Cognitive behavioral therapy for psychosis to divert delusions in schizoaffective depressive type

PROCEDIA
Studi Kasus dan Intervensi Psikologi
p-ISSN 2302-1462; e-ISSN 2722-7669
ejournal.umm.ac.id/index.php/procedia
2024, Vol 12(1):44–50
DOI:10.22219/procedia.v12i1.29912

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Abstract
The schizoaffective disorder is a mental disorder characterized by a combination of symptoms of Schizophrenia and affective disorders. One symptom is delusions, which can lead to maladaptive behaviour. This research aims to overcome delusional symptoms which have an impact on sleepless behaviour. The assessment methods were clinical interviews, observation, WAIS test, Graphic test (Draw a Person (DAP) and BAUM), WWQ test, TAT test, Beck Depression Inventory (BDI), and World Health Organization Disability Assessment Scale 2.0 (WHODAS). Cognitive Behavioral Therapy for Psychosis (CBTP) intervention using cognitive reframing techniques and behavioural coping skills has been proven to be able to overcome the problems experienced by the subject. CBT helps subjects ignore, distract, and adapt to delusions but does not suppress or confront the delusions themselves. The subject diverts the delusion by thinking about a better goal in life, thereby helping to reduce the behaviour of sleeplessness experienced by the subject.

Keywords
Cognitive behavioral therapy, depressive, divert delusion, psychosis, schizoaffective, schizophrenia

Introduction

Schizophrenia is a mental disorder that includes symptoms of psychosis, which are described by a person's mental condition being out of touch with reality, such as hearing voices that do not exist or believing in things that are not proven to be true (Wintari, 2020). Schizophrenia is characterized by an acute episode, a separation from reality that is visible from delusions, hallucinations, illogical thoughts, disorganized (chaotic) speech, strange behaviour such as catatonia, and negative symptoms such as withdrawal and flat emotions (Habsara et al, 2021).

One of the schizophrenia spectrum disorders is schizoaffective. Schizoaffective disorder is a disorder in which symptoms of Schizophrenia and affective disorders are both prominent at the same time. The main feature of schizoaffective disorder is the presence of major, manic, or mixed depressive episodes that co-occur with schizophrenia symptoms (delusions, hallucinations, strange behaviour, and negative symptoms) (Habsara et al, 2021). Schizoaffective symptoms include a period of persistent disturbance, and there is a major mood episode (depressive or manic) that appears together with A symptoms of Schizophrenia (simultaneously). These symptoms must last for one month.

To establish a diagnosis of schizoaffective, an individual must show at least two weeks of positive psychotic symptoms followed by symptoms of a mood disorder such as mania or depression. If an individual experiences one of the symptoms of a mood disorder and meets the criteria for the disorder, it can be concluded that the person is schizoaffective (Mintarsih, 2021). In this case, the diagnosis was made based on a depressive condition as an initial symptom indicated by impulsive behaviour, namely a suicide attempt. The depressive condition he experienced influenced his negative thoughts and suspicions, which then developed into symptoms of Schizophrenia.

Delusions that appear in individuals with psychotic disorders can be a manifestation of events that are felt to have special meaning and have been experienced by the individual (Arciniegas, 2015; González-Rodríguez, 2002). The formation of delusions in individuals leads to disturbances in cognitive processes such as perception and judgment, which are accompanied by emotional, physical and behavioural changes (Fowler, 2000). The subject displays symptoms of Schizophrenia in the form of delusions, namely the belief that his wife is unfaithful and that his household will fall apart. This delusion appears when the subject is going to sleep and wakes up in the middle of the night.

The delusions that arise have an impact on anxiety, and he desires to look for objective evidence of their delusions; they feel suspicion and sadness toward their wife cannot be maintained, and they have to divorce. Apart from that, physiological responses also appear, such as getting tired quickly and losing energy. Even if the condition declines drastically, the subject feels full chest, nausea, and vomiting. Apart from emotional and physiological responses, there are maladaptive behaviours, namely difficulty sleeping at night and frequently waking up in the middle of the night.

