New developments in CBT for persecutory delusions

Daniel Freeman, Katherine Pugh, Felicity Waite
Advancing treatment

- Target key causal factors
- Developing a menu of treatment modules
- Simplify messages; active; frequent contact
Overview of causal factors

• Less Worry
• Better Sleep
• Positive Self
• Engagement with the world (external focus)
• Finding out safer than feared

Putting it all together
Six key causal factors
1. Worry

“...sit and think. Then get paranoider and paranoider and paranoider and paranoider”
Worry: the evidence

- Worry style often present in individuals with persecutory delusions (Freeman & Garety, 1999; Morrison & Wells, 2007; Startup, Freeman, Garety, 2007; Bassett, Sperlinger, & Freeman, 2009).
- Worry style predicts occurrence of persecutory thinking (Freeman, Pugh, Antley et al, 2008; Freeman, Stahl, et al, 2012).
- Associated with delusion distress (Freeman & Garety, 1999; Freeman et al, 2001; Morrison & Wells, 2007; Startup et al, 2001; Bassett et al, 2009)
- Predictor of persistence (3mths) of persecutory delusions (Startup et al, 2007).
2. Sleep

“I've even been too scared while driving to look in the rear view mirror because I knew I would 'see' the bloke who's there ready to kill me. I wouldn't sleep for hours and hours because I thought as soon as I closed my eyes there would be someone standing there when I opened them.”
## Paranoia and insomnia: the evidence

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Odds ratio</th>
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<tbody>
<tr>
<td>Association of insomnia and paranoia</td>
<td>8580</td>
<td>2.5</td>
</tr>
<tr>
<td>Insomnia predicting new paranoid thinking</td>
<td>1647</td>
<td>3.6</td>
</tr>
<tr>
<td>Insomnia predicting persistence of paranoid thinking</td>
<td>735</td>
<td>2.0</td>
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</tbody>
</table>

3. Negative self/Inter-personal sensitivity

“I've always felt that when I go down hallways people are looking at me, making fun of me, ridiculing what I'm wearing, my hair, no matter if they are or not. It's even worse if I hear them talking about someone else, because then I just assume it's me. No matter who I talk to, I feel like I'm annoying them, like no one wants to talk to me. In essence, I guess it feels like everyone's always out to get me, and that in reality, I'm a nuisance to everyone.” Gillian
• 50% of individuals with persecutory delusions had self esteem scores more than two standard deviations below that of non-clinical controls (Freeman et al, 1998).

• ‘In the past year, have there been times when you felt that people were deliberately acting to harm you or your interests?’ (N = 7200), 10 times the odds to have depressive cognitions (Freeman et al, 2011).

• Interpersonal sensitivity predicts the occurrence of paranoid thinking (e.g. Freeman, Pugh et al, 2008; Freeman et al, 2003; 2005).
The paranoia hierarchy

- **Severe threat** (e.g. people trying to cause significant physical, psychological or social harm; conspiracies, known to wider public)
- **Moderate threat** (e.g. people going out of their way to get at you)
- **Mild threat** (e.g. people trying to cause minor distress, such as irritation)
- **Ideas of reference** (e.g. people talking about you, being watched)
- **Social evaluative concerns** (e.g. fears of rejection, feelings of vulnerability, thoughts that the world is potentially dangerous)

Freeman D et al. BJP 2005;186:427-435

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4. Reasoning

“I noticed myself jumping to conclusions. A woman was walking round the estate. Under normal circumstances I would have found this really dodgy, but I asked a neighbour who’d been out gardening and she told me she was looking for her lost cat. I felt a lot better then.”
Jumping to conclusions: the evidence

- People with delusions ‘jump to conclusions’, taking fewer beads to make a decision on a probabilistic reasoning task - a data gathering bias (see reviews by Garety & Freeman, 1999; Freeman, 2007; Fine et al, 2007).
- Data-gathering associated with belief inflexibility (Freeman et al, 2004; Garety et al, 2005).
- Data-gathering associated with delusional conviction (Garety et al, 2005; Freeman et al, 2008).
5. Anomalous internal experiences

“I get these strong feelings and thoughts that I am being watched by people at work, all of my family and friends (Everyone, basically) and the police including the government!”
Anomalous experiences: the evidence

• Anomalous experiences very common in people with delusions (e.g. Bunney et al, 1999; Bell et al, 2006; Freeman et al, 2010; Cernis et al, in press).

• Anomalous experiences predict the occurrence of delusional ideation (e.g. Freeman, Pugh et al, 2008; Freeman et al, 2005)

• Anomalous experience mediates the paranoia-inducing effects of cannabis (Freeman et al, in press).

• Differentially predict occurrence of paranoia and social anxiety (Freeman, Gittins et al, 2008)
6. Threat beliefs

“I make a list of how many times I thought someone was gonna kill me after any kind of conflict or confrontation. The list is really long. So I can then start telling my self how it's probably not gonna happen this time either.”
Threat beliefs: the evidence

• Paranoia associated with levels of anxiety, self focus, and anticipation of threat (e.g. Martin & Penn, 2001; Lincoln et al, 2010; Freeman et al, 2012).

• Safety behaviours used to reduce threat (Freeman et al, 2001; 2007).

• Evidence that testing out beliefs, using CBT for anxiety techniques, leads to reduction of delusions and anxiety (e.g. Key et al, 2004).
“My paranoid thoughts gravitate towards feeling like someone is watching me, feeling as though someone is following me home, or in my house. Ideas that close family members are purposefully doing things to make me angry or ruin the stability in my life are contributors, as well as worries of natural disasters.

