The Cognitive Behaviour Therapist (2025), vol. 18, e48, page 1 of 13
doi:10.1017/S1754470X25100214

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CASE STUDY

CBT for psychosis with a young adult experiencing grandiose beliefs: a case study

Poppy Brown[1,2,3]*, Louise Isham[1,3] and Louise Johns[1,3,4]

[1]Department of Experimental Psychology, University of Oxford, Oxford, UK, [2]Department of Psychiatry and Behavioral Sciences, Stanford University, CA, USA, [3]Oxford Health NHS Foundation Trust, Oxford, UK and [4]Department of Psychiatry, University of Oxford, Oxford, UK
Corresponding author: Poppy Brown; Email: poppy.brown@stanford.edu

(Received 3 January 2025; revised 13 March 2025; accepted 21 June 2025)

Abstract
Grandiose delusions have received comparatively little attention in the literature and there is limited empirical evidence assessing the efficacy of cognitive behaviour therapy for psychosis (CBTp) for individuals with grandiose beliefs. This case study presents Noah, a 23-year-old referred to our Early Intervention Service with persistent grandiose beliefs alongside other psychotic experiences. Noah received 26 sessions of CBTp. Scores on measures of perseverative thinking, delusional distress and conviction, wellbeing, and daily functioning were completed at baseline, mid-therapy, end of therapy, and at follow-up 12 weeks after the end of therapy. Results demonstrated improvement across all measures, particularly preservative thinking about beliefs. Improvement in all but one outcome was not only sustained but continued to increase at follow-up. This is one of few known reports on using CBTp with an individual with current grandiose delusions.

Highlights

(1) To explore the use of CBTp with a young male experiencing grandiose beliefs.
(2) To apply learning from recent research on grandiose delusions into the delivery of CBTp.

Keywords: case study; CBTp; grandiose delusions

Introduction

There has been considerable development of cognitive behavioural models and treatments for psychosis over the past few decades, with NICE guidance now recommending psychological intervention in conjunction with anti-psychotic medication (NICE, 2015). There is also considerable evidence for the independence of psychotic experiences, including the independence of different types of delusion, e.g. persecutory *vs* grandiose (Ronald *et al.*, 2014; Sheffield *et al.*, 2021; Zavos *et al.*, 2014). Theoretical models and associated interventions for individual psychotic experiences are therefore increasingly being developed, and this process has been highly successful for persecutory delusions, where the theoretically driven Feeling Safe Programme demonstrated the highest treatment effects ever seen for improving a psychotic experience in a randomised controlled trial (Freeman *et al.*, 2021) (Cohen's $d = 1.2$ *vs* Cohen's $d = 0.3$ for generic CBT for

*Work completed at affiliations 1 and 3; author now at affiliation 2.

psychosis (CBTp); Bighelli *et al.*, 2018). Grandiose delusions, defined as inaccurate beliefs that one has a special power, wealth, mission or identity (Leff *et al.*, 1976), have received less attention in the clinical literature, however. This is despite some estimates suggesting that grandiose beliefs are very common, with several analyses reporting they are experienced by as many as 30–50% of those with schizophrenia or non-affective psychosis (Appelbaum *et al.*, 1999; Garety *et al.*, 2013, Knowles *et al.*, 2011) and experienced by as many as 60% of individuals with bipolar disorder (Goodwin and Jamison, 2007).

Grandiose delusions, like other beliefs, vary with regard to conviction, pre-occupation, and associated distress and dysfunction (Knowles *et al.*, 2011). Recent research suggests that the meaning behind grandiose delusions is important: they can provide a sense of coherence, i.e. helping to make sense of past and current experiences, purpose for the future, and significance, i.e. making life feel worthwhile (Isham *et al.*, 2022). Patients have also reported wanting more opportunities to be able to talk about their beliefs (Isham *et al.*, 2019). Crucially, research findings do not support the belief that grandiosity is synonymous with feelings of superiority or arrogance (Isham *et al.*, 2019), which might previously have been considered barriers to psychological intervention. Moreover, in a study of 268 patients with grandiose delusions, over three-quarters identified harms to their beliefs and over half wanted help (Isham *et al.*, 2023).