Appropriate treatment is needed to help the subject divert the delusions they are experiencing. Interventions that can overcome these problems in individuals with schizoaffective

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depressive type include pharmacotherapy and cognitive-behavioural therapy. The use of antipsychotics can be used as therapy to reduce psychotic symptoms such as delusions, and the use of antidepressants is also recommended to treat symptoms of depressed mood (Lintunen et al , 2021). Cognitive behavioural therapy for psychosis (CBTP) has relatively high levels of scientific evidence and is recommended for treating psychotic patients (Naeem et al, 2016; Switzer & Harper, 2019).

The research by Refanthira (2021) also shows that CBT can effectively help divert or refocus an individual's thoughts from negative or delusional thought patterns to more realistic and adaptive ones. Thus, the author chose CBTP as an intervention used to overcome delusional problems in individuals with schizoaffective depressive type because of evidence of its effectiveness. This case study aims to deal with the subject's problem, namely overcoming delusions, which have an impact on sleepless behaviour.

Assessment Methods

The assessment methods used include (1) Clinical interviews, which are carried out to collect as much information as possible, which will support the diagnosis of the problem; (2) Observations were carried out through direct observation, namely the subject's body language and expressions during the interview process and the subject's activities in the ward; (3) The WAIS test is given to see the extent of intellectual abilities and how the subject can receive information and process the instructions given; (4) Graphic tests, namely Draw a Person (DAP) and BAUM, aim to explore personality structure from essential functions such as emotions, control and reality functions; (5) The WWQ test is an inventory test to see the dynamics of an individual's personality; (6) The TAT test aims to project the drives, emotions, complexes and conflicts that dominate an individual's personality both consciously and unconsciously; (7) Beck Depression Inventory-II (BDI-II) to measure depression; and (8) The World Health Organization Disability Assessment Scale 2.0 (WHODAS) is used to assess the severity of the symptoms experienced by the subject in terms of daily functions.

Case Presentation

The subject is a 30-year-old man with a wife and one 7-year-old child. The onset of the disorder occurred when the subject was 29 years old. The subject's height is 164 cm, and his weight is 71 kg. The subject needs a better understanding of time, place, and orientation and often needs to improve when writing the date of birth or the current date. While in the ward, the subject did not look enthusiastic when singing and seeing other patients entertained. The subject did not do much activity and often lay in bed looking at the ceiling.

The subject once experienced a fall and bleeding from the head due to being hit by a brick while at the house, causing the subject to faint. However, the subject did not receive an official examination by a doctor. The subject also drank water with amethyst seeds in grade 1 of junior high school 4 to 5 times for three months with his friends, resulting in a poisoning reaction. Apart from that, the subject was cheated on by his ex-girlfriend, who had been in a relationship for approximately four years with the subject's close friend.

The subject has work experience making bread moulds for one year, from 2006 to 2007. After their business went bankrupt, they restarted it on a small scale in 2008 with an income of around two million rupiah per month. Even though the subject's family life was harmonious, in 2022, income decreased drastically—the subject experienced mental problems, such as hallucinations, delusions, and violent actions towards his family.

The subject's family tried to treat the subject for three months. However, he relapsed again in 2023 with increasingly severe behaviour, such as committing violence against his wife and sister-in-law. The subject felt controlled by whispers threatening to destroy his family and suspicious of his wife. Due to economic pressure and failure to achieve the goal of building a house, the subject felt sad, disappointed, and worthless as head of the family. This incident began with the subject being treated at a Mental Hospital.

The subject said that what he wanted to do after leaving the mental hospital was to find out whether the whispers and suspicions about his wife were true. The subject felt very hopeless because he imagined having to divorce his wife. The subject spends much time thinking about these suspicions daily. The negative thought makes the subject feel tired because he feels very depressed, combined with the absence of his family, which makes him feel sad, empty and lost. His sleep pattern also became disturbed, and the subject experienced difficulty sleeping both during the day and at night.

Based on the test results, it was found that the subject had intellectual capacity at an average level, with balanced verbal and performance abilities. Subjects tend to be introverted, paranoid, and lacking in self-control, with complex internal conflicts. In addition, subjects need affection and emotional support but also face anxiety, relationship conflicts, and difficulties in problem-solving. These conditions are also strengthened by the discovery of pathological signs in emotional expression, anxiety management, and significant depressive symptoms, giving rise to symptoms such as loss of pleasure, changes in sleep patterns, and excessive fatigue.