Things that have helped me:

1. Sleep. I find that whenever I'm low on sleep, even if I'm not stressed out, my mind starts racing.


3. Having habits. Having a schedule and a constant concrete idea of where I'm going and what I'm doing next keeps my mind from wandering into the unnecessary black whole that is paranoia.


5. Having an physical outlet. I don't know what it is - probably something deep within our roots - but having a physical activity as an outlet is a great way to get rid of all of the stress and intensity that life can carry become. Its like starting fresh.

I think the MOST IMPORTANT thing to remember is that the paranoia is not you. You do in fact have the upper hand here. It may not seem like it, but you are actually capable of tell it to bugger off. It takes work. But you can choose what you want to believe.”
Modules in context: Not just technique
• Convey to patient that their problems are being taken seriously: Listen empathically, give ‘pocket summaries’, suggest or enhance coping strategies if there is a particularly immediate concern.
• Be flexible eg. length of sessions, homework tasks, non-attendance.
• Provide an understanding of what is likely to happen in therapy.
• Do not start by challenging delusions: listen and understand.
• Always elicit feedback.
• Anticipate potential problems with engagement.
Modules in context II: Messages

• There is an emerging literature indicating that careful attention should be given to appraisals of illness – concerning cause, course, outcome, loss, entrapment and humiliation – because they can lead to distress (Birchwood et al, 2000a; Lobban et al, 2003).

• Patients who take up CBT actively believe they have control over problems, and have psychological ideas about the causes (Freeman, Dunn et al, 2012).

• Need to use ideas that are acceptable to the person, non-stigmatising, and makes their experiences understandable and within their control.
<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree nor disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My problems can improve</td>
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<td>2. There is a lot which I can do to improve my problems.</td>
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<td>3. What I do can determine whether my current problems/illness get better or worse.</td>
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<td>4. My current problems/illness will improve in time</td>
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<td>5. There is very little that can be done to improve my current problems/illness</td>
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<td>6. Talking therapy will be effective in improving my current problems/illness</td>
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<td>7. Recovery from my current problems/illness is largely dependent on fate or chance</td>
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<td>8. My current problems/illness will last a short time</td>
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<td>9. My current problems/illness are likely to be permanent rather than temporary</td>
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<td>10. My current problems / illness will last for a long time</td>
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<tr>
<td>11. My state of mind played a major part in causing my current problems/illness</td>
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<tr>
<td>12. Something about my personality played a role in causing my current problems/illness</td>
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<tr>
<td>13. Changing the way I think or the way I do things can improve my problems</td>
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<tr>
<td>14. Looking at things differently can be helpful</td>
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</tbody>
</table>
• Assess key variables repeatedly.
• Normalise and decatastrophize.
• Activities are vital.
The drive to simplicity is not always simple:
Complexity even within simple messages
Decisions when to deviate from focus
Difficult circumstances
Does it work?
New outcome studies


Pilot study

- A brief focussed CBT intervention reduced worry and paranoia in people with persecutory delusions.
- Changes in worry were associated with changes in paranoia.

Worry Intervention Trial

Worry Intervention Trial

Daniel Freeman, David Kingdom, Helen Startup, Graham Dunn, Jacinta Cordwell, Helen Mander, Katherine Pugh, Emma Cernis, Kate Shirvell, Gail Wingham,

2011-2014
‘Winning Against Worry’
Monitoring worry

- Amount of time, triggers and what helped.
- Work towards goals.
- Between session phone calls to help motivation and provide support.

Rating Your Worry
How worried have you been about other people this week? Rate this on the scale below.

[Scale with ratings 0 to 10]
Not worried at all

How distressed have you been about your worries about other people this week?

[Scale with ratings 0 to 10]
Not distressed at all
Key elements for today

- Normalising worry.
- Worry cycle.
- Building motivation to reduce worry.
- Techniques to reduce worry.
- Removing the sting from worry.
Normalising worry

- We all do it.
- It takes up time.
- Peaks at certain times of the day.
- Can be about anything.
- Can feel necessary.
- Leaves us feeling unsafe.
Why worry?

• I have to worry to remain organised.
• Worry helps me sort things out in my mind.
• Worry keeps me safe.
• Worry prevents bad things from happening.
• Worry helps me to avoid problems in the future.
• Worry prepares me for the worst.
• Worrying helps me to cope.
• If I did not worry I would make more mistakes.
Worry cycle

- Feeling under threat
- Positive belief/reasons for worry
  "worrying will help me"
- I dwell on all the very worst things that could happen,
  e.g. "What if..."
- Worry
Worry cycle - video

• What aspects of worry are described in the video?

• What are the key elements of therapy demonstrated in the video?
## Building motivation to give up worry

<table>
<thead>
<tr>
<th>Advantages of worrying</th>
<th>Disadvantages of worrying</th>
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<tbody>
<tr>
<td></td>
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<tr>
<td><strong>Advantages of NOT worrying</strong></td>
<td><strong>Disadvantages of NOT worrying</strong></td>
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</table>
Worry periods

• Two parts:
  1. Planning a time and place to worry.
  2. Planning how to postpone worry until the worry period.

• Aim to help patients see that worry is in their control.
A time and a place to worry
Tips for worry periods

• Collaboratively construct a clear set-up
• Be flexible
• Be supportive
• Explore what the patient thinks about them
• Problem solve
Boosting worry periods

• Activities.
• Making contact with someone.
• Thinking of something different.
• Relaxation.
• Problem solving.
• 5 ways to wellbeing.
Activities

• Brainstorm enjoyable activities/hobbies/pastimes.
• What do they avoid because of their fears?
• Consider music, films, comedies.
Making contact with someone

• Talk to friends/family- either about worries or something else.

• Plan contact for a time of day when worry is a problem.
Think about something different

• A positive memory.

• A positive quality.

• The best that could happen.