Isham *et al.* (2019) theorised six mechanisms that may maintain grandiose beliefs: meaning-making, anomalous experiences, mania symptoms, fantasy elaboration, reasoning biases, and immersion behaviours. Each factor can be considered as an inus condition, an unnecessary but non-redundant part of an unnecessary but sufficient condition, as in the cognitive model of persecutory delusions (Freeman, 2016). This model was developed out of qualitative data with individuals with grandiose delusions, and there is also developing quantitative data showing the associations between grandiosity and these mechanisms. For example, immersion behaviours and perseverative thinking explained 40% and 20% of the variance in grandiosity, respectively, in a cross-sectional sample of 352 patients (Isham *et al.*, 2023). Although further empirical evidence is needed, interventions based on this model could be developed that focus on any of these factors, perhaps mirroring the modular approach of the Feeling Safe Programme, or, specifically on reducing any harms and distress associated with the beliefs (Isham *et al.*, 2023). However, such an intervention has not yet been developed or tested, despite historical literature often reporting poor clinical outcomes of existing psychological interventions for grandiosity (Thara and Eaton, 1996). Given the developments of both CBTp and theoretical models of grandiose delusions, it is helpful to explore outcomes of CBTp for individuals experiencing grandiose delusions. This case report therefore provides some initial evidence. The individual described provided informed consent for a report of the therapeutic work to be written up and published.

Presenting problem

Noah (pseudonym), a white male in his early 20s, was referred to our Early Intervention Service (EIS) after an acute instance of substance misuse led to several psychotic experiences that became persistent. He began experiencing symptoms in September 2022, was assessed and accepted into the service 6 months later in March 2023 and referred for CBTp, which then began in December 2023 (9 months after symptom onset). Noah's diagnosis was first episode psychosis. When first assessed in EIS, Noah was experiencing severe low mood and suicidal ideation, auditory hallucinations, including hearing one positive voice that he thought was the voice of God, and distressing visual hallucinations and intrusive mental images. By the start of therapy it was evident that Noah's mood had increased significantly since initial referral and his suicidal ideation had subsided. He had a complex set of beliefs around his experiences, however. Briefly, these included that he was 'the chosen one' by God, that his past traumatic experiences and associated mental health problems were part of his 'cross to bear', given to him by God, and that he had had to

endure these experiences in order to then be rewarded with 'transcendence into a parallel reality', which was imminently due to happen. Throughout the day Noah would experience distressing and intrusive mental images, and occasional visual hallucinations, that typically depicted his or someone else's death. Noah felt these images were sent to him by God as a test of his faith and ability to endure suffering.

Noah spent most of his day thinking about his beliefs and considering his future transcendence and interpreted a wide range of environmental stimuli as having various meanings in relation to his beliefs. The longest breaks he had from thinking about his beliefs were when he played video games online with friends, which he did most evenings. Apart from gaming, Noah had little other activity built into his days. He lived at home with his family and was not engaged in employment or education. Noah had previously been in full-time education before finding employment working as a research assistant. However, he found employment difficult to maintain due to his mental health problems and therefore had not worked since September 2022. During assessment sessions with the therapist, Noah initially expressed that he was content with this, feeling that given the enormity of being the chosen one, there was little reason to engage with other aspects of life. Aside from the visual intrusions, he also initially did not verbally express much distress, stating that he felt comforted by the voice of God and confident in his understanding of his past and future experiences.

Noah reported a number of traumatic past events, including childhood sexual abuse (which had previously been disclosed, and the perpetrator assessed to no longer be a threat to Noah or to others) and severe bullying at school. Noah had been given a diagnosis of post-traumatic stress disorder (PTSD) as a teenager. Trauma-focused work was considered; however, Noah was not experiencing any current PTSD symptoms and expressed no desire to focus on these past events given he felt he understood them all as part of his journey to being the chosen one.

It was also important to note that although his delusions had religious content, Noah's delusions were not considered primarily to be related to religious belief, a distinction that has been helpfully discussed in past literature (Gipps and Clarke, 2024). Noah did not align himself with, or engage with, any particular religion, and in fact described negative views on religion as a whole.

Goals

Having initially expressed no desire to change any aspect of his life, after several sessions of exploring Noah's beliefs and experiences with the aid of motivational interviewing, he was able to identify some goals. In the immediate term he wanted to reduce his intrusive mental images. In the medium term he wanted to build more meaningful activity and routine into his days while he awaited transcendence, including going to the gym twice a week. In the long term he wanted to have the confidence to get a job.

Outcome measures

Measures were administered pre-therapy, mid-way through therapy, at the end of therapy, and 12 weeks after the end of therapy. The service core battery of measures included the Psychotic Symptoms Rating Scale (PSYRATS) delusions subscale, a measure of mood and anxiety, a measure of general wellbeing, and a measure of impact on functioning. To specifically measure a further aspect of Noah's grandiose delusions, the Thinking about Exceptional Experiences Questionnaire (TEEQ; Isham *et al.*, 2023) was chosen. It was clear during the first two assessment sessions that Noah spent considerable time each day thinking about his grandiose beliefs, and that this was likely to be a barrier to him meeting his goals of building more routine and activity into his days while also positively reinforcing his beliefs. Table 1 provides further details on measures.