The subject's problem formation dynamics can be explained using the diathesis-stress model approach. The diathesis-stress model emphasizes the picture that individuals can experience pathological disorders due to interactions between biological, psychological (personality) vulnerabilities and stressors from the environment or stressful life experiences (Ediati et al, 2020; Nevid et al , 2018). Biological vulnerability can be divided into three causes, namely genetic, biochemical, and neurotransmitter problems (Boland et al, 2015).

Several possible biological vulnerabilities may affect the subject. First, the history of consuming water with amethyst seeds in the First grade of junior high school. Amethyst fruit contains alkaloid compounds such as atropine, hyoscyamine, and scopolamine, which are anticholinergic and can cause hallucinations and cognitive disorders (Aprira, 2022; Samuel et al, 2018; Singh et al, 2019). Second, the subject has experienced a severe head injury. Studies explain that head injuries that occur before the age of 18 are one of

the predictors and neurodevelopmental risk factors for the development of psychotic disorders in the future (Orlovska et al, 2014; Yau et al, 2023).

The subject's psychological vulnerabilities include a tendency to harbour feelings and remain silent when facing problems to avoid more significant conflict. Social factors also play a role where the subject has childhood experiences of not getting enough attention from parents, having been cheated on, and experiencing failed businesses.

The formation of problems of the subject can used in the Cognitive theory. Individuals who have traumatic experiences or are considered stressors will have an impact on cognition, which can give rise to beliefs (Beck & Alford, 2009). The subject experienced strong delusions triggered by past traumatic experiences, including being cheated on by an ex-girlfriend and seeing his wife cheating with her boss. The subject believes he should find a loyal partner to maintain a stable economy and will not abandon. The triggering event was a decline in income due to business being quiet since 2022 and decreasing drastically in 2023, so the target of building a house could not be completed—the "events" caused the individual to experience delusions about his current condition. Individuals create delusions/cognitive distortions in the form of beliefs that their wives are unfaithful because they are having an affair and their household will fall apart.

The delusions experienced by the subject fall into the category of magnification, namely, exaggerating the problem related to his wife that he believes that his wife was cheating. Subjects feel worthless, greatly desire to prove the truth, and even consider separating. The subject experiences anxiety, excessive worry, and deep sadness. Physiological responses include fatigue, loss of energy, and physical symptoms such as chest fullness, nausea, and vomiting. Maladaptive behaviour also appears, such as difficulty sleeping and frequent waking up in the middle of the night.

Diagnosis and Prognosis

Based on the case description and assessment results, a diagnosis can be made based on DSM-V that the subject meets diagnostic criteria 295.70 (F25.1) Schizoaffective disorder, depressive type with difficulty sleeping as a reaction to strong delusions. Subjects show symptoms characterized by (a) Persistent depressive periods such as feelings of sadness and loss of interest in activities, experiencing difficulty sleeping and becoming tired quickly when doing activities. Depressive episodes appear at the same time as schizophrenia symptom criteria such as persistent delusions of jealousy and auditory hallucinations; (b) Depressive episodes appear before the presence of hallucinations and delusions, namely an impulsive attempt in the form of a suicide attempt in 2022, then delusions and hallucinations appear after the event but have decreased due to treatment. At the beginning of 2023, the subject's symptoms of delusions and hallucinations recurred without any episodes of depressive mood, so he entered intensive care at the Mental Hospital for the effects of a substance (drug abuse or other medical condition).

The prognosis was considered good because of the subject's cooperative attitude during the assessment. The IQ capacity was average, so it was considered adequate to participate in the intervention session. Apart from that, it is also supported by a support system, namely a family that has sufficient concern and tries to respond quickly to the subject's condition.

Intervention

The target of the intervention is to overcome delusions that have an impact on the sleepless behaviour of the subject. Overcoming delusions in individuals with psychotic disorders is not to replace thoughts or oppose delusions but to invite individuals to adapt, ignore, or think about other things without suppressing existing delusions. The intervention provided is cognitive behavioural therapy for psychosis (CBTP). The goal of CBTP is to help the subject able to accept their delusions so that they do not create tension within themselves. The delusion that the subject will overcome is related to the belief that his wife is cheating on him and his household will be destroyed.

CBTP is an intervention that focuses on helping individuals reduce the impact of their psychosis symptoms and learn coping strategies for the tension resulting from psychosis (Morrison et al, 2004). CBT focuses on overcoming individual problems related to erroneous thinking or negative beliefs (Haddock et al , 2018; Kopelovich et al , 2019).CBTP involves reframing thoughts when delusions arise with other alternative thoughts so that it can be used as a form of intervention for individuals with schizoaffective symptoms (Sutjiono et al, 2022).