• A safe place—generate an image.
Relaxation

• Progressive muscle relaxation.
• Guided imagery.
• Breathing exercises.
• Mindfulness.
Define the problem

Think of different solutions and weigh up the pros and cons of each (What has worked in the past? What would a friend say?)

<table>
<thead>
<tr>
<th>1.</th>
<th>Pros</th>
<th>Cons</th>
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<th>2.</th>
<th>Pros</th>
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Removing the sting from worry

Emotional Processing and Metacognitive Awareness (EPMA)

- Help clients distance themselves from negative thoughts.
- Understand that can have intense positive as well as negative feelings.
- Realise that emotions are discrete, they pass and changing perspective can speed this along.
When to use EPMA

- EPMA can be helpful when clients find that they are getting upset or worried but are not sure why.
- However, EPMA is only appropriate if they are keen to explore why this is.
- EPMA can create distress and so both client and therapist should be aware of this and allow extra time in sessions.
- EPMA may not be appropriate if the client struggles to retain focus or is already spending a lot of time ruminating on distressing memories.
Pilot study

• 3 sessions of EPMA (Emotional Processing and Metacognitive Awareness) reduced paranoia in people with persecutory delusions.
• Worry and depression were also reduced.

Stages of EPMA

1. Introduction.
2. 1\textsuperscript{st} positive memory recall.
3. 2\textsuperscript{nd} positive memory recall with labelling.
4. 1\textsuperscript{st} negative memory recall.
5. 2\textsuperscript{nd} negative memory recall with labelling.
Stage 1. Introduction

• A new way of talking about worries.
• A different way of talking about things from talking about them with friends and family.
• Can help to process them, understand them and feel differently about them.
• A technique that has been tried with people with anxiety and depression.
• Start when they have a clear picture.
• Describe it in first person, as if they are right there, right now e.g. “I am walking down the road to meet my friend”.
• Prompt for extra information as it is happening.
• Reflect on thoughts, images, sensations, emotions, memories.
• Repeat back the experience labelling those and then encourage the client to do the same.
Letting go
Positive memory recall
Negative memory recall

Facebook helps you connect and share with the people in your life.

Create an account
It’s free and always will be.

First Name
Last Name
Your email address
Re-enter email address
New Password
Birthday
Day Month Year
Why do I need to provide my date of birth?

Female Male
• Thoughts- what are people writing about me?
• Images- see wall with horrible messages on it.
• Memories- people being nasty in the past.
• Sensations- palms sweaty, breathless.
• Emotions- anxiety, fear, anger.
Staying one step ahead of worry
Considerations

• Lots of different types of worries
• Worries in the session
• Paranoia in the session
• Motivation to engage in activities
• External barriers to activities
• Identity
Sleep
Sleep

Sleep is ESSENTIAL!
We would like to find out what your current sleep pattern is like by asking you to complete a ‘sleep diary’ to record when you went to bed and when you fell asleep each night.

Fill in your sleep diary each day we have agreed. Try to fill in your diary when you get up. Bring this diary with you each time we meet up for an assessment.

If it would be helpful for you, your therapist/research worker will call you during the week to check how you are getting along.

<table>
<thead>
<tr>
<th>1. What time did you wake up today?</th>
<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
<th>Thu</th>
<th>Fri</th>
<th>Sat</th>
<th>Sun</th>
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<tbody>
<tr>
<td></td>
<td>5:11</td>
<td>5:13</td>
<td>2:30</td>
<td>4:30</td>
<td>12:00</td>
<td>5:30</td>
<td>6:15</td>
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<table>
<thead>
<tr>
<th>2. What time did you get out of bed today?</th>
<th>Mon</th>
<th>Tue</th>
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<th>Thu</th>
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<td>6:15</td>
<td>6:00</td>
<td>2:45</td>
<td>4:30</td>
<td>12:00</td>
<td>5:45</td>
<td>6:15</td>
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<thead>
<tr>
<th>3. What time did you go to bed last night (put the light out)?</th>
<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
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<tr>
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<td>6:05</td>
<td>7:15</td>
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<td>7:00</td>
<td>9:00</td>
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<tr>
<th>4. How long did it take you to fall asleep last night (in hrs)?</th>
<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
<th>Thu</th>
<th>Fri</th>
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<td>3:00</td>
<td>9:00</td>
<td>15:00</td>
<td>5:00</td>
<td>2:15</td>
<td>1:15</td>
<td>1:45</td>
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<tr>
<th>5. How long were you awake during the night? (how many times you work up and how long awake)</th>
<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
<th>Thu</th>
<th>Fri</th>
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<th>Sun</th>
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<td></td>
<td>6:15</td>
<td>8:15</td>
<td>9:45</td>
<td>6:15</td>
<td>1:00</td>
<td>1:45</td>
<td>4:45</td>
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</table>

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<thead>
<tr>
<th>6. Did you take medication to help you sleep?</th>
<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
<th>Thu</th>
<th>Fri</th>
<th>Sat</th>
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<tbody>
<tr>
<td>What?</td>
<td>7:30</td>
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<td>What dose?</td>
<td>2:30</td>
<td>2:30</td>
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<tr>
<th>6. Did you drink alcohol last night?</th>
<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
<th>Thu</th>
<th>Fri</th>
<th>Sat</th>
<th>Sun</th>
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<tbody>
<tr>
<td>What?</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
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<tr>
<td>How much?</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
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<tr>
<th>Did you nap during the day? If so, how long for in total (in hrs)?</th>
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<th>Tue</th>
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Insomnia Severity Index


The following questions ask about your sleep in the past two weeks. For each question please CIRCLE the number that best describes your answer.

Please rate the following in relation to your CURRENT sleep (in the past two weeks).