Table 1. Outcome measures

Construct	Measure
Psychotic experiences Thoughts about Exceptional Experiences Questionnaire (TEEQ) Psychotic Symptoms Rating Scale (PSYRATS) delusions subscale	The TEEQ is a recently developed measure of preservative thinking about grandiose beliefs. The seven items are rated from 0 to 4, with higher scores depicting greater severity of symptoms. The measure significantly positively correlates with grandiose delusion conviction and has good internal consistency and test–retest reliability (Isham *et al.*, 2023). The PSYRATS is a clinician rated scale with excellent inter-rater reliability. This subscale measures six aspects of delusions including pre-occupation, conviction, distress, and disruption on a scale of 0 to 4, with higher scores showing greater severity of delusions (Haddock *et al.*, 1999).
Distress and functioning Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-10)	The CORE-10 (Barkham *et al.*, 2005) measures mood, anxiety, functioning, and risk over the previous seven days. Scores range from 0 to 40, with higher scores depicting more severe difficulties. Presence of clinically significant symptoms (caseness) is defined as a score of 10 or above (Barkham *et al.*, 2005). A change in score of 6 or more is considered reliable and clinically significant change (Barkham *et al.*, 2013).
Wellbeing Warwick Edinburgh Mental Wellbeing Scale (WEMWBS)	This 14-item scale measures both feeling and functioning aspects of mental wellbeing with good internal consistency and test–retest reliability (Tennant *et al.*, 2007). Higher scores depict better wellbeing. A score of 41–44 is indicative of possible/mild depression, and a score of <41 is indicative of probable clinical depression. A change in 3 or more points is considered reliable and clinically significant change (Maheswaran *et al.*, 2012).
Functioning Work and Social Adjustment Scale (WSAS)	The WSAS measures the impact of mental health difficulties on day-to-day functioning (Mundt *et al.*, 2002). The scale has 5 items covering work, home management, social leisure, private leisure, and relationships. Scores range from 0 to 40, with higher scores indicating greater impairment. The scale demonstrates good internal consistency, reliability, convergent and criterion validity. Caseness is defined as a score of 10 or above (IAPT, 2011) and a change in score by 13 points is considered reliable and clinically significant change (Mundt *et al.*, 2002).

Cognitive behavioural formulation

Throughout therapy mini maintenance formulations were co-created with Noah (see Appendix A in the Supplementary material). For example, worries about people laughing at him would make him feel tense and anxious, leading to avoidance of going out or not looking around if he did go out and thus no access to disconfirmatory evidence of his thoughts. The clinician also developed a separate more complete formulation of Noah's grandiose beliefs using Isham's (2019) theoretical model of the maintenance of grandiose delusions as a guide. All six hypothesised maintenance mechanisms from Isham's model were relevant to Noah, with some unique factors also added. Although not part of Noah's goals, formulating Noah's grandiose beliefs was considered important by the clinician given his beliefs were a barrier to him meeting his goals and therefore directly causing harm: the intrusive images were distressing, but part of him did not wish to reduce them because they were his 'cross to bear', and similarly, a part of him saw no reason to build meaningful activity into his day because he believed he would soon transcend, leading to significant lost potential to engage with meaningful parts of life. The formulation was therefore used as a framework for understanding Noah's beliefs and guiding the intervention but was not discussed with Noah given he did not see his beliefs as a problem that needed understanding.

Appendix B in the Supplementary material shows this more complete formulation. First, his beliefs played a clear role in helping him to understand and give meaning to both his past experiences ('I had to suffer to earn the right to be the chosen one') and future purpose, thereby

creating a motivation for retaining the belief. Within his longitudinal formulation it was clear that Noah had grown up with some strong negative self-beliefs as a result of the bullying and abuse he suffered, leading to an understandable search for clarity, meaning, and purpose. Secondly, his beliefs gave a plausible explanation of his anomalous experiences (intrusive images and hearing the voice of God). These anomalous experiences first began following an acid trip, then continued to occur frequently, and although he primarily abstained during the course of therapy, he was motivated to use substances further in order to elicit more anomalous experiences that would confirm his beliefs, even if they were distressing. Third, formation of, and engagement with, his beliefs had led to significant improvements in Noah's mood, in turn positively reinforcing the beliefs. Prior to coming to understand himself as the chosen one, Noah experienced severe depression and suicidal ideation, which subsided once he started to believe he was the chosen one. While his mood was not as elevated as to suggest the presence of mania as is posited in the theoretical model, the improvement in mood and reduction in suicidal ideation remained a significant maintaining factor for Noah.