The results of previous research explain that CBTP can be effective in treating delusional problems in psychotic patients (Mehl et al, 2019; Naeem et al, 2016). Apart from that, research conducted by (Sitko et al, 2020) shows that cognitive behavioural therapy for psychosis (CBTP) has a significant effect in reducing the level of delusions in psychotic individuals. In addition, the results of the analysis show that the positive effects of CBTP on delusions tend to increase over time. The cognitive behavioural therapy for psychosis intervention design that will be given to the subject includes engagement, goals, intervention, and relapse work (Avasthi et al, 2020; Kingdon& Turkington, 2019). The details of the CBTP intervention are as follows:

Session 1: Introduction to the flow of intervention and engagement (normalization) This session begins by understanding the intervention session and trying to normalize the subject regarding their problems.

Session II: Identify problems and goals This session is carried out by identifying the problems experienced by the subject. Next, map specific thoughts that individuals believe or delusions that often appear at certain times to show the maladaptive behaviour that appears. The problem identification process transforms into a goal in solving problems in the cognitive and behavioural domains.

Session III: Provides an understanding regarding the dynamics of problem formation. The therapist provides an understanding that the delusions that arise are interrelated with emotions, behaviour and physiology so that the subject gets an idea of how his delusions can have a significant influence on his emotions and behaviour so far.

Session IV: Cognitive therapy by reframing thoughts and giving tasks The therapist explains that the reframe in this

cognitive therapy session invites the subject to ignore the delusions and divert to thoughts that make the subject more comfortable.

Session V: Behavioral coping skills and assignments . The therapist reinforces the subject by asking questions that are alternative explanations. Then, proceed with providing behavioural coping skills such as behavioural therapy.

Session VI: Evaluation and assignment. This session begins by first evaluating the tasks given in the previous session to carry out assignments to ignore delusions again and apply the coping efforts made. The therapist again reinforces the subject with de-catastrophizing questions and the impact of the automatic thought questions. This question is asked to determine the best and worst conditions for the problem focus.

Session VII: Evaluation and assignments. The therapist begins this session by re-evaluating the assignment the subject carried out. The therapist evaluates the subject's progress in carrying out the tasks that have been given, including ignoring delusions or thoughts and making coping efforts. After the evaluation, the therapist reinforces the subject with questions to help provide psychological distance from the focus of the problem so that we can measure the problem more broadly and remotely.

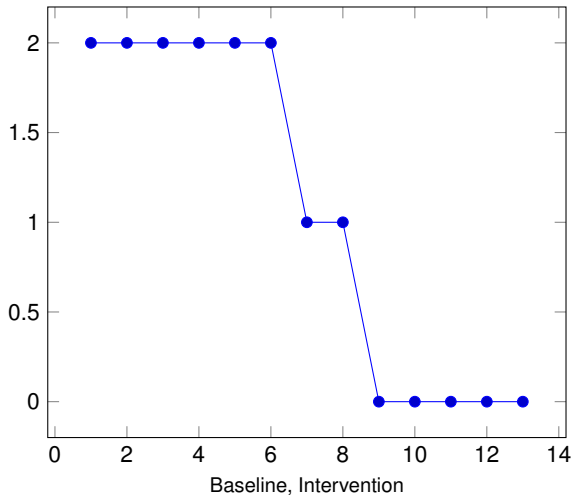
Session VIII: Evaluation and termination. The therapist begins this session by re-evaluating the assignment the subject carried out. The therapist evaluates the subject's progress in carrying out the tasks that have been given, including ignoring delusions or thoughts and making coping efforts. After the evaluation, the therapist reinforces the subject with questions to help provide psychological distance from the focus of the problem so that we can measure the problem more broadly and remotely.

After two weeks post-termination, the subject could maintain the changes in the cognitive and behavioural domains well. The subject was able to achieve the expected intervention target, namely overcoming the delusions that caused the subject to have difficulty sleeping. The wife also confirmed this, stating that the subject's development improved at home and that he slept soundly. The wife also said she would try to provide full support for the subject's optimal recovery at home.