<table>
<thead>
<tr>
<th>Sleep problem</th>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Very Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Difficulty falling asleep</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. Difficulty staying asleep</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. Problem waking up too early</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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</tbody>
</table>

4. How satisfied/dis satisfied are you with your current sleep pattern?
   - Very Satisfied: 0, 1, 2, 3, 4

5. To what extent do you consider your sleep problem to interfere with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood etc.).
   - Not at all interfering: 0, 1, 2, 3, 4

6. How noticeable to others do you think your sleep problem is in terms of impairing the quality of your life?
   - Not at all noticeable: 0, 1, 2, 3, 4

7. How worried/distressed are you about your current sleep problem?
   - Not at all worried: 0, 1, 2, 3, 4

20
Actigraphy

Sleep Analysis

- Lights out: 23:12
- Fell asleep: 23:12
- Got up: 07:00
- Woke up: 07:00
- Time in bed: 07:48
- Actual sleep time: 07:35
- Actual wake time: 00:12
- Sleep efficiency (%): 97.4%
- Sleep bouts: 33
- Mean sleep bout: 00:13:49
- Immobile mins: 455.25
- Mobile mins: 12.76
- Immobile bouts: 40
- Immobile bouts <=1 min: 2
- Total activity score: 1870
- Mean nonzero activity / epoch: 36.67
- Threshold: 40.0

Assumed sleep: 07:48
Actual sleep (%): 97.4
Actual wake (%): 2.6
Sleep latency: 00:00
Wake bouts: 32
Mean wake bout: 00:00:23
Immobile time (%): 97.3
Mobile time (%): 2.7
Mean immobile bout: 00:11:23
Immobile bouts <=1 min (%): 5.0
Mean activity / epoch: 1.00
Fragmentation index: 7.7
Types of sleep disorders?
Circadian Rhythm Disorders
Delayed/advanced sleep phase

• Pattern of sleep characterised by internal body clock not in sync normal bedtime/rise time of majority of adults.
• Tackle by moving sleep schedule approx. an hour in desired direction each day/week.
• Exposure to daylight – to reduce melatonin in daytime
Hypersomnolence

I want to sleep until I feel better.
Sleep apnoea

- Loud snoring
- Interrupted breathing while sleeping
- Disrupted sleep
- Treatment = CPAP

Audit of sleep apnoea in individuals with schizophrenia:

- 26.1% (18/69) of broad inpatient sample reported snoring and breathing interruptions – sleep apnoea risk.
- Risk linked to obesity and atypical medications
- Clinicians should ask about snoring and breathing pauses during sleep
Actigraphy no sleep problems
Actigraphy: different types of sleep problems

17.30 pm  Midnight  11.00 am
Treatments
Hypnotic-dependent insomnia
Sleep disturbance and psychosis

With insomnia, nothing’s real.
Everything’s far away.
Everything’s a copy of a copy of a copy.
• 15 patients with *persistent* persecutory delusions and insomnia.
• 4 session CBT for insomnia intervention (no work on the delusions).
• Assessed insomnia using ISI and Pittsburgh Sleep Quality Index; assessed delusions using Psychotic Symptoms Rating Scale and the Paranoid Thoughts Scales.
Treating insomnia: results

- Clear and large reductions: Insomnia (ISI) \( \downarrow (d = 2.6) \), Delusion (PSYRATS) \( \downarrow (d = 1.13) \)
- Two-thirds made substantial reductions in insomnia (>25%)
- One half showed substantial reductions in delusions (>25%)
- Reductions in depression and anxiety.
Treating insomnia in patients with delusions and hallucinations

Daniel Freeman, Helen Startup, Felicity Waite, Elissa Myers, John Geddes, Allison Harvey, Ly-Mee Yu, Zenobia Zaiwalla, Ramon Luengo-Fernandez, Russell Foster, Rachel Lister.

2012-2014
Treatment of insomnia

- Based on established CBT-I (A Harvey; C Morin; M Perlis; C Espie).
- Includes standard CBT format including an agenda at the beginning of each session, frequent summaries, feedback, guided discovery and Socratic questioning (Beck, 1995).
## What is stopping me sleep?

<table>
<thead>
<tr>
<th>What stops me sleeping?</th>
<th>Not at all</th>
<th>Some-what</th>
<th>Quite a lot</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thoughts go through my head and keep me awake.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have a lot of worries which keep me awake.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel anxious when I am trying to sleep.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can’t relax when I am trying to sleep.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I worry about other people harming me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I hear voices.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have nightmares.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel too upset to sleep.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I don’t do much during the day.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I find it too noisy to sleep.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My room it too light.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My room is too hot/ cold.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I snore heavily.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I sleep during the day.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have a lot of caffeine (coffee, tea, coke, chocolate)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I smoke before I go to bed.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I drink alcohol before I go to bed.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I don’t have a regular bed time and waking time.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I spend a lot of time lying in my bed not sleeping.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I go to bed when I don’t feel tired.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Getting started

Aim of treatment to get the basic rhythms right - sleep, diet, activity

- Relaxation
- Putting the day to rest
  - Worry time
  - Testing out fears/worries
  - Coping with voices
- Exercise/daytime activity
- Developing day and night routines
- Sleep hygiene - creating the right sleep environment
  - Bed = sleep
- Thoughts
  - Voices
  - Worries
- Things we do to try and cope
- Body
- Emotions
Goal setting

• SMART goals

• **Specific to sleep**

• **E.g.**
  1. A regular bedtime routine and regular getting up time.
  2. Reduce time spent in bed when not sleeping – go to bed later.
  3. Manage voices/ worry at night.
  4. Learn and practice relaxation.
  5. Take dog for a walk each day.
  6. Plan fun activities during the day.
CBT-I 24 hour treatment

- Regular bed time
- Wind down routine
- Relaxation
- Daytime activity
- Regular meals

Bed = Sleep ¼ hour rule
Nightmare re-scripting
RISE UP routine
Regular wake time
Psycho-education

Normalise sleep problems.

