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Behaviour therapy as an adjunct to treatment of systematized delusion—a case report

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Summary

Systematized delusion can sometimes be very difficult to treat. In the present case of identity confusion in a single girl, operant conditioning technique was employed when physical and other forms of psychological treatment had failed. The patient's system of delusion was dissolved and she remained symptom free 12 months after discharge.

Résumé

L'hallucination systématisée peut être parfois très difficile à traiter. Dans le cas présent de délire hallucinatoire chez une célibataire, une technique de conditionement était utilisée, quand le traitement physique ou psychologique, sous autres formes, avait échoué. Le forme d'hallucination chez la malade avait disparu et elle n'avait eu aucun symptôme pendent 12 mois après sa sortie d'hôpital.

The use of operant conditioning to bring about a reduction in delusional verbalizations in psychiatric patients has been reported extensively in the literature (Ayllon & Michael, 1959; Ayllon & Haughton, 1964; Bandura, 1969). Recently, Richardson, Karlcalas & Lal (1972) using a tactile hallucination for experimental purposes and an auditory hallucination as a control reported a dramatic decrease in the emission of tactile hallucinations upon the application of operant techniques. There was no change in the 'control' hallucination for which non-contingent reinforcement was given.

We report below the successful treatment of a system of delusion in a schizophrenic patient.

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Case report

M.D. was a 23 year old single girl when she was first seen by one of us (M.O.O.) in April 1972. The relative who sought help for her indicated that the patient had of recent become very quarrelsome, often kept to herself, was not eating well and was unable to keep a job.

Initially the patient was very circumstantial when asked about her symptoms. Eventually she narrated a 5 year history of persecution. Failure in secondary school, nursing-training, working for 'O' levels, were all attributed to deliberate acts by others to prevent her achieving these goals. Similarly, in work situations she remained only a short while as she felt her colleagues did not like her. At the present time she claimed her relatives were saying nasty things about her.

The interview further revealed that she was not eating well, because she suspected the food was poisoned. She admitted to hearing voices, which were abusive in nature. On many occasions, her thoughts had been muddled and she had a phobia of travelling in mini-buses. When she was asked to discuss her family, she indicated that she had for a long time been unsure who she was and who her true parents were. At one stage she was sure her uncle, and at another her distant cousin, was her father; she was quite emphatic that her true father was some undefined relative. At one stage she indicated she had two fathers.

At the age of seven, the patient went to live with her uncle. She moved her cousins and other members of the extended family into an intricate but systematized delusional system. The patient felt that the one solution to her problem was to go to Britain where people minded their own business. A diagnosis of paranoid schizophrenia was made and the patient was admitted for treatment.

Management

The patient's parents were invited and a confrontation interview arranged. The father went over the patient's life history, focussing on life events in the polygamous set up and getting the patient to identify culture specific father-daughter relationship and responsibility. At the end of 90 min, the patient was still intellectualizing clear evidence of true father-daughter relationship. The patient was on trifluoperazine (stelazine) and chlorpromazine (largactil) for 8 weeks. At the end of this period, the patient was sleeping well, the hallucinations had disappeared, but the patient was as confused as ever about her identity. She was discharged to be followed up in the out-patient because of pressure on beds.

Subsequent events

She kept only one out-patient appointment and was not heard of for the next ten months until the relative reported with the following account. After discharge from hospital, the patient persuaded her family to send her to Britain so that she could study in peace. This request was acceded to without seeking professional advice. It is also necessary to add that the parents were not really convinced that their daughter had a serious mental illness since she was otherwise well apart from this area of delusion. They were soon to be surprised by the contents of the patient's letters from London. The letters showed that their daughter was confused about who she was and about her relationship to the various members of the family who had received letters from the patient. Moreover, the patient indicated that her life was in danger and someone should come for her at once. A relative brought the patient home from London.

At interview the patient indicated that the street where she had been living for the previous 4 months in London looked strange. She was convinced that she was being watched by the police. The situation was so bad that she locked up herself in her room in London. While there, she heard voices of some old women in Nigeria talking about her. In some unclear fashion, she felt changed as a human being. She looked tired, lean and confused. The loss of identity was the most constant phenomenon present. She was again admitted and put on heavy doses of stelazine and largactil. She was given six electro-convulsive treatments. The delusions remained fixed although she was otherwise better mentally and nutritionally.

After 5 weeks in the ward, she started to clamour to be discharged. Interviews about her delusions showed that they were as fixed as ever. She was referred for behaviour therapy.

Behaviour therapy

As observations had revealed that hospitalization was most aversive to the patient, it was felt that her feelings about this situation could be used to modify her delusions.

Daily interviews with the behaviour therapist (B.A.) commenced. She was informed that the only reason she had to remain in hospital was that she claimed to have more than one father; since this was biologically impossible she must be very sick. She was then asked to write down the name of her father. She responded by writing the name of her biological father but proceeded to verbalize the belief that she had other fathers. For the first two sessions the therapist explained to her why it was impossible to have more than one biological father.

Thereafter, at each interview she was asked to write the name of her biological father. When she made qualifying remarks to explain why she felt she had more than one father, the therapist merely responded, 'But you know it is impossible to have more than one father—you must be very sick. You will not be able to go home for a while yet'.

After a further 2 weeks she dropped the qualifying statements, at which the therapist asked sternly, 'Are you sure? You told me you had other fathers!' She became more and more adamant that she had only one father. Interviews then became spaced out, every other day, for a week, and then not for several days.

At discharge, she appeared to have shed all her psychotic verbalizations. Furthermore, the patient was reminded that she was being discharged because she was no longer 'sick'. She was discharged on the same medication she was on before the operant conditioning programme began.

Follow-up interviews

Initially, the patient was seen once a month and then less frequently in the out-patient clinics. A 12 month follow-up revealed that the patient has remained well. She had a room in her father's house

and was functioning adequately with other siblings and her father's wives. Moreover, she has enrolled in a secretarial college. Her insight has fully returned. A full report from her relative who brought her for treatment showed that the patient has been very well.

Discussion

It is well known that after intensive treatment of paranoid psychosis with psychoactive drugs and even ECT some patients 'shed' all their symptoms except the delusion. Such patients can go about their daily routine without obvious signs of illness until the area of their delusion is touched upon (Mayer-Gross, Slater & Roth, 1969). When such patients are seen at follow-up interviews, they may report good progress but still hold on to their delusions.

This case illustrates the point that behaviour therapy is a useful additional tool in the management of delusional verbalizations. The success of the operant technique in this case seems to lie in the fact that maintenance of the delusion deprived her of a number of desirable rewards, e.g. being at home, having companions and so forth. Without any attempt to change the belief system that she held, it gradually shifted in such a way that she could obtain these rewards. It appears that behavioural change (in this case, the verbal response) preceded the change in belief.

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