Results and Discussion

Results

Cognitive behavioural therapy for psychosis (CBTP) intervention can overcome the problems experienced by the subject. CBTP given to subjects was effective in overcoming delusions in subjects who were individuals with depressive-type schizoaffective disorder. In dealing with delusions, subjects can overcome and overcome these symptoms by learning to adapt, ignore or divert their attention when they are in situations that trigger delusions. The subject's ability to deal with delusions influences sleepless behaviour, which gradually decreases. Change and development can occur because the subject can follow each session well, starting from engagement (normalization), identifying problems and goals,



Gambar 1. Decreased sleepless sehavior

and cognitive therapy by reframing thoughts and behavioural coping skills.

In the initial session, the subjects could make choices to solve the problems they were experiencing. Then, the subject can identify problems, namely delusions, which give rise to problems in the subject's cognitive and behavioural domains. The subject can understand well that the problem was formed due to the influence of delusions triggered by certain events. The event that triggers the subject to develop delusions is when the subject is not doing anything, such as when going to sleep or waking up from sleep in the middle of the night. The delusion that emerged was the subject's belief that his wife was having an affair with another man and his household would be destroyed, causing the subject to have difficulty sleeping. Apart from that, the influence on emotions is that the subject feels anxious, worried, and sad because he imagines that his household with his wife cannot be maintained and that he has to divorce.

Cognitive therapy sessions by reframing the subject's thoughts provide an understanding that what will be overcome are delusions. Reframing is not intended to break thoughts but to invite the subject to ignore delusions and focus on life goals after leaving the hospital. Reframing allows the subject to make peace with delusions and create more comfortable thoughts by focusing on his life goals, such as improving the household and making his children and wife happy. In this session, the subject can understand how to ignore delusions and formulate life goals that will be carried out in the future to divert the delusions that arise.

Subjects were also given behavioural therapy, namely behavioural coping skills as a habit of coping, providing subjects with activities when facing situations that give rise to delusions, such as when going to sleep or being silent. The coping chosen by the subject is simple activities such as singing, listening to music, trying to perform worship better or playing with children when they can go home. Coping, something that is liked, can help the subject slowly ignore the delusions that arise. The subject can do this well during the assignment. The results also show that the subject can divert delusions and can sleep more quickly and comfortably. The following is a graph that illustrates the decrease in the subject's sleepless behaviour during the intervention:

Figure 1. Assessment results show a decrease in the subject's sleepless behaviour Description: (0 indicates behavior without difficulty sleeping) (1 shows the behaviour of having a little difficulty sleeping) (2 shows behaviour that still has difficulty sleeping) (B is Baseline)

From the evaluation session, the subject can get used to ignoring delusions, positively impacting behavioural changes that make the subject no longer have difficulty sleeping and wake up at night. The subject can also cope when he is not doing any activities so that he does not give rise to delusions of suspecting his wife is having an affair and that his household will be destroyed. The sleeping behaviour experienced by the subject can be reduced because the cognitive intervention involves efforts to ignore/distract delusions from thinking about their suspicions so that the subject can sleep more quickly and no longer wake up frequently at night.

In the follow-up session, the subject could maintain and apply the techniques that had been taught to experience the problems they were experiencing. The subject was able to maintain the changes that occurred both in the cognitive and behavioural domains well. The subject said that delusions could be diverted and focused on their life goals accompanied by adaptive coping so that the subject could become calmer. The subject was able to achieve the expected intervention target, namely overcoming the delusions that caused the subject to have difficulty sleeping. The wife also confirmed this, stating that the subject's development improved at home and that he slept soundly.

Discussion

Cognitive behavioural therapy for psychosis (CBTp) intervention is effective in overcoming delusional problems which result in sleepless behaviour in subjects with depressive-type schizoaffective disorder. The changes are pretty significant from the beginning of the assessment to the evaluation and termination sessions. CBTP can be an intervention to overcome delusional problems that influence behaviour in patients with psychosis (Kingdon& Turkington, 2019). CBT is an effective intervention for treating positive symptoms in individuals with psychotic disorders (Lutgens et al, 2017). Cognitive behavioural therapy for psychosis (CBTp) can be given to individuals with schizoaffective disorder effectively as an effort to overcome problems in the cognitive and behavioural domains (Laws et al, 2018; Wood et al, 2015).