- How much sleep do I need?
  - Varies from person to person.
  - 4 - 10 hours

- What is the normal pattern of sleep?

<table>
<thead>
<tr>
<th>Age</th>
<th>Average amount of sleep needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth-2 months</td>
<td>10.5-18 hours</td>
</tr>
<tr>
<td>2-12 months</td>
<td>14-15 hours</td>
</tr>
<tr>
<td>12-18 months</td>
<td>13-15 hours</td>
</tr>
<tr>
<td>18 months-3 years</td>
<td>12-14 hours</td>
</tr>
<tr>
<td>3-5 years</td>
<td>11-13 hours</td>
</tr>
<tr>
<td>5-12 years</td>
<td>9-11 hours</td>
</tr>
<tr>
<td>Teenagers</td>
<td>8-10 hours</td>
</tr>
<tr>
<td>Adults (18-65)</td>
<td>7-9 hours</td>
</tr>
<tr>
<td>Older adults (65 and above)</td>
<td>6-7 hours</td>
</tr>
</tbody>
</table>
What factors promote ‘good sleep’?

Sleep hygiene is not enough on its own.
Stimulus control

"No wonder you have insomnia... lying there awake all night."
Stimulus control

- Reduce time in bed not sleeping.
- Regular bedtime and getting up time.
- Go to bed only when sleepy.
- Use the bed and the bedroom only for sleep (no TV, phone, etc.).
- Avoid napping.
Wind-down routine

• Regular bed time and waking up time.

• Wind-down routine which starts 60-90 before your bedtime.

• Pre-bed routine e.g. cleaning your teeth, putting your pyjamas on, locking up.

• Relaxing activities in this time e.g. having a warm bath, reading, watching TV, having a light snack and a decaffeinated drink, anything which helps you relax.
¼ hour rule

• If you are lying in bed unable to sleep for longer than around ¼ hour, when you try to go to sleep or when you wake up in the night, get up and go to another room.

• Do something relaxing (like reading a book, having a light snack) until you feel sleepy before returning to bed.

• If you can’t sleep when you return to bed after ¼ hour then get up again. Again this helps to link bed with sleepiness.

• Tip = plan out in detail with patient.
Morning routine

R – Refrain from snoozing
I – Increase activity
S – Shower and wash face
E – Expose self to sunlight
U – Upbeat music
P – Phone a friend
Day time routine

A well-spent day brings happy sleep.

(Leonardo da Vinci)
**Day time routine and relaxation**

**WEEKLY ACTIVITY SCHEDULE**
Note: Grade Activities: A for Achievement (0-10) and P for Pleasure (0-10)

<table>
<thead>
<tr>
<th></th>
<th>Mon</th>
<th>Tues</th>
<th>Wed</th>
<th>Thurs</th>
<th>Fri</th>
<th>Sat</th>
<th>Sun</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morning</td>
<td>Work, lunch tests, walk downtown</td>
<td>Battery work</td>
<td>Meet at Costa, ingredients for stew</td>
<td>Walking in town to get dinner for evening P6 P7</td>
<td>Carrot Cake, Rachel Allen, ingredients town</td>
<td>Get guitar out of storage, M&amp;Ms, cream</td>
<td>Play guitar 10 mins</td>
</tr>
<tr>
<td>Afternoon</td>
<td>Knitting, walk dog, walk dog</td>
<td>Baking, A6 P6</td>
<td>Making Stella dumplings, call Mark, Back walk</td>
<td>Costa Picnic, Spinn</td>
<td>Bake cake, A6 P6</td>
<td>Washing, Texo roll, A7 P6</td>
<td>Walk puppy, walk puppy</td>
</tr>
<tr>
<td>Evening</td>
<td>Cook dinner, A6 P6</td>
<td>Cook dinner, A6 P6</td>
<td>Shower, music, CD</td>
<td>Cook dinner, A7 P5</td>
<td>Cook dinner, A6 P6</td>
<td>Cook dinner, A7 P5</td>
<td>Cook dinner, A7 P5</td>
</tr>
</tbody>
</table>

*Activities marked with a check*
Relaxation

Use CD and in session practice
Cognitive restructuring

- Review unhelpful beliefs and attitudes about sleep.
- E.g. ‘If I don’t sleep I will get ill’; ‘If I lie in bed even if I’m not sleeping I’m resting my body’; ‘If I can’t sleep then I won’t be able to do anything tomorrow’.
## Cognitive restructuring

<table>
<thead>
<tr>
<th>Situation</th>
<th>Automatic Thoughts</th>
<th>Emotion</th>
<th>Alternative Perspective</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evening at home</td>
<td>‘I’m never going to be able to sleep tonight’ – 100%</td>
<td>Anxious–90%</td>
<td>‘I will almost certainly fall asleep eventually, I always get some sleep’.</td>
<td>Follow wind-down routine and relaxation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Anxious – 50%</td>
<td>Anxious – 50%</td>
</tr>
<tr>
<td>In bed trying to sleep</td>
<td>‘If I don’t sleep I will get ill and have to go back to hospital’ – 100%</td>
<td>Fear – 100%</td>
<td>‘I have been feeling better recently and have been able to cope better using sleep techniques; haven’t been in hospital for past 5 years’.</td>
<td>Reduce zopiclone and keep to regular sleep routine.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Fear - less than 50%</td>
</tr>
<tr>
<td>Situation</td>
<td>Prediction</td>
<td>Experiment</td>
<td>Outcome</td>
<td>What I learned</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td>1. Bad night’s sleep – feeling tired.</td>
<td>“Being active will make me more tired” – 80%</td>
<td>30 mins going for a walk. Vs. 30 mins sitting down.</td>
<td>I had more energy and less foggy after I had been for a walk even when I was tired.</td>
<td>I can create more energy by being active even after a bad night’s sleep.</td>
</tr>
<tr>
<td></td>
<td>Or “Being active will give me more energy” -50%</td>
<td>Measure energy and fogginess.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conserving energy vs. expending energy.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I won’t be able to sleep without extra half tablet of Zopiclone</td>
<td>“I will not able to sleep” – 100%</td>
<td>Two nights not taking extra half tablet of Zopiclone.</td>
<td>Woke up and thought I wouldn’t go back to sleep but remembered therapists words and next thing I know I had fallen asleep again within approx. 15 mins. Felt less groggy and more energy next day.</td>
<td>I don’t need to take extra Zopiclone. I can get natural sleep.</td>
</tr>
</tbody>
</table>
Managing sleep related worry

