journal*, *55*(5), 755–767. <https://doi.org/10.1007/s10597-018-00365-6>

Kopelovich, S. L., Basco, M., Stacy, M., & Sivec, H. (2021). Position statement on the routine administration of cognitive behavioral therapy for psychosis as the standard of care for individuals seeking treatment for psychosis. ***National Association of State Mental Health Program Directors (NASMHPD) Publications.*** <https://www.nasmhpd.org/sites/default/files/CBTp_Position_Statement_NASMHPD.pdf>

Kopelovich, S. L., Nutting, E., Blank, J., Buckland, H. T., & Spigner, C. (2022). Preliminary point prevalence of Cognitive Behavioral Therapy for psychosis (CBTp) training in the US and Canada. *Psychosis*, 1-11.

Kopelovich, S. L., Blank, J., McCain, C., Hughes, M., & Strachan, E. (2023). Applying the Project ECHO Model to Support Implementation and Sustainment of Cognitive Behavioral Therapy for Psychosis. *Journal of Continuing Education in the Health Professions*.

Lincoln, T. M., Jung, E., Wiesjahn, M., & Schlier, B. (2016). What is the minimal dose of cognitive behavior therapy for psychosis? An approximation using repeated assessments over 45 sessions. *European Psychiatry*, *38*, 31–39. <https://doi.org/DOI>: 10.1016/j.eurpsy.2016.05.004

Lincoln, T. M., & Peters, E. (2019). A systematic review and discussion of symptom specific cognitive behavioural approaches to delusions and hallucinations. *Schizophrenia Research*, *203*, 66–79. <https://doi.org/https://doi.org/10.1016/j.schres.2017.12.014>

McDonagh, M., Dana, T., Kopelovich, S., Monroe-DeVita, M., Grusing, S., Blazina, I., Bougatsos, C., & Selph, S. (2021). Psychosocial interventions for adults with schizophrenia: An overview and update of systematic reviews. *Psychiatric Services*. <https://doi.org/10.1176/appi.ps.202000649>

McDonagh, M., Dana, T., Selph, S., Devine, E. B., Cantor, A., Bougatsos, C., Blazina, I., Grusing, S., Fu, R., Kopelovich, S. L., Monroe-DeVita, M., & Haupt, D.W. (2017). Treatments for Schizophrenia in Adults: A Systematic Review. Comparative Effectiveness Review No. 198. (Prepared by the Pacific Northwest Evidence-based Practice Center under Contract No. 290-2015-00009-I.) AHRQ Publication No. 17(18)-EHC031-EF. Rockville, MD: ***Agency for Healthcare Research and Quality***. Retrieved from https://effectivehealthcare.ahrq.gov/products/schizophrenia-adult/research-2017 doi: 10.23970/AHRQEPCCER198. PMID: 29537779

Proctor, E., Hooley, C., Morse, A. et al. Intermediary/purveyor organizations for evidence-based interventions in the US child mental health: characteristics and implementation strategies. Implementation Sci 14, 3 (2019). <https://doi.org/10.1186/s13012-018-0845-3>

Shields, G.E., Buck, D., Elvidge, J., Hayhurst, K.P., Davies, L.M. (2019). Cost Effectiveness Evaluations of Psychological Therapies for Schizophrenia and Bipolar Disorder: A Systematic Review. International Journal of Technology Assessment in Health Care 35, 317–326. https://doi.org/10.1017/ S0266462319000448

Substance Abuse and Mental Health Services Administration (2021). Routine Administration of Cognitive Behavioral Therapy for Psychosis as the Standard of Care for Individuals Seeking Treatment for Psychosis: State of the Science and Implementation Considerations for Key Stakeholders. Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. Retrieved from <https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-03-09-001.pdf>

Turner, D. T., Burger, S., Smit, F., Valmaggia, L. R., & van der Gaag, M. (2020). What Constitutes Sufficient Evidence for Case Formulation–Driven CBT for Psychosis? Cumulative Meta-analysis of the Effect on Hallucinations and Delusions. *Schizophrenia Bulletin*, *46*(5), 1072–1085. <https://doi.org/10.1093/schbul/sbaa045>

Turner, D. T., Turner, M., Reijnders, M., van der Gaag, E., Karyotaki, L. R., Valmaggia, S., Moritz, T., Lecomte, D., Turkington, R., Penadés, H., Elkis, C., Cather, F., Shawyer, K., O’Connor, Z.-J., Li, E. M., & de Paiva Barretto, P. (2020). Efficacy and Moderators of Cognitive Behavioural Therapy for Psychosis versus Other Psychological Interventions: An Individual-Participant Data Meta-Analysis. *Frontiers in Psychiatry., 11.,* 402. https://doi.org/10.3389/fpsyt.2020.00402

Valmaggia, L. R., Tabraham, P., Morris, E. & Bouman, T. K. (2008). Cognitive behavioral therapy across the stages of psychosis: Prodromal, first episode, and chronic schizophrenia. *Cognitive Behav. Practice*, *15*, 179–193.

van der Gaag, M., Dennis Stant, A., Wolters, K. J. K., Buskens, E. & Wiersma, D. Cognitive–behavioural therapy for persistent and recurrent psychosis in people with schizophrenia-spectrum disorder: cost-effectiveness analysis. Br. J. Psychiatry 198, 59–65 (2011).

van der Gaag, M., Smit, F., Bechdolf, A., French, P., Linszen, D. H., Yung, A. R., McGorry, P., & Cuijpers, P. (2013). Preventing a first episode of psychosis: Meta-analysis of randomized controlled prevention trials of 12month and longer-term follow-ups. *Schizophrenia Research*, *149*(1), 56–62. <https://doi.org/https://doi.org/10.1016/j.schres.2013.07.004>

Washington State Institute for Public Policy. Cognitive behavioral therapy (CBT) for schizophrenia/psychosis Adult Mental Health: Serious Mental Illness. (2019).

Wykes, T., Steel, C., Everitt, B., & Tarrier, N. (2008). Cognitive Behavior Therapy for Schizophrenia: Effect Sizes, Clinical Models, and Methodological Rigor. *Schizophrenia Bulletin*, *34*(3), 523–537. <https://doi.org/10.1093/schbul/sbm114>

**This Fact Sheet was created by:**

Sarah Kopelovich, PhD; Associate Professor and Professor of Cognitive Behavioral Therapy for Psychosis. Dr. Kopelovich is core faculty with the Northwest MHTTC at the University of Washington, Department of Psychiatry and Behavioral Sciences SPIRIT Lab. Dr. Kopelovich gratefully acknowledges Wenqi Zhang, BS, Research Coordinator for the UW SPIRIT Lab, for her assistance in the preparation of this Fact Sheet.

***For more information, contact your local MHTTC Regional National or Focus Area Center.***

***Visit*** [*https://mhttcnetwork.org/centers/selection*](https://mhttcnetwork.org/centers/selection)***to find your center.***

Text

Description automatically generated

Text

Description automatically generated

1. The full report can be accessed here: <https://store.samhsa.gov/sites/default/files/pep20-03-09-001.pdf> [↑](#footnote-ref-2)