CBT is carried out by improving the individual's thinking about problems to function positively in daily life (Lopez-Fernandez et al, 2018). Subjects can get used to switching to alternative thoughts gradually after carrying out therapy sessions. Engagement techniques in CBT influence the success of therapy because they can increase self-confidence in individuals with psychotic symptoms (Bersani & Delle Chiaie, 2021). The success of CBTP can occur because, in the process, the subject learns to accept and make peace with delusions without having to confront them (Naeem et al, 2016).

Cognitive therapy sessions using the reframing technique involve the subject being able to reframe the problems experienced more positively so that they can generate and develop alternative thoughts from a new perspective (Refanthira, 2021). As a result of this cognitive reframing session, the subject could state a more positive thought solution, namely a life goal that could be used in a situation that gave rise to delusions. Of course, this thought solution will influence the subject's emotions and behaviour. If the subject had previously felt anxious and worried, the subject could have felt calm because he could have diverted his delusions with more positive thought solutions.

Cognitive behavioural therapy for psychosis (CBTP) aims to reduce the symptoms experienced, the distress caused by these symptoms, and the extent to which the symptoms interfere with the individual's function and quality of life. The results of this session can change the subject's behavioural patterns, allowing subjects who experience difficulty sleeping to sleep slowly, quickly, and soundly.

What influences the success of the intervention is the subject's cooperative level, which is high enough to carry out the intervention session from start to finish. The level of success of interventions in patients with psychosis can be determined by the therapist's relationship with the patient (Goldsmith et al, 2015; Krijnen et al, 2021). Apart from that, changes can also occur because the subject has an intellectual capacity that is in the average category. The intellectual capacity of the subject makes the intervention easier for the subject to understand, especially in the session, and understand the dynamics of the problem. Individuals with a standard or average level of intelligence will facilitate the cognitive-based intervention process (Birulés et al, 2020).

No significant obstacles were found in the intervention process. The obstacle experienced was the limited time for the intervention because it was carried out while the subject was being treated at the RSJ. Recommendations for further research include evaluating the long-term effects of CBTP by observing patients over a more extended period. This condition can provide a better understanding of the sustainability of the intervention's positive effects.

Conclusion

Cognitive behavioural therapy for psychosis (CBTP) can overcome delusions that cause sleeplessness in subjects. CBT helps subjects ignore, distract, and adapt to delusions but does not suppress or confront the delusions themselves. The subject was able to divert the delusions he was experiencing by thinking about a better goal in life so that the effect on the behaviour of having difficulty sleeping was also reduced. CBTP, which involves cognitive reframing techniques and behavioural coping skills, helps subjects divert the potential emergence of delusions. So, it can be concluded that the cognitive behavioural therapy for psychosis (CBTP) intervention given to subjects who are individuals with a schizoaffective disorder of the depressive type can overcome delusional problems effectively and provide changes in the subject's behaviour, namely reducing insomnia.

Referensi

Aprira. (2022). Penggunaan ekstrak buah kecubung sebagai agen eutanasia mencit putih (Mus Musculus). *Jurnal Pengelolaan Laboratorium Sains Dan Teknologi, 2*(1), 28–34. 10.33369/labsaintek.v2i1.15439

Arciniegas, D. B. (2015). Psychosis continuum: lifelong learning in neurology. *Behavioral Neurology and Neuropsychiatry, 21*(3), 715–736.

Avasthi, A., Sahoo, S., & Grover, S. (2020). Clinical practice guidelines for cognitive behavioral therapy for psychotic disorders. *Indian Journal of Psychiatry, 59*(4), 2017–2018. 10.4103/psychiatry.IndianJPsychiatry

Beck, A. T., & Alford, B. A. (2009). *Depression: causes and treatment, 2nd ed*. University of Pennsylvania Press.

Bersani, F. S., & Delle Chiaie, R. (2021). The end method: normalization. In *Empathy, Normalization and De-escalation* (pp. 57–64). Springer Publishing Company.

Birulés, I., López-Carrilero, R., Cuadras, D., Pousa, E., Barrigón, M. L., Barajas, A., Lorente-Rovira, E., González-Higueras, F., Grasa, E., Ruiz-Delgado, I., Cid, J., de Apraiz, A., Montserrat, R., Pélaez, T., Moritz, S., Ochoa, S., Acevedo, A., Anglès, J., Argany, M. A., … Villellas, R. (2020). Cognitive insight in first-episode psychosis: changes during metacognitive training. *Journal of Personalized Medicine, 10*(4), 1–13. 10.3390/jpm10040253

Boland, R., Verduin, M., & Ruiz, P. (2015). *Kaplan & sadock's synopsis of psychiatry (11th ed.)*. Wolters Kluwer.