Writing my worries down at night means I think about them less when I go to bed...

And use all the strategies you’ve already learnt!
Nightmare Re-scripting


Re-writing your nightmares:

• Write down your nightmare scene by scene.
• Rate the distress for each scene.
• Develop a new (happy) ending- insert this just before the peek of distress
• Use this second version as a script for guided imagery and use your imagination to picture the dream scenario.
• Practice daily.
Nightmare Re-scripting
Pulling it altogether

- 12:00 Midnight
- Suppressed
- 11:00 P.M.
- Secretion starts
- 10:00 P.M.
- Body temperature
- 9:30 P.M.
- Greatest
- Eff.
- Muscle strength
- 9:00 P.M.
- Relaxing
- 6:30 P.M.
- Reaction time
- 6:00 A.M.
- Bowel movement
- 5:30 A.M.
- Sharpest b.
- Pressure
- 5:00 A.M.
- Melatonin
- Secretion stops
- 4:30 A.M.
- Lowest
- Temperature
- 3:00 P.M.
- Work
- 2:00 P.M.
- Write
- Down
- Worries
down
- 1:00 P.M.
- A well-spent
- Day
- brings happy
- Sleep.
- (Leonardo da Vinci)
Pulling it altogether and relapse prevention

Final session

• Review progress
  • What learnt? Helpful?
  • What still needs to be done?
  • Goals for the future?

Consider who to invite and involve? Care team? Family? Who can support maintenance of progress and long term goals?
Case example: Ruby

• Ruby is a 20 year old woman. She lives on her own, however she spends a lot of time with her partner. Her partner has just had a baby.
• Ruby is not currently at work but would like to go back to college and perhaps one day become a paramedic.
• Ruby has had a long history of contact with mental health and social care services. She has been diagnosed with schizophrenia and potentially emotionally unstable personality disorder. She hears a voice ‘Warrior’ who comments on what she is doing and sometimes commands her to harm herself. Sometimes she harms herself as she fears that if she doesn’t do it then ‘Warrior’ will make her life much worse. She also fears that other people are conspiring to harm her and that this is part of the Illuminati.
Case example: Ruby

Sleep problem:
- Sleep problems for past few years. Difficulty sleeping every night; 1 or 2 nights a week with no sleep. Very hard to get to sleep, often awake until 5am and therefore sleeping in in the daytime.
- To manage not sleeping Ruby stays up late watching TV, uses cannabis to try and get to sleep, sleeps in during the morning, avoids doing too much in the daytime, sleeps on the sofa in front of the TV, plays on her phone at night time.

Other information:
- Panic attacks at night (and daytime); believes she will have a heart attack. Has had several nights in A&E in the last month due to fears of having a heart attack.
- Low mood. Previous suicide attempts and ongoing self harm.
- Finds it hard to trust professionals as they are “paid to care”
- Tried CBT for anxiety in the past. Didn’t find it very helpful and is not expecting much from therapy as she is a “lost cause”
- Nightmares sometimes about others trying to harm her.
- Ruby has OCD and spends hours in the night time cleaning or watching TV to distract from worries.
Ruby: Actigraphy
<table>
<thead>
<tr>
<th>Question</th>
<th>Mon</th>
<th>Tues</th>
<th>Wed</th>
<th>Thur</th>
<th>Fri</th>
<th>Sat</th>
<th>Sun</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What time did you wake up today?</td>
<td>12pm</td>
<td>2pm</td>
<td>11am</td>
<td>2pm</td>
<td>12pm</td>
<td>10am</td>
<td>10am</td>
</tr>
<tr>
<td>2. What time did you get out of bed today?</td>
<td>12.30pm</td>
<td>2.15pm</td>
<td>11.10am</td>
<td>2.30pm</td>
<td>12.10pm</td>
<td>10.05am</td>
<td>11.30am</td>
</tr>
<tr>
<td>3. What time did you go to bed last night (put the light out)?</td>
<td>2.30am</td>
<td>1am</td>
<td>3.30am</td>
<td>5am</td>
<td>4am</td>
<td>3am</td>
<td>3.30am</td>
</tr>
<tr>
<td>4. How long did it take you to fall asleep last night (in hrs)?</td>
<td>2hrs</td>
<td>4hrs</td>
<td>1hr</td>
<td>15mins</td>
<td>15mins</td>
<td>15mins</td>
<td>1.5hrs</td>
</tr>
<tr>
<td>5. How long were you awake during the night?</td>
<td>awake 3 times for 15mins</td>
<td>once 15mins</td>
<td>once 30mins</td>
<td>No</td>
<td>twice 10 mins</td>
<td>4 times – 15mins x3; 30 mins x 1</td>
<td>twice for 15 mins</td>
</tr>
<tr>
<td>6. What medication did you take to help you sleep? What? What dose? What time?</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>7. How much alcohol did you take last night?</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>8. Did you nap in the day? If so, how long?</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>
Case example: Treatment plan.
Negative self/Interpersonal sensitivity
The elements of well-being

**POSITIVE EMOTION**
- Pleasure
- Meaning
- Engagement

**FEWER NEGATIVE EMOTIONS**
* High correlation between factors (-0.6).
* 40% of genetic influence shared, and 30% of environmental factors.
How to calm negative thoughts & increase positive thoughts.