Fourth, Noah spent considerable time each day thinking about his beliefs, which created positive reinforcement through bringing the beliefs to mind, elaborating details, and increasing conviction. Termed 'fantasy elaboration' in Isham's (2019) theoretical model, it was also clear that time spent doing this prevented Noah from focusing on any other aspects of his life. During this elaboration, Noah would also find symbols and draw meaning in multiple aspects of his environment, often demonstrating reasoning biases such as jumping to conclusions and confirmation bias that would support his beliefs. Fifth, although less prevalent during the therapy period, Noah described a number of immersion behaviours that he engaged with from time to time. For example, he believed that God had asked him to complete certain rituals such as smiling at himself in the mirror to show his pride at being the chosen one. These reinforced his beliefs via a similar mechanism to his fantasy elaboration. Performing such actions may also create stronger memories than just imagined actions and events, thereby strengthening the belief further (Isham *et al.*, 2019).

Finally, it has been suggested that imagery susceptibility, i.e. the tendency to visualise information rather than verbalise information could increase susceptibility to mental health difficulties due to emotional processing being more sensitive to visual imagery than verbal thought (Holmes and Mathews, 2005). Although there is limited empirical investigation into this, it has been suggested as a potential mechanism in grandiose delusions (Knowles *et al.*, 2011). Noah had a particularly strong tendency towards mental imagery and visual processing. This appeared to directly contribute to his grandiose beliefs as it allowed him to see his future as the chosen one in great detail, as well as indirectly via an increase in anomalous experiences (distressing and intrusive images).

Course of therapy

In line with NICE guidance and the Early Intervention in Psychosis Access and Waiting Time Standard, CBTp was offered (National Institute for Health and Care Excellence, NHS England, & National Collaborating Centre for Mental Health, 2016). Working on the factors directly maintaining specific sub-types of delusions has shown significant success for persecutory delusions (Freeman *et al.*, 2021). Following suit, therefore, it may have been helpful to similarly work step by step on each factor depicted in the formulation shown in Appendix B. However, Noah's grandiose delusions were not causing high levels of overt distress or risk in the way that is often the case with delusions. Therefore, the intervention was mainly guided by the maintenance formulations created around Noah's goals and the barriers to meeting them. Several of the maintaining factors depicted in the wider formulation, however, were worked on indirectly, in the process of helping Noah to meet his goals, and this formulation was held in mind as a framework

for identifying barriers and facilitators to the therapeutic work. Twenty-six sessions were delivered in total. Appendix D in the Supplementary material provides a session-by-session summary of the therapeutic work.

The first phase of CBTp involves assessment, goal development, and socialisation (Kingdon and Hansen, 2004). As such, this was the focus of sessions 1–4. From session 5, we began working towards Noah's goals, beginning with his short-term goal of coping with his distressing images. At first Noah was unsure whether he should try out strategies for coping as he wondered whether he was meant to endure the distress as part of his journey to transcendence. We used motivational interviewing (see e.g. Miller and Rollnick, 2002) to address his ambivalence towards trying out therapeutic strategies, with the therapist drawing on the principles of showing empathy for Noah's distressing experiences, supporting self-efficacy by reminding Noah of his strengths and coping, rolling with Noah's resistance to change/discord, and exploring the pros and cons of leaving things as they were *versus* trying out strategies within CBT, while also querying extremes in Noah's responses and thinking about his goals and values. Following this process, Noah felt that it could be both helpful to him and acceptable to God that he try out the strategies to cope with his distressing images (as it would perhaps further demonstrate to God his ability to cope well), and that God would be able to let him know if he should not be using a particular strategy.

We therefore practised imagery modification, where Noah changed his distressing images into something ridiculous. We elaborated all the sensory aspects of the modified image, then Noah practised it daily, and then used it to replace the distressing images whenever they arose. This worked well, with the frequency of images over the prior week dramatically reducing from multiple times an hour (rated by Noah in the session before we introduced the imagery modification) to just a few times a day (rated in the following session after we had introduced imagery modification and Noah had practised it further during the week), and associated distress from 7/10 to 3/10.