Ediati, A., Kaloeti, D. V. S., Sakti, H., Dewi, K. S., Kahija, Y. La, Rahmandani, A., & Salma. (2020). *Psikologi klinis: Teori & Aplikasi*. Erlangga.

Fowler, D. (2000). Psychological formulation of early episodes of psychosis: a cognitive model. In *Early Intervention in Psychosis (eds Birchwood, M., Flower, D. & Jackson, C.)*. John Wiley.

Goldsmith, L. P., Lewis, S. W., Dunn, G., & Bentall, R. P. (2015). Psychological treatments for early psychosis can be beneficial or harmful, depending on the therapeutic alliance: An instrumental variable analysis. *Psychological Medicine, 45*(11), 2365–2373. 10.1017/S003329171500032X

González-Rodríguez, A., & Seeman, M. V. (2022). Differences between delusional disorder and schizophrenia: a mini narrative review. *World Journal of Psychiatry, 12*(5), 683–692. 10.5498/wjp.v12.i5.683

Habsara, D. K., Kusumawardhani, N., Suryadi, D., Risnawaty, W., Putranto, A. K., & Ibrahim, A. R. A. (2021). *Penatalaksanaan gangguan psikologis (Jilid I)*. Pustaka Pelajar.

Haddock, G., Berry, K., Davies, G., Dunn, G., Harris, K., Hartley, S., Holland, F., Kelly, J., Law, H., Morrison, A. P., Mulligan, J., Neil, S. T., Pitt, L., Rivers, Z., Taylor, C. D. J., Wass, R., Welford, M., Woodward, S., & Barrowclough, C. (2018). Delivery of cognitive-behaviour therapy for psychosis: a service user preference trial. *Journal of Mental Health, 27*(4), 336–344. 10.1080/09638237.2017.1417549

Kingdon, D., & Turkington, D. (2019). Cognitive therapy of psychosis: research and implementation. *Schizophrenia Research, 203*(1), 62–65. 10.1016/j.schres.2017.09.023

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. 10.1007/s10597-018-00365-6

Krijnen, L. J. G., Lemmers-Jansen, I. L. J., Fett, A. K. J., & Krabbendam, L. (2021). Benefits of social contact in individuals with psychotic symptoms: do closeness of the contact and empathic skills make the difference?. *Frontiers in Psychology, 12*(December), 1–11. 10.3389/fpsyg.2021.769091

Laws, K. R., Darlington, N., Kondel, T. K., McKenna, P. J., & Jauhar, S. (2018). Cognitive behavioural therapy for schizophrenia - outcomes for functioning, distress and quality of life: A meta-analysis. *BMC Psychology, 6*(1), 1–10. 10.1186/s40359-018-0243-2

Lintunen, J., Taipale, H., Tanskanen, A., Mittendorfer-Rutz, E., Tiihonen, J., & Lähteenvuo, M. (2021). Long-term real-world effectiveness of pharmacotherapies for schizoaffective disorder. *Schizophrenia Bulletin, 47*(4), 1099–1107. 10.1093/schbul/sbab004

Lopez-Fernandez, E., Sole, B., Jimenez, E., Salagre, E., Gimenez, A., Murru, A., Del Mar Bonnín, C., Amann, B. L., Grande, I., Vieta, E., & Martínez-Aran, A. (2018). Cognitive remediation interventions in schizoaffective disorder: A systematic review. *Frontiers in Psychiatry, 9*(OCT). 10.3389/fpsyt.2018.00470

Lutgens, D., Gariepy, G., & Malla, A. (2017). Psychological and psychosocial interventions for negative symptoms in psychosis: systematic review and meta-analysis. *British Journal of Psychiatry, 210*(5), 324–332. 10.1192/bjp.bp.116.197103

Mehl, S., Werner, D., & Lincoln, T. M. (2019). Does cognitive behavior therapy for psychosis (CBTp) show a sustainable effect on delusions? a meta-analysis. *Frontiers in Psychology, 6*(1450), 1–13. 10.3389/fpsyg.2015.01450

Mintarsih, R. A. (2021). Pengaruh token ekonomi untuk meningkatkan kemampuan rawat diri pada individu dengan gangguan skizoafektif. *Procedia: Studi Kasus Dan Intervensi Psikologi, 9*(4), 145–151. 10.22219/procedia.v9i4.16346

Morrison, A. P., Renton, J. C., Dunn, H., Williams, S., & Bentall, R. P. (2004). *Cognitive therapy for psychosis*. Routledge.