Describes the evidence-based techniques.
Treating negative self in paranoia

Small pilot studies: treat self-esteem, psychosis lowers

• Hall & Tarrier (2003), seven weekly sessions.
• Knight et al (2006), seven weekly group sessions.
• Laithwaite et al (2007), ten weekly group sessions.

We have just finished data collection for a RCT evaluating treating negative self in patients with persecutory delusions ($N = 30$).
The real voyage of discovery consists not in seeing new landscapes but in having new eyes.

— Marcel Proust
Increasing well-being/happiness

Three pronged structure for sessions:
1. Fewer negative thoughts/emotions
2. More positive thoughts/emotions
3. Positive activities (Pleasure, Meaning, Engagement).
1. How would you describe yourself?
2. On a bad day?
3. On a good day?
1. What makes you think you are…?

2. Describe a recent situation that brought negative thoughts to mind: check for triggers, self-focus, negative voices, negative images, and safety behaviours.

3. What would you be doing if you had greater confidence?
<table>
<thead>
<tr>
<th></th>
<th>None of the time</th>
<th>Rarely</th>
<th>Some of the time</th>
<th>Often</th>
<th>All of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>I've been feeling optimistic about the future</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I've been feeling useful</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I've been feeling relaxed</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I've been feeling interested in other people</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I've had energy to spare</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I've been dealing with problems well</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I've been thinking clearly</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I've been feeling good about myself</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I've been feeling close to other people</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I've been feeling confident</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I've been able to make up my own mind about things</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I've been feeling loved</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I've been interested in new things</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I've been feeling cheerful</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

*Warwick-Edinburgh Mental Wellbeing Scale (NHS Health Scotland)*
Monitor

<table>
<thead>
<tr>
<th>MYSELF</th>
<th>Believe it slightly</th>
<th>Believe it mod.</th>
<th>Believe it very much</th>
<th>Believe it totally</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am unloved</td>
<td>NO</td>
<td>YES</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>I am worthless</td>
<td>NO</td>
<td>YES</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>I am weak</td>
<td>NO</td>
<td>YES</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>I am vulnerable</td>
<td>NO</td>
<td>YES</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>I am bad</td>
<td>NO</td>
<td>YES</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>I am a failure</td>
<td>NO</td>
<td>YES</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>I am respected</td>
<td>NO</td>
<td>YES</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>I am valuable</td>
<td>NO</td>
<td>YES</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>I am talented</td>
<td>NO</td>
<td>YES</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>I am successful</td>
<td>NO</td>
<td>YES</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>I am good</td>
<td>NO</td>
<td>YES</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>I am interesting</td>
<td>NO</td>
<td>YES</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

*Brief Core Schema Scale* (Fowler et al, 2006)
At end of first session have two visual analogue scales (negative self description, confidence/positive self-description)
Activities
5-a-day
5-a-day for well-being
5-a-day for well-being

“If you desire an hour’s happiness, take a nap. If you desire a day’s happiness, go fishing. If you desire a month’s happiness, get married. If you desire a year’s happiness, inherit a fortune. If you desire a lifetime’s happiness, help someone else.”
5-a-day for well-being

- Build activities on strengths and values.
- Excellent way of also spending time on positive aspects of the person.
- Schedule, keep fresh, ideally do with others.
Negative thoughts
Calming negative thoughts I: Acknowledge

- The therapist listens to them.
- Acknowledge the disappointments
- Understand & normalise.
- Emotional processing.
- Bring worries to sessions, otherwise use worry periods.
Calming negative thoughts II: Reframing and hope

• Developing an alternative perspective/narrative on the difficulties e.g. ‘Self as hero’ ‘Life throws nasty things at many people, it is how you react that matters and you’ve been strong...’.

• Normalisation of anomalies that make the person feel different (– may even be signs of anxiety/depression).

• Discussion of issues around diagnosis sometimes.

• Longer term planning, working with rest of clinical team.
Calming negative thoughts III: Reducing social comparison

- Jante Lov – “You’re no better than anyone else”
- “Other people just look happier than I am”
- Keep watch on the diet of what read and watch.
- Encourage self-compassion.
- * Shift focus of attention.
Looking for trouble
Voices often source of negative thoughts.

Need to help person see that voices are not a good source of information and best to disengage from them. i.e. change relationship to voices and shift attention.

And...
Initial evaluation of the effects of competitive memory training (COMET) on depression in schizophrenia-spectrum patients with persistent auditory verbal hallucinations: A randomized controlled trial

Mark van der Gaag¹,²*, Bas van Oosterhout³, Kirstin Daalman⁴, Iris E Sommer⁴ and Kees Korrelboom⁵
Don’t treat thoughts as facts.

Think of evidence for and against.

Think of alternative explanations.

Test out the explanations (dropping safety behaviours).
Am I mad?

• The scenario: The patient is low in mood, nervous, and is detailing ways that people have been persecuting. The person believes that the government is spreading malicious rumours and stopping a normal life being led. The client cites comments on TV/radio/newspapers and the looks and comments overheard when out. Sometimes the person hears things but does not know whether they are real people saying them. The client hesitantly asks the therapist: ‘Do you think I am mad?’