Sessions 6–13 focused on Noah's next goals of increasing meaningful activity and confidence going out and about. Through maintenance formulations and behavioural experiments, Noah was able challenge difficult thoughts and reduce anxiety. Throughout these sessions we explored different ways of remembering learning, e.g. through the creation of flash cards with memorable phrases on them. As is recommended in CBTp, the therapist often checked in with Noah in between sessions to provide reminders and encouragement around homework (Johns *et al.*, 2020). Within these sessions further barriers that arose were problem-solved collaboratively. For example, despite the positive impacts of the imagery modification work, in session 8 Noah reported experiencing different distressing images and auditory hallucinations at night which were disrupting his ability to get to sleep. After formulating where his focus of attention lay during these experiences, we co-created a safe place image for him to focus on instead as he went to sleep, which Noah found helpful for allowing him to wind down and get to sleep.

In session 10 it became clear that Noah was struggling to carry out the behavioural experiment targeting his second goal specifically of going to the gym due to avoidance and being unsure as to what his exact worries actually were. We therefore spent sessions 11 and 12 *in situ* – walking from his house to, and into, the gym. This allowed assessment of what thoughts and feelings came up for Noah in the moment, so we could then set more manageable, accurate, and useful behavioural experiments accordingly. By walking around together we observed Noah's safety seeking behaviours – wearing a hood, staring down at the floor, and avoiding looking at anyone – which he used to manage his feelings of anxiety around beliefs that people would be staring at him because he 'doesn't belong'. With his anxiety at a 7/10, Noah predicted he would feel more anxious if he walked around with his head and eyes up off the floor. After testing this out, he discovered his anxiety dropped to a 5/10 as he saw that people did not stare or look at him. In the week that followed, continuing to apply this learning, Noah was able to begin meeting his second goal, as he successfully went to the gym on his own for the first time. At this point, several sessions were spent reviewing learning so far and ensuring implementation.

To continue meeting his second goal of building more meaningful activity into his days, session 17 set up a Theory A ('there's no point in doing anything until I transcend') *vs* Theory B ('I can live a meaningful life in the meantime while I await transcendence') comparison and introduced behavioural activation principles to aid with Noah's motivation and low energy. The Theory A/Theory B concept was set up as an elongated behavioural experiment, where Noah could try out living as though Theory B was true and see whether it improved how he felt day-to-day, and whether God commended or criticised his attempts to do so. A further four sessions were spent formulating daily tasks and activities that Noah struggled with in order to help him enact Theory B, and concepts such as the 'choice point' and 'passengers on the bus' metaphor from acceptance and commitment therapy (Hayes, 2016) were drawn upon. The choice point helps individuals to increase their mindful awareness of moments of decision making where you are choosing either to move away from your values (typically because of getting 'hooked' by difficult thoughts and feelings), or towards your values (by 'unhooking' from difficult thoughts and feelings). The passengers on the bus metaphor depicts how thoughts, emotions, and experiences can be difficult blockages ('passengers') while you (the 'bus driver') try to navigate towards your values and goals. Instead of trying to remove or control these passengers, the aim is to acknowledge their presence while trying not to let their presence dictate the direction of your journey. Noah resonated well with the concept of being able to take meaningful action in this way despite his internal struggles and difficult experiences. From this work, Noah began helping a family friend with gardening twice a week, spending some time walking or sitting in his local park, and engaged with a physical health worker to help him learn about how to make healthy meals. Overall, following this work Noah felt that 'living to enact Theory B' did indeed positively impact his mood, motivation, and distress, and God had commended his efforts to better look after himself, which acted as an additional positive reinforcer for continuing these meaningful activities.

Two sessions were then spent talking through Noah's past traumatic experiences. Initially in therapy Noah had not wished to discuss these, but he now felt it was important for him to voice his experiences in detail, as a means of processing and then exploring any ways they may still be impacting him. Using the Post Traumatic Cognitions Inventory (Foa *et al.*, 1999), we were able to formulate how his experiences had impacted his ability to trust other people and his sense of how dangerous the world is. We integrated these beliefs with his updated learning from our behavioural experiments.

Finally, three sessions were spent reviewing, blueprinting, celebrating Noah's achievements, and handing over to his care coordinator. Noah agreed to be referred to the service's Youth-Individual Employment Support team, who would help him with the search for employment or further education.

Noah participated actively in therapy. Initially, he was unsure of whether he wanted therapy given he felt he had God by his side, therefore did not need additional support. However, during the first few sessions he reported finding it extremely helpful to be able to talk about his experiences. The therapist put considerable focus on curiosity, collaboration, and rapport-building during these early sessions, taking care to work within Noah's belief system, to provide validation for his distress, and to normalise his experiences where relevant. Combined with motivational interviewing, this process appeared to be helpful for allowing Noah to consider aspects of his experiences that he would like to be more manageable, and parts of his life he would like to change. Rather than trying to reduce Noah's conviction in his grandiose beliefs (Theory A), the focus of the second half of therapy was to build up the complimentary belief (Theory B) that Noah could live a meaningful life while he awaited transcendence, and that God would value him doing so. This enhanced engagement and Noah's motivation to meet his goals.

