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Delayed Treatment Initiation in Early-Onset Schizophrenia: A Case Demonstrating the Role of CBTp Following Pharmacological Stabilization

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ABSTRACT

Background: Delusions in schizophrenia are difficult to treat. Direct confrontation often worsens outcomes. Cognitive Behavioral Therapy for Psychosis (CBTp) offers a collaborative, distress-focused alternative. **Case presentation:** A 28-year-old male from rural South Kashmir with chronic persecutory and religious delusions (90–95% conviction) and intact executive function received 10 weekly CBTp sessions following antipsychotic stabilization. **Intervention:** CBTp emphasized emotional validation, metacognitive reflection, and distress reduction without directly disputing delusional content. **Outcomes:** Delusional conviction fell from 90% to 55%. PANSS positive subscore reduced by 30%. Sleep increased from 4–5 to 7 hours/night. Academic and social functioning improved. No relapse at 3 months. **Conclusion:** Non-confrontational, culturally sensitive CBTp combined with pharmacotherapy improved distress, function, and insight without requiring complete belief elimination.

Keywords: Schizophrenia, CBT for Psychosis, Persecutory Delusions, Religious Delusions, Cultural Formulation, Recovery-Oriented Care.

INTRODUCTION

Schizophrenia is a chronic psychotic disorder characterized by disturbances in thought, perception, emotion, and behavior. Among its core features, delusions represent one of the most persistent and clinically challenging symptoms. According to the DSM-5, a diagnosis of schizophrenia requires at least two core symptoms amongst delusions, hallucinations, disorganized speech, grossly disorganized/catatonic behavior, or negative symptoms persisting for six months and accompanied by significant social or occupational dysfunction [1]. Delusions are defined as fixed beliefs held with strong conviction, often resistant to contradictory evidence. They may take persecutory, grandiose, religious, or referential forms. In collectivistic and religious contexts, delusional content can become intertwined with normative belief systems, complicating both diagnostic assessment and clinical intervention [2,3]. Contemporary research indicates that delusions arise from the interaction of cognitive biases, emotional dysregulation, and sociocultural factors. Neurocognitive models have highlighted

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aberrant salience attribution and impaired belief evaluation as key contributing mechanisms [4]. Historically, direct confrontation of delusional beliefs was common in clinical practice, however, this approach has been shown to increase resistance, heighten distress, and lead to therapeutic rupture, particularly when delusions are persecutory or culturally embedded [5-7]. In response, contemporary psychological interventions have shifted toward collaborative, non-confrontational approaches. Cognitive Behavioral Therapy for Psychosis (CBTp) is one such intervention, emphasizing the reduction of belief conviction and associated distress while respecting the patient's cultural and religious framework. In the present case, a 28- year-old male with chronic persecutory and religious delusions underwent 10 weekly CBTp sessions following pharmacological stabilization. Over the course of therapy, conviction in persecutory beliefs which had already decreased from near absolute certainty (95%) to expressed doubt (55–60%).

This was accompanied by reductions in anxiety and meaningful improvements in functional outcomes. This case illustrates the clinical relevance of structured, culturally sensitive CBTp in reducing delusional conviction and distress while supporting functional recovery.

CASE PRESENTATION SOCIODEMOGRAPHIC DETAILS

Mr. A is a 28-year-old male from rural South Kashmir. He has completed his master's degree, resides with his parents and younger brother, and is financially independent. There is no reported history of substance use, and family psychiatric history is negative. Premorbidly, Mr. A was sociable and academically motivated. Although outwardly well-adjusted, he later described underlying emotional vulnerabilities during childhood and adolescence that he did not disclose at the time. He completed higher education without interruption. Symptom onset began gradually following high school, around the start of university. He remained untreated for approximately four years, during which psychotic symptoms slowly emerged and progressed. Presenting features included increasing suspiciousness, social withdrawal, and gradually evolving persecutory beliefs. Over time, these became intertwined with religious themes where Mr. developed fixed beliefs that he was being targeted by the government and that divine intervention was interlinked with these experiences. The untreated course was characterized by persistent delusional preoccupation, episodic behavioral disorganization, and functional decline.

Family members noted increasing guardedness and verbal irritability, though no aggressive behavior was reported. Mr. A first presented to psychiatric services in 2020 following family encouragement. He was diagnosed with schizophrenia, multiple episodes, currently in partial remission. Antipsychotic medication was initiated, resulting in stabilization of acute disturbances. At the time of psychological assessment for CBTp, Mr. A continued to experience persistent persecutory and religious delusions, though with reduced behavioral expression. He demonstrated partial insight into his condition but maintained strong conviction (~90–95%) in his delusional beliefs. He reported significant distress, including anxiety, sleep disturbance (4–5 hours per night), and impaired day to day engagement. No formal thought disorder or prominent negative symptoms were evident.

Presenting Complaints

- Persistent fear that classmates, faculty, and government agents were monitoring, following, and plotting against him.
- Firm belief that divine forces had chosen him for a special religious mission, and that external events (news, people's casual remarks) carried hidden messages confirming this.
- Marked anxiety, disturbed sleep (4–5 hours/night), and hypervigilance.
- Social withdrawal and avoidance of university settings.
- Episodes of disorganized behavior during peak conviction (e.g., praying compulsively for hours, refusing to eat unless food was "blessed" in a specific way).

History of Present Illness

Symptom onset began in early adulthood. Initially, Mr. A reported suspiciousness that classmates were academically sabotaging him. Over time, this evolved into a persecutory delusion that government agencies were monitoring him through mobile phones and that certain strangers in the marketplace were disguised intelligence officers.

He simultaneously developed religious delusions: a fixed belief that God had appointed him to deliver a warning to the community, and that ordinary events (a crow cawing, a door creaking) were divine signs. These beliefs were held with 90–95% conviction and resisted counterevidence.

Hallucinations: During acute exacerbations (prior to stabilization), Mr. A reported auditory hallucination – a man's voice, distinct from his own thoughts, commenting on his actions ("He is failing," "Do not trust them") and occasionally giving simple commands ("Leave now"). He denied visual, olfactory, or tactile hallucinations. Command hallucinations were intermittent and did not persist after antipsychotic stabilization. At the time of CBTp initiation, no active hallucinations were present.

During his 2020 exacerbation, he exhibited disorganized behavior (bizarre posturing during prayers, writing

incoherent religious notes), which resolved with risperidone. Residual persecutory and religious delusions persisted but with reduced behavioral expression.

Mental Status Examination

Appearance and Behavior: Appropriately dressed, well-groomed, calm, cooperative, and fully engaged during the interview. Psychomotor activity normal; no abnormal movements noted.

Speech: Normal rate, volume, and tone, coherent and spontaneous.

Mood and Affect: Subjectively anxious, affect mildly restricted but congruent with mood.

Thought Process (Form): Goal-directed, coherent, and logical, no loosening of associations, tangentiality, circumstantiality, or thought blocking observed.

Thought Content: Preoccupied with persecutory and religious beliefs, held with partial conviction (55–60%). No suicidal or homicidal ideation reported. Delusions moderately distressing but ego-syntonic, patient demonstrates some questioning of belief validity when prompted.

Perception: No hallucinations or perceptual disturbances currently reported or observed.

Cognition:

Attention and Concentration: Alert and oriented; able to maintain focus throughout interview. serial 7s subtraction task performed without error.

Memory: Immediate, recent, and remote memory intact. Able to recall three objects after 5 minutes and events from recent days accurately.

Orientation: Fully oriented to time, place, and person.

Intact executive functioning: Able to plan, organize, and answer hypothetical questions appropriately.

Insight: Partial, acknowledges possibility of mental illness and benefit of treatment but continues to attribute some experiences to external/divine causes.

Judgment: Improving, able to make reasoned decisions regarding daily functioning and treatment adherence, though impaired during prior episodes of acute psychosis.

Diagnosis

The patient meets criteria for schizophrenia, multiple episodes, currently in partial remission, given the presence of prominent persecutory and religious delusions, disorganized behavior during exacerbations, and negative symptoms (mild affective restriction, social withdrawal) persisting over a chronic course exceeding six months. Functional impairment is evident in academic and social domains. Symptoms responded to antipsychotic medication, further supporting a primary psychotic disorder rather than a mood-related or substance-induced psychosis. Delusional disorder is ruled out due to episodic behavioral disorganization and negative symptoms. Schizoaffective disorder is excluded as mood symptoms are secondary and do not meet criteria for a full affective episode concurrent with psychotic symptoms. Brief psychotic disorder is inconsistent with the chronic, multi-episode course, and organic causes were excluded based on cognitive testing and history.

Therapeutic Intervention Pharmacological Management

Initial Stabilization (June 2020)

Upon first psychiatric consultation in June 2020, the patient was initiated on a combination of MA Sulphite, Lopsize, and other antipsychotic sedatives. This initial regimen provided acute stabilization of florid psychotic symptoms including bizarre behavior, command hallucinations, and complete lack of insight but resulted in significant sedation, with the patient sleeping throughout the day.