• Talk in pairs about how the therapist might respond. Think of at least two ways.

• Then role play the different ways of responding. One person the client, the other person the therapist. Try to find the best way to respond.
Positive thoughts
Positive thoughts I: Basic environmental elements

- Music
- Television
- Reading
- Pictures
- Style in interactions (role play smiling vs looking miserable)
Positive Thoughts II:
Identifying positive aspects of self

- Ask person to list positive aspects
- Spend time going through Seligman’s strengths and values list
- Aim to make positive knowledge about the self as accessible as other specialist areas of knowledge in his or her life (e.g. football).
- Make sure you are feeding back positive aspects of person that you are noticing.
Identifying positive aspects of self

<table>
<thead>
<tr>
<th>Creativity</th>
<th>Curiosity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Love of learning</td>
<td>Open-mindedness</td>
</tr>
<tr>
<td>Perspective</td>
<td>Authenticity/genuineness/honesty</td>
</tr>
<tr>
<td>Bravery</td>
<td>Persistence</td>
</tr>
<tr>
<td>Zest/energy/wholeheartedness</td>
<td>Kindness</td>
</tr>
<tr>
<td>Love</td>
<td>Social intelligence (being sensitive to other people’s needs and desires)</td>
</tr>
<tr>
<td>Fairness</td>
<td>Leadership</td>
</tr>
<tr>
<td>Teamwork</td>
<td>Forgiveness/mercy</td>
</tr>
<tr>
<td>Modesty/humility</td>
<td>Prudence</td>
</tr>
<tr>
<td>Self-discipline</td>
<td>Appreciation of beauty and excellence</td>
</tr>
<tr>
<td>Gratitude</td>
<td>Hope</td>
</tr>
<tr>
<td>Humour</td>
<td>Religiousness/spirituality</td>
</tr>
</tbody>
</table>

http://uat.viacharacter.org
The modesty concept

• A tendency to ‘hide light under a bushel’. Give greater prominence to negative then positive.
• Use this to help give person permission to focus upon the positive.
• *Aim to help the person develop a more balanced view of the self, that can help foster a sense of greater control and hope for the future.*
Positive Thoughts III: Savouring

1. ‘What’s going right for me right now?’
2. At end of day, list three positive events.
3. Keep data log of positive events.
Positive Thoughts: Imagery

1. Visualise positive outcomes.
2. Recall positive memories.
3. Create positive places for relaxation.
“My mind isn’t wandering. I am not thinking of something else. I am totally involved in what I am doing. My body feels good. I don’t seem to hear anything. The world seems to be cut off from me. I am less aware of myself and my problems.”
“What sweetness in life remains if you take away friendship? Depriving life of friendship is like depriving the world of the sun.”

Cicero
Strengthening Relationships

- Quality more than quantity
- Express your gratitude
- Praise
- Remember what makes your friend special
- Be helpful
- Respond positively to good news
Make clear (and accessible) plan for days when particularly low mood occurs.
Anomalous Internal Experiences
‘The delusional belief is not being held “in the face of evidence normally sufficient to destroy it,” but is being held because of evidence powerful enough to support it.’
Maher (1974)
Anomalous internal experiences

Paranoid thoughts often build upon:

- Hallucinations
- Anxious arousal
- Perceptual disturbances
- Derealisation/depersonalisation
Anomalous internal experiences

Cardiff Anomalous Perceptions Scale (CAPS) 
(Bell et al, 2006)

Cambridge Depersonalisation Scale (CDS; Sierra and Berrios, 2000)
Intervention techniques

• Need to raise awareness that these are central to the experience.
• Often switch focus onto anomalous internal experiences e.g. ‘the problem is these terrible fearful feelings that you get on the bus’.
• Diary the experiences.
• Identify the triggers (e.g. waking up in morning) and alter behaviour accordingly (e.g. get up and active).
• Normalise them (provide personal accounts).
• Encourage toleration of them. Bring them on (at least float idea).
• Once decatastrophize then encourage mindful attitude to them i.e. change the reaction to anomalous experiences.
Bringing the techniques together

• A menu of treatment options for patients, with selection on basis of assessment and choice.
• But these ideas can also be integrated together in practice.
• The art is to know where to focus...
Bill

- Bill is absolutely convinced his neighbours are breaking into his flat when he is out and when he is in the flat that they use black magic against him. This has been happening for over 20 years, even after moving flat. He does not like his belief doubted.
- At night, when in bed, he feels punched by the neighbours. This happens for at least an hour every night.
- He gets very angry and bangs upon the walls. The neighbours often bang back.
- He believes that they do these things because he has failed in his life. He seldom speaks to people because he feels they will dislike him. He believes this is unfair.
- When he goes to a day centre two days a week, the neighbours move things around in his flat (e.g. cutlery) to demonstrate the power that they have over him. He worries about this when out and immediately checks everything in his flat when he gets back. Otherwise he sits in his armchair thinking about the neighbours.
Tracey

• Tracey was terrified that she would be attacked when outside. She thought she might be knifed and had a clear picture of this. She could see the hostility in people’s faces and felt very anxious when out (her heart would pound, she would feel faint and could even feel sick). In the past she had seen people’s eyes turn red.
• She was not sure why people were targeting her but thought she looked odd and vulnerable and perhaps they could read her thoughts. She had been bullied as a teenager.
• Some days the fear was so strong that she did not leave the house. Often when out she would return home early after being unable to remain on the bus.
• Her mood went up and down a lot. A diary showed that the fears were worse if she had woken up anxious, tired, had not eaten, or was bored.
• Tracey felt powerless, trapped, and would use alcohol most days to calm her fears. She did not think she could control the situation.
Therapy books


www.paranoidthoughts.com