Naeem, F., Khoury, B., Munshi, T., Ayub, M., Lecomte, T., Kingdon, D., & Farooq, S. (2016). Brief cognitive behavioral therapy for psychosis (CBTp) for schizophrenia: literature review and meta-analysis. *International Journal of Cognitive Therapy, 9*(1), 73–86. 10.1521/ijct_2016_09_04

Nevid, J. S., Rathus, S. A., & Greene, B. (2018). *Abnormal psychology in a changing world (tenth edition)*. Pearson.

Orlovska, S., Pedersen, M. S., Mortensen, P. B., Agerbo, E., & Nordentoft, M. (2014). Head injury as risk factor for psychiatric disorders: a nationwide register-based follow-up study of 113,906 persons with head injury. *American Journal of Psychiatry, 17*(4), 463–469. 10.1176/appi.ajp.2013.13020190

Refanthira, N. (2021). Teknik reframing untuk mengurangi pemikiran negatif pada wanita depresi dengan gejala psikotik. *Procedia: Studi Kasus Dan Intervensi Psikologi, 9*(1), 1–11. 10.22219/procedia.v9i1.16022

Samuel, J., Sudisma, I. G. N., & Dada, I. K. A. (2018). Respon analgesia, sedasia dan relaksasi tikus putih yang diberi ekstrak biji kecubung (Datura Metel L.) Intraperitoneal. *Indonesia Medicus Veterinus, 7*(1), 16. 10.19087/imv.2018.7.1.16

Sari, D. N., & Kusumawati, M. (2022). Schizoaffective disorder depressive type: case report. *15th Continuing Medical Education*, 958–967.

Singh, S., Kosana, D., & Lal, R. (2019). Long-term intentional datura use and its consequences. *Indian Journal of Psychiatry, 61*(5), 543–544. 10.4103%2Fpsychiatry.IndianJPsychiatry_276_18

Sitko, K., Bewick, B. M., Owens, D., & Masterson, C. (2020). Meta-analysis and meta-regression of cognitive behavioral therapy for psychosis (CBTp) across time: The effectiveness of CBTp has improved for delusions. *Schizophrenia Bulletin Open, 1*(1), 1–13. 10.1093/schizbullopen/sgaa023

Sutjiono, B., Ahmad, S. F., & Jaya, E. S. (2022). Feasibility and benefit of cognitive behavioural therapy for psychosis via teleconsultation in indonesia: a case study of a 40-year-old schizoaffective disorder patient. *Behaviour Change, 1*(1), 1–14. 10.1017/bec.2022.11

Switzer, F., & Harper, S. F. (2019). A narrative review of the barriers to the implementation of cognitive behavioural therapy for psychosis. *Psychosis, 11*(2), 151–161. 10.1080/17522439.2019.1578400

Technology, O. H. (2018). Cognitive behavioural therapy for psychosis: a health technology assessment. In *Ontario Health Technology Assessment Series*, 18 (5), 1–141.

Wintari, S. T. (2020). Studi kasus dinamika psikologis pasien dengan gangguan mental psikotik skizoafektif. *Psyche 165 Journal, 13*(1), 114–120. 10.35134/jpsy165.v13i1.69

Wood, L., Burke, E., & Morrison, A. (2015). Individual cognitive behavioural therapy for psychosis (CBTp): a systematic review of qualitative literature. *Behavioural and Cognitive Psychotherapy, 43*(3), 285–297. 10.1017/S1352465813000970

Yau, K., Revill, G., Blackman, G., Shaikh, M., Bell, V., & London, S. (2023). Paediatric traumatic brain injury as a risk factor for psychosis and psychotic symptoms: a systematic review and meta-analysis. *MedRxiv, 1*(1), 1–31. 10.1101/2023.02.17.23286118