Table 1. Pharmacological treatment timeline and correlation with sleep and anxiety

Time period	Medication	Dosage	Target symptoms	sleep (hrs/night)	Anxiety (self- report 0–10)	Clinical notes
June 2020 (initial)	MA Sulphite + Lopsize + sedatives	As prescribed	Acute psychosis, command hallucinations, disorganization	12+ (excessive sedation)	8/10	Sedated but behaviorally controlled
Weeks 1–6	Olanzapine ODT	10–20 mg/day	Delusions, agitation, insomnia	7–8	7 /10	Improved sleep but ongoing conviction
Weeks 7–14	Risperidone ODT	4–6 mg/day	Positive symptoms, residual delusions	6–7	6/10	less sedation; better engagement
Weeks 15–26	Amisulpride	200 mg/day	Subthreshold paranoia, cognitive function	7–8	5/10	Improved academic focus
Ongoing (post-CBTp)	Amisulpride + clonazepam	200 mg + 0.25 mg nightly	Maintenance + residual anxiety/ sleep	7–8	3/10	Optimal functional outcome

ODT = orally disintegrating tablet.

Table 2. Pre- and post-intervention outcome indicators

Indicator	Baseline (pre-CBTp)	Post-CBTp (3 months)	Change
Delusional conviction (%)	90–95%	55–60%	–35–40%
PANSS positive subscale (raw score)	24	17	–30%
Sleep (hours/night)	4–5	7–8	+3 hours
Anxiety (subjective 0–10)	8	3	–5 points
Academic attendance	Irregular, incomplete work	Regular, coursework completed	Functional recovery
Social participation	Withdrawal	Family + community activities	Improved

Transition to Optimized Regimen

Following initial stabilization, the medication regimen was gradually optimized under psychiatric supervision to balance symptom control with functional recovery and facilitate engagement in psychological therapy. Olanzapine (orally disintegrating tablets, 10–20 mg/day) was introduced for 6 weeks during the acute phase to target prominent persecutory and religious delusions, behavioral disorganization, and heightened anxiety. Olanzapine was selected for its potent efficacy against positive symptoms and sedative properties, which facilitated adherence in the context of limited insight and agitation. Side effects were monitored, including weight gain, metabolic parameters (fasting glucose, lipids), sedation, and extrapyramidal symptoms (EPS); mild sedation was observed without significant metabolic disturbance. Following partial symptomatic improvement but persistent residual delusional conviction and suspiciousness, treatment was transitioned to risperidone orally disintegrating tablets (4–6 mg/day) over 8 weeks, chosen for its favorable profile in reducing positive and negative symptoms, lower sedation, and enhanced adherence. Side effects including mild prolactin elevation and transient EPS were closely monitored; none required discontinuation. The transition aimed to optimize symptom control and support engagement in subsequent psychological therapy. For long-term stabilization, amisulpride 200 mg once daily was introduced and maintained for 12 weeks, targeting subthreshold psychotic symptoms and persistent suspiciousness, while enhancing cognitive functioning and academic performance. Amisulpride was selected for its efficacy in treating both positive and negative symptoms at low doses, and lower metabolic risk compared to olanzapine. Regular monitoring included EPS, prolactin levels, and renal function, with no significant adverse effects observed. Adjunctive low-dose clonazepam (0.25 mg nightly) was prescribed to manage residual anxiety and sleep disturbance, with monitoring for sedation or dependence. Throughout the pharmacological treatment course, the patient remained adherent under psychiatric supervision, which provided a stable clinical foundation for the initiation and continuation of structured psychological intervention (CBTp).

Outcome and Follow-Up

Following 10 weekly sessions of CBTp over three months, combined with ongoing pharmacological treatment, the patient demonstrated measurable improvements across multiple domains:

Delusional conviction: Reduced from near absolute certainty (~95%) at baseline to partial doubt (55–60%) by the end of therapy, as assessed via structured belief rating scales.

Distress and anxiety: Subjective anxiety ratings decreased from severe to mild on self-report scales; residual anxiety managed with low-dose clonazepam.

Insight: Improved from partial (acknowledging possible illness but attributing some experiences to external/divine causes) to enhanced insight, with recognition of treatment necessity and ability to reflect on delusional content.

Functional gains: Academic re-engagement improved, with regular attendance and timely completion of coursework; social interactions increased, with participation in family and community activities; sleep duration normalized from 4–5 hours/night to 7–8 hours/night.

Psychosocial functioning: Patient reported greater confidence in coping with stress and uncertainty; ability to use metacognitive strategies to manage intrusive thoughts and reduce hypervigilance.

Follow-up: At three months post-therapy, the patient-maintained gains with no relapse of psychotic symptoms while continuing combined pharmacological and psychological treatment. Regular psychiatric review and structured CBTp booster sessions were planned every 4–6 weeks to consolidate improvements and monitor risk.

