An Introduction to CBT for Schizophrenia

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The Starting Place

- The starting place for cognitive therapy is that people are distressed not by events but what they think of them.
- An event can be something that happens to or around the individual but it can also include internal experiences.
- Examples of events
  - Someone makes a remark
  - A person on TV says something
  - Seeing two people talking and laughing
  - Feeling one's heart beating
  - Hearing a voice

What we think leads to our emotional reaction

- What we think about any event is determined or influenced by many things including past experience and learning, the current setting, mood, and beliefs about ourselves and the world.
- An Example
  - The event is feeling my heart beat
    - Past experiences include my father died at a young age from a heart attack
    - I am in an anxious mood.
    - I believe my body is not healthy and that I am vulnerable
      - The result is a thought that the sensation of my heart beating means I am in danger of or actually having a heart attack and I will probably die.
        - The result is I panic

A brief history of models of psychosis

- 1900 Kraepelin distinguished two types of psychosis and although the names have changed they correspond to Schizophrenia and Bipolar disorder.
- 1959 Schneider described “first rank” symptoms including hallucinations and delusions, and second rank or more difficult to detect symptoms.
- The modern models generally used in psychiatry generally assume there is a clear dividing line between sick and not sick, and that the sick have a brain disease

What is the problem?

- The distinctions between disorders don't hold up.
  - If a new doc gives a new diagnosis does the patient have a different brain disease?
- Genetic evidence suggests these may not be separate disorders
- Diagnosis does not predict response to a particular drug or class of drugs
- The data on genetics and brain differences suggest that environment plays a very important role in development of psychotic disorders

What do we really see?

- Patients diagnosed with psychotic disorders can be understood to have symptoms in 3 sub groups
  - Positive symptoms
    - Hallucinations and delusions
  - Disorganization
    - Incoherent speech
  - Negative symptoms
    - Social withdrawal
    - Apathy
    - Inability to experience pleasure

A new alternative

- It may be helpful to think of a stress/vulnerability model for the development of psychotic symptoms
- It may be more helpful to think about a symptom based approach rather than an approach based on diagnosis.
  - Hallucinations may be understood as people talking to themselves without realizing it.
  - Delusions are not different from ordinary beliefs.
    - Delusions are the product of jumping to conclusions too quickly
    - They represent an attempt to explain upsetting events

Grounds for hope

- There is now substantial evidence that psychological treatments can produce measurable changes in brain function and that in some cases these are the same as the changes seen in successful drug treatment.
- If the problem in psychosis is understood in terms of biases in reasoning and perception then this would be expected to respond to treatments that address these biases. This is what CBT does successfully do in treatment of other disorders.

The core assumption of CBT

- It is not the situation or events that upset us but what we think about them.
  - Beliefs, attitudes, assumptions etc. influence our perception of events and thus our emotional reaction to them.
  - It is not what you say but what I think it means that leads to my reaction.
- Everyone has distorted ways of looking at things and biases and beliefs. We tend to interpret experience to fit these pre-existing beliefs.

Implications of a cognitive model

- If everyone has distortions and bias in their thinking but only some have psychosis the difference is likely to be a difference of degree not type of distortion or bias.
- Delusional beliefs can be changed using the same sort or approaches that work for any other belief.
- Hallucinations represent a misinterpretation of ordinary experiences

Collusion vs. Therapy

- We have all been taught that we should not engage in collusion or reinforce delusional beliefs.
- This doesn't mean that we can't respond in an accepting way to statements from patients that involve delusional beliefs or refer to hallucinatory experiences.
- Confrontation of delusional beliefs does not seem to lead to the person abandoning them but does seem to lead to the individual feeling invalidated, and belittled. In some cases it may actually strengthen the delusional belief (especially paranoid ideas)

Confrontation vs. Help

- It is not necessary to believe the delusions are true or that hallucinations are real to recognize that they are distressing.
- We can profitably engage the patient in a collaborative effort to reduce distress.
- Confrontation is unlikely to lead to the patient accepting your explanation.
- Confrontation of delusions and hallucinations is not likely to lead to reduced distress even if it is successful.
- Disproving some delusional beliefs may increase distress or have other adverse effects.

What does Cognitive Therapy do?

- It attempts to engage the patient in a collaborative working relationship.
- Working within this relationship we encourage an empirical approach to understanding experiences.
- Using guided discovery, behavioral experiments or similar ideas we work toward reality testing.
- Hypotheses about the nature of causation and maintenance of symptoms can be evaluated.

The message to give patients

- You are not crazy the problems you have are understandable
- Either your concerns are real or you believe them to be real. (both explain how you feel)
- How you interpret events affects how you feel
- It is important to evaluate beliefs by testing them by making changes in your behaviour
- What you pay attention to and how you pay attention can affect how you feel and what you believe

Hallucinations

- 60% of schizophrenia patients experience auditory hallucinations most commonly in the form of voices
- Hallucinations may represent a misinterpretation of intrusive thoughts and that thinking they are from outside may serve to make people less uncomfortable than the idea that they are internally generated.
- Using a cognitive model we can think of the experience of hallucinations as the event, and the distress associated with them as a result of what the person thinks of the event.

Delusions

- Very common in schizophrenic patients
  - Most common themes are ideas of reference, delusions of persecution, and delusions of control
- Delusional beliefs are subject to the same variation as “normal” beliefs.
- People with delusions tend to jump to conclusions and have a rapid over confident style of reasoning
- People with persecutory delusions tend to have a bias toward attributing negative events to intentional actions of others

Are hallucinations really crazy?

- Samples of college students report 37-39% have auditory hallucinations at some time.
- An estimated 10-25% of the general population report some experience of auditory hallucinations
- In a study recruiting subjects who experienced auditory hallucinations, 39% were not in psychiatric treatment.
- Hallucinations may be experienced by “normal” subjects under predictable circumstances such as sleep deprivation and stimulus deprivation.

Are delusions that different?

- What is delusional vs. a “normal” belief is more a matter of cultural validation than the content of the belief.
- Beliefs in possession, control by spirits, abduction by aliens, ghosts, communication with the dead are common in some subcultures and among select groups.
- The difference between delusional patients and the general population appears to be in degree of conviction, distress and preoccupation not content

Common beliefs

		Sex				Age			
All Adults	All Adults	Male	Female	18-12	25-29	30-39	40-49	50-64	65 & over
		%	%	%	%	%	%	%	%
God	90	86	93	84	82	91	90	91	95
Survival of Soul after death	84	78	89	85	88	81	86	82	84
Miracles	84	77	90	86	85	82	85	83	82
Heaven	82	75	89	83	71	83	84	80	85
Resurrection of Christ	80	73	86	76	68	81	82	81	84
The Virgin birth of Jesus	77	70	83	76	60	79	80	78	80
Hell	69	65	73	74	63	69	72	66	68
The Devil	68	64	73	68	62	72	72	68	62
Ghosts	51	45	58	58	65	55	57	48	27
Astrology	31	25	36	37	43	37	23	32	17
Reincarnation	27	23	30	30	40	30	25	26	14

Delusional beliefs may have survival value in some settings

- In an abusive or dangerous environment it makes sense to be vigilant and to believe some people are out to get you.
- It is the failure to adopt a different view when circumstances change that is dysfunctional.
- