Cognitive Behavioral Treatment of Delusions and Paranoia

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Many persons consider that the only effective treatments for schizophrenia are antipsychotic medications.

Pessimism over traditional talk therapy approaches to schizophrenia.

American Psychiatric Assn. (1999) guidelines state that psychological therapies can be useful.

Most beneficial once the person becomes stable; less benefit in the acute phase of illness.
Empirically Supported Treatments

- Behavioral and Supportive Family Therapy
- Social Skills Training
- Cognitive-Behavioral Therapy
- Supported Employment
- Assertive Case Management
- Behavior Therapy/Token Economy programs

Chambless & Ollendick, 2001; Roth & Fonagy, 1996; Nathan & Gorman, 1998)
Cognitive Therapy for Delusions
Cognitive Therapy

- Cognitive therapy for psychosis arose from treatment methods for anxiety and depression.

- CT is based on the idea that psychotic symptoms are associated with information processing biases.
  - Attention, appraisal, attributional, belief formation and maintenance.
Cognitive Therapy, cont.

- CT is most effective in the treatment of persistent, residual psychotic symptoms
  - 25-60% of individuals with psychosis have symptoms following medication treatment
- Each episode of psychosis leads to more functional and social impairment
- Co-morbid mood symptoms are also quite common in psychosis (40%)
Cognitive Therapy, cont.

- Well-established treatment in England - offered to all persons
- Can treat specific symptoms
  - Delusions
  - Hallucinations
  - Negative Symptoms
- Part of a comprehensive treatment package
- Combined with other treatments such as social skills training, coping skills
Cognitive Therapy for Delusions

- Delusions can be modified and are not as rigidly held as previously believed.
- Conviction levels vary over time (naturally) and in response to cognitive therapy.
- Watts et al. (1973) argued that psychological reactance is present when direct confrontation is used:
  - Avoid a direct challenge to beliefs.
Cognitive Therapy for Delusions, continued

1) Challenging the evidence
2) Challenging the delusion itself
3) Empirical or behavioral testing
   – Behavioral testing is less effective when delivered alone, but more effective when it follows verbal challenge
   – Verbal challenge weakens the belief for the behavioral intervention to be effective
Challenging the Evidence

The first few sessions are devoted to understanding how the delusion was formed or important events in the client’s life.

Rank order the evidence from least important to most important.

Challenge the least important evidence first.

Therapist provides an alternative explanation.

Client explanation is weaker method.
Sample Hierarchy

- **Delusion:** “Neighbors are trying to kill me.”
- 1) Neighbors were up late at night
- 2) Put curtains up in their house
- 3) Husband went inside when I got home
- 4) Looked outside and they were pointing at my house
- 5) Came over to talk and then I got sick the next day
Supplementary Interventions

1) Accommodation
   - Have the client seek out or look for things in the environment that are contrary to their belief
   - Homework exercise
   - Gradual increase in perception of these events over the course of treatment
Challenging the Delusion Itself

1) Focus on the inconsistency and irrationality of the belief
   - “Would it make sense for things to be this way?”
   - Point out inconsistencies or problems in reasoning
   - Bizarre delusions are especially vulnerable

2) Belief is an attempt to explain unusual, puzzling, or ambiguous events
   - Normalizes the belief
   - Anxiety is a common pre-cursor

3) Discuss emotional and behavioral costs of the delusions vs. alternative belief
Behavioral Experiments

- Behavioral experiments are ways to test out the clients belief
- Direct disconfirmation, powerful
- Must be collaborative in nature to be effective
- Must be specific (delusion vs. alternative prediction)
- Not to “prove” the belief, but to test it out
- Predictions are done in advance and agreed to by the client
Sample Experiments

- Client believes she can tell the future
  - Test: Pause a videotape and ask client what will occur

- Client believes he is a professional football star
  - Test: Access list of players on website to check

- Works well for grandiose or delusions of reference, but persecutory delusions require more care and planning.
Cognitive Therapy for Paranoia
Overview

- Definitions and development
- Why focus on paranoia?
- Cognitive biases found in paranoia
- Behavioral characteristics
- Treatment issues and methods
Paranoia can be defined as a form of self-referential thinking characterized by suspicion, ill will, wariness, and resentment.

“Self as a target of others”

At delusional levels, the beliefs of harm and malevolent intentions become specific (Garety & Freeman, 2000).

Harm is on-going and/or anticipated.

Paranoid ideation can be found in normal persons and persons with psychosis.

Continuum approach of paranoia.
Development

- Paranoia can arise from several areas
  - Contextual factors
    - Incarceration, public settings, racism, one way mirrors
  - Modeling and learning influences (Haynes, 1986)
  - Vulnerability-Stress model of psychosis
    - Anxiety producing events, especially ambiguous events
    - Perception of threat or unusual experiences
Why Focus on Paranoia?

- Negative emotions
  - Anxiety, anger, and depression
- Personally distressing
- Low self-esteem
- Social avoidance/Occupational problems
- Poor intimate relationships
- Cognitive rigidity/poor tolerance for ambiguity
- Poor rapport and treatment compliance
Paranoia is a significant concern for treatment staff and others.

Negative reactions to these persons.

The treatment of paranoia stems from an understanding of the cognitive and behavioral biases associated with the condition.
Cognitive Biases in Paranoia

- Selective attention for threat
  - Take longer to read threatening words than neutral or depressed words

- Memory bias for negative events

- Externalizing attributional style
  - Tend to blame others rather than the situation for negative events
  - Very common for ambiguous situations

- Theory of mind deficits
  - Problems inferring the intentions and motivations of others

- Jumping to conclusions bias
  - Using less evidence to make decisions; gather less data
Associated Behaviors

- Safety behaviors to prevent negative outcomes
  - Avoidance and Escape from others who may harm them
  - Prevents disconfirmation of beliefs and person interprets these as “near misses”

- Increased social distance from others

- Poor social skills and expression of hostile statements
Treatment Issues

- Rapport building is key
- Antecedent - Belief- Consequence model for understanding events
- Motivation and engagement to find out more about beliefs and events in life
- Reduce personal distress and negative moods
- Improve trust and relationships
Cognitive Techniques

Attention and social perception biases

- Encourage the person to fully attend to and describe each situation
- Practice in session and then move to real life events
- Separate out facts vs. interpretations (paranoid beliefs)
- Emotional expression training
When a problematic event is reported or expressed in therapy

Verbal disputation of paranoid beliefs with standard cognitive therapy methods

Supporting vs. disconfirming evidence for the belief

Pre-post rating of paranoia following this exercise
Jumping to conclusions, theory of mind, and externalizing attributions

- Consider situational interpretations as alternatives (cognitively more demanding)
- May not be the default way of processing events for these persons
- When stressed blames others is the automatic attribution
- Emphasize the link between blaming others and emotional/behavioral consequences
Social avoidance and safety behaviors

- Encourage the person to “check things out”
- Role play social skills beforehand
- May need to use third person information at first (distancing)
- Increase involvement of the client over time in this activity
- Form or behavioral experimentation
Contact Information

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