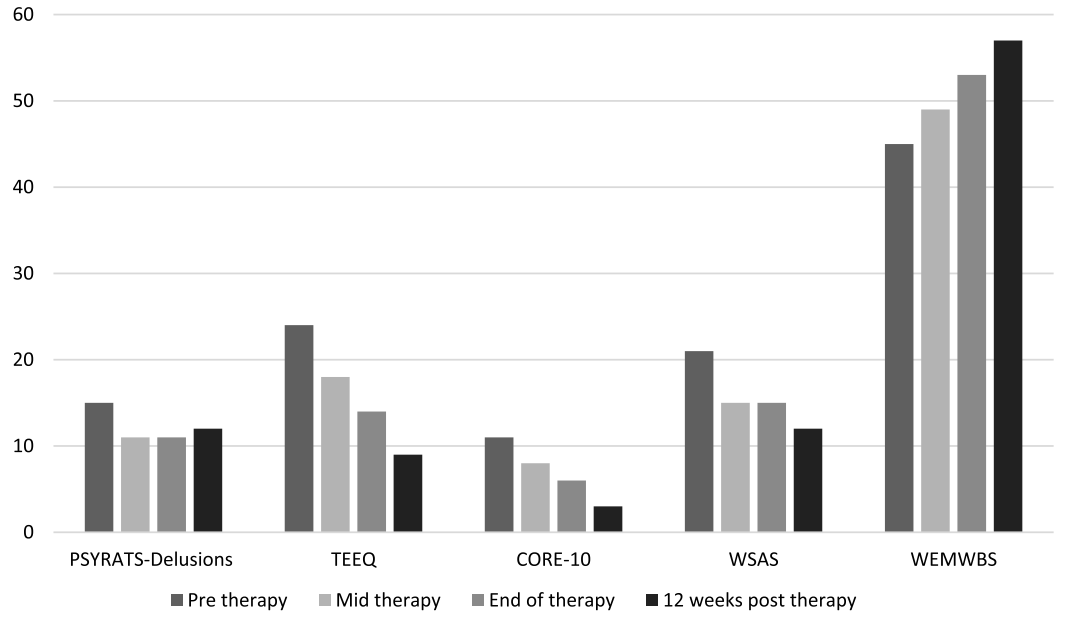

Figure 1. Changes in outcome measures across therapy.

Results

By the end of therapy, Noah was reporting significant progress towards his goals. His intrusive mental images were less frequent, his activity level had increased, and he was willing to be referred to our Youth Individual Placement Support (IPS) team to explore the potential for paid work or further education (a referral which he previously had not felt ready for). He was not regularly meeting his medium term operationalised goal of attending the gym twice a week, but he had acquired his gym membership and had attended by himself on a small number of occasions.

Figure 1 shows Noah's scores on the outcome measures at the start of therapy, mid-therapy, post-therapy, and at a follow-up 12 weeks after the end of therapy. Pre-intervention, Noah's PSYRATS delusions score was 15, depicting high conviction and pre-occupation in his beliefs, and he was demonstrating severe perseverative thinking about his grandiose beliefs, scoring the highest possible score for every item on the TEEQ except for the item about impact on sleep. His WSAS score of 21 was also considerably above the cut-off for caseness (10), meaning his mental health difficulties were causing significant difficulties completing usual daily activities. His baseline wellbeing score was 45, putting him just outside the cut-off for what is considered mild depression (41–44, where higher scores depict better wellbeing), and his CORE-10 score was 11, just above the cut-off for what is considered clinically severe difficulties.

Despite the intervention at no point directly focusing on reducing his beliefs or his perseverative thinking about his beliefs, by the end of therapy his PSYRATS score reduced from 15 to 11, and TEEQ from 24 to 14. The PSYRATS improvement was across pre-occupation, duration, and distress, and the TEEQ improvement was fairly well distributed across the items, with most items moving from a response of 'all of the time' to 'some of the time'. In addition, there was a corresponding reduction in the impact of Noah's difficulties on his daily functioning, demonstrated in the decreased WSAS score of 21 to 15, an improvement in his mental wellbeing, demonstrated by the increase in Warwick-Edinburgh Mental Well-Being Scale (WEMWBS) from 45 to 53, and improvement in his distress and functioning, demonstrated by a reduction in CORE-10 score from 11 to 6, the latter of which is below the cut-off for clinically severe difficulties (a score of 10 and below).