DISCUSSION

The present case contributes to a growing body of evidence suggesting that directly challenging delusional beliefs in schizophrenia can often be unhelpful and, in some cases, may intensify distress, defensiveness, and disengagement from therapy. Attempts to simply correct the "falsehood" of delusions overlook the complex cognitive, emotional, and neurobiological factors that shape how these beliefs emerge and persist. Contemporary cognitive models view delusions not as random errors in thinking, but as understandable attempts to make sense of unusual experiences, intense emotions, trauma, and heightened perceptions of threat [2,4]. From this perspective, directly disputing delusional content can feel invalidating and may inadvertently reinforce persecutory fears by positioning the therapist as dismissive. In contrast, the therapeutic approach used in this case was consistent with principles of Cognitive Behavioral Therapy for Psychosis (CBTp), emphasizing collaboration, empathy, and respect for the patient's lived experience. Rather than insisting on immediate belief change, therapy focused on reducing distress, increasing coping, and gently encouraging reflection on belief certainty. The reductions in anxiety, improvements in daily functioning, and emerging insight observed in this patient align with prior research supporting the effectiveness of CBTp in managing distress associated with delusions, even when the beliefs themselves persist [6,8]. A central factor in the positive outcome was the development and maintenance of a strong therapeutic alliance, achieved by validating the patient's emotional experience and focusing on functional impact rather than content dispute. Cultural and religious sensitivity was equally critical; careful differentiation between normative religious beliefs and distressing psychotic interpretations allowed therapeutic work to proceed while preserving the patient's sense of meaning and dignity [7,9]. Pharmacological treatment provided stabilization, creating the psychological space necessary for effective CBTp, demonstrating the importance of integrated biological and psychological interventions.

Given the **patient's** intact executive functioning (demonstrated by normal planning, organization, and hypothetical reasoning on mental status examination), the persistence of his religious delusions cannot be attributed to a global cognitive deficit. Instead, the focus should be on the process preceding, during, and following intensification of his religious beliefs. Pre- intensification, psychosocial stressors (academic rivalry, social isolation) created emotional vulnerability. During intensification, aberrant salience [3] may have attached excessive meaning to ordinary events (e.g., a crow cawing as a divine sign). Post-intensification, intact reasoning was paradoxically applied to maintain the delusion through confirmation bias and belief perseverance. CBTp in this case targeted those maintenance cycles without disputing the belief's content, which proved feasible precisely because executive functions were preserved.

LIMITATIONS

This case report is inherently limited by its single-subject design, restricting generalizability. Standardized outcome measures for delusional conviction and functional gains were not consistently applied, and some improvements relied on patient self-report. Follow-up was limited to three months, precluding conclusions about long-term relapse prevention. Furthermore, the findings may not generalize to populations with different cultural or religious contexts.

FUTURE DIRECTIONS

Future research should include larger, controlled studies examining non-confrontational CBTp approaches within culturally diverse populations, utilizing standardized measures to quantify belief conviction, distress, insight, and functional outcomes. Long-term follow-up is essential to assess relapse prevention, and comparative studies could clarify the optimal sequencing and integration of pharmacological and psychological interventions. Investigating metacognitive and distress-reduction strategies across varied sociocultural contexts will further inform culturally competent care for individuals with schizophrenia.

CONCLUSION

This case illustrates the importance of an integrated, recovery-oriented approach in the management of schizophrenia, wherein pharmacological stabilization and psychological intervention function in a complementary manner. Antipsychotic treatment played a crucial role in reducing acute psychotic symptoms, emotional dysregulation, and behavioral disturbance, thereby creating the clinical stability necessary for meaningful psychological engagement. The subsequent application of Cognitive Behavioral Therapy for Psychosis emphasized collaboration, emotional validation, and cultural sensitivity, rather than direct confrontation of delusional content. This approach facilitated a reduction in distress and delusional conviction, improved coping, and enhanced academic and social functioning, even in the presence of residual beliefs. The case underscores that successful outcomes in schizophrenia need not be defined by complete symptom eradication, but rather by improved insight, reduced distress, functional recovery, and sustained engagement with treatment. It further highlights the value of coordinated pharmacological and psychological care in promoting long-term stability and quality of life for individuals with chronic psychotic disorders.

Practical Implications: Clinicians should prioritize non-confrontational, culturally sensitive CBTp strategies alongside pharmacological management to target distress, functional impairment, and belief conviction, rather than attempting immediate elimination of delusional content. Structured therapy, with measurable outcome indicators and ongoing follow-up, can enhance engagement and support recovery-oriented goals. Moreover, careful monitoring of medication response, side effects, and cognitive functioning is essential to optimize both psychological and functional outcomes. This case supports the broader adoption of integrated, individualized treatment plans that balance symptom management with restoration of everyday functioning in schizophrenia.

According to the DSM-5, a diagnosis of schizophrenia requires at least two core symptoms [1].

Contemporary research indicates that delusions arise from the interaction of cognitive biases, emotional dysregulation, and sociocultural factors [2,3].

Direct confrontation has been shown to increase resistance [5,6].

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