Twelve weeks after the end of therapy, Noah's scores on almost all measures continued to improve. His TEEQ score dropped a further 5 points to a score of 9, his CORE-10 score to 3 (well below the clinical cut-off of 10), and his WSAS score dropped from 15 to 12 (closer to, though still not below, the clinical cut-off of 10). His wellbeing score also continued to improve, increasing a further 4 points to a score of 57. Changes on both the CORE-10 and WEMWBS from baseline to follow-up were above the threshold for reliable and clinically significant improvement (6 and 3 points, respectively). The only measure that did not continue to improve was Noah's PSYRATS delusions score, which increased in total by 1 point from a mid and end of therapy score of 11, to 12, depicting a marginal increase in reported symptoms. However, there was variation when looking at the itemised scores across time points. At follow-up Noah scored lower for the distress and disruption items of the PSYRATS, but higher for pre-occupation and conviction.

Discussion

This report describes 26 sessions of CBTp with a young male who had experienced a first episode of psychosis and had ongoing grandiose beliefs. Across the course of the intervention, significant improvements were seen across all measures of his beliefs, wellbeing, and functioning, with almost all improvements either sustained or continuing at follow-up. Interestingly, across most of the measures, the greatest improvements were seen between baseline and mid-therapy, with the PSYRATS delusions and WSAS scores in particular remaining the same from mid to end of therapy, with large gains then again seen between end of therapy and 12 weeks after the end of therapy.

It is interesting that at follow-up Noah's score on distress and disruption items of the PSYRATS were lower, but higher for pre-occupation and conviction. It is noteworthy that although the clinician rated his preoccupation as high, Noah explained that he was choosing to think about and consider his beliefs a lot, rather than it being automatic and preservative, which fits well with his lower TEEQ score and levels of distress and disruption. This may reflect that as he engaged less with the negative parts of his beliefs (e.g. the distressing images) and more with the positive elements (e.g. his ability to cope and achieve things despite being the chosen one), he chose to think about his beliefs more, thereby increasing pre-occupation. It is possible that by this point his pre-occupation could be lower if in fact he chose it to be, but that his pre-occupation and conviction was now a means to reminding him of his ability to cope.

It was also notable that Noah's WSAS score remained at 15 at end of therapy, above the clinical cut-off score of 10, despite him making significant progress towards his goals. This likely reflects that although Noah did manage to complete much more day-to-day, he still found it difficult to do so, and he was not always able to maintain his gains. For example, he did not manage to maintain the goal of going to the gym twice each week, even though his activity level remained higher than it had been pre-therapy. The improvements he did see on the WSAS score during therapy was focused on two items in particular: social leisure activities and relationships with others. The items on ability to work and do household activities saw less change until the follow-up time point, when his score on ability to work/study then improved by 5 points, and ability to do household activities improved by 1 point. At the end of therapy Noah was referred for support from IPS and received a first session with an IPS worker prior to meeting for follow-up. This could account for some of the improvement on the work/study item at follow-up, highlighting the importance of ongoing multi-disciplinary care and how different professionals can work together to support patient goals.

Given the success of the early imagery modification work, it may have been helpful to practise further imagery work in therapy. Taylor *et al.* (2019) report a 6-session imagery focused therapy for persecutory delusions, which we could have drawn from, including for example, helping Noah deliberately generate positive images of his future. Nightmare rescripting, as outlined in Sheaves *et al.* (2019), was considered and discussed with Noah, but he did not wish to try this technique given he liked to spend time trying to interpret his nightmares.

Overall, the results provide a helpful example of the benefits of CBTp for an individual where there are ongoing strongly held grandiose beliefs. Brabban and colleagues summarise ten tips for ethical and competent delivery of CBTp of which we feel this intervention particularly aimed to enact in order to achieve engagement and meaningful change (Brabban *et al.*, 2017): the therapist was collaborative, particularly in choosing what goals and difficulties to work with; the therapist used Noah's own everyday language to talk about his experiences; historical experiences were acknowledged and used to collaborative build a longitudinal formulation; Noah's beliefs were explored and evaluated rather than challenged; experiences both past and present were validated and empathised with; choice was continually offered in terms of what therapy focused on and how progress could be made towards goals; the therapist placed strong emphasis on building both rapport but also hope from the early sessions that Noah could meet whatever goals he would like to set; and finally, the work of the therapist (P.B.) was regularly supervised by an experienced clinical psychologist (L.J.), including gaining additional input from a clinical-researcher whose expertise lies in grandiose beliefs (L.I.).

Moreover, as recommended by Johns and colleagues (Johns *et al.*, 2020), we focused on Noah's unique goals (that concerned improved engagement with everyday activities) rather than focusing on symptom reduction and increasing compliance with e.g. his medications, which was clearly a successful approach. This may be one reason, however, why we did not see a more significant decrease in Noah's PSYRATS scores, particularly on the pre-occupation item, yet we did see improvements in the distress and impact items, and the measures of mood and wellbeing. It is interesting to consider whether different treatment strategies may have more successfully reduced conviction and pre-occupation, and/or whether this may happen naturally with more time, particularly if Noah were to successfully find employment.

Additionally, while working within Noah's belief system, it was helpful to gently explore the potential challenges and harms of his experiences. Isham *et al.* (2023) found that over three-quarters of people with grandiose delusions reported some form of harm associated with their beliefs, most commonly related to social and occupational harms, leading to a 'both and' evaluation of grandiose beliefs being both positive/meaningful and harmful/burdensome. However, as in Noah's case, associated harms often do not immediately come to light, with Noah for instance not feeling initially like he needed any psychological support or had any goals he was struggling to meet. After building a shared understanding of an individual's beliefs, and the important meaning they hold, consideration of any potential harms of the beliefs and experiences (while also maintaining their positives and importance) can be a helpful route into therapy.

There are limitations to this report, not least that it is of only a single case. It would have been useful to complete additional measures with Noah. For instance, given its frequent co-occurrence with grandiosity (Sheffield *et al.*, 2021), measuring paranoia may have been informative. Moreover, ratings of Noah's conviction in his beliefs, levels of distress regarding parts of his experience, and conviction in the Theory A/B that was set up in therapy, could have been informative. However, the existing measures already placed considerable burden on Noah, and given his preference was to complete them together in session it was generally considered better not to lose additional therapeutic time to questionnaire completion. A further limitation is that the measures were completed with the clinician present, and in the case of the PSYRATS at all time points except the follow-up, rated by the clinician who delivered the therapy. Ideally measure collection would have been done by someone blinded to, for example, the nature and stage of intervention, to minimise any potential bias. Having the majority of measures being self-report aided to minimise any potential bias, however. The inclusion of a follow-up 12 weeks after the end of therapy is a strength of the report, but given Noah was still under the care of the EIS team and receiving ongoing support, e.g. from IPS, it is not possible to ascertain whether the improvements between end of therapy and follow-up would have been seen had this ongoing support not been available.

Conclusion

This young male with grandiose delusions found CBTp acceptable and beneficial and change scores on outcome measures showed reliable change in a number of areas. Improvements were sustained 3 months after the end of therapy. Isham *et al.* (2019) theoretical model of grandiose beliefs was well suited as a guide to formulating Noah's difficulties and guiding aspects of the intervention. Further work to assess CBTp for individuals with grandiose delusions and to develop a form of CBTp more specifically targeted at grandiose beliefs, in a similar way to what has been achieved with persecutory beliefs, could be beneficial.

Key practice points

(1) CBTp can be an acceptable and effective intervention for individuals with ongoing grandiose beliefs.
(2) CBTp interventions with individuals with grandiose delusions can be enhanced by applying learning from recent research, including exploring the unique maintenance factors and any harms associated with grandiose beliefs.
(3) Building a trusting therapeutic relationship and working within an individual's belief system are cornerstones of good CBTp, and may be particularly important for individuals with delusions who may be sceptical about the value of therapy.

Further reading

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Supplementary material. To view supplementary material for this article, please visit https://doi.org/10.1017/S1754470X25100214

Data availability statement. The data that support the findings of this study are available from the first author (P.B.) upon reasonable request.

Acknowledgements. The authors are grateful for Noah's consent to write up this report for publication.

Author contributions. **Poppy Brown:** Conceptualization (lead), Investigation (lead), Methodology (lead), Writing - original draft (lead); **Louise Isham:** Supervision (supporting), Writing - review & editing (supporting); **Louise Johns:** Investigation (supporting), Supervision (lead), Writing - review & editing (supporting).

Financial support. This research received no specific grant from any funding agency, commercial or not-for-profit sectors.

Competing interests. The authors declare no competing interests.

Ethical standards. The authors have abided by the Ethical Principles of Psychologists and Code of Conduct as set out by the BABCP and BPS. Informed consent to write and publish this case report was obtained from the client. All names and any other identifiable information have been changed in order to preserve confidentiality.

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Cite this article: Brown P, Isham L, and Johns L (2025). CBT for psychosis with a young adult experiencing grandiose beliefs: a case study. *The Cognitive Behaviour Therapist* 1–13. https://doi.org/10.1017/S1754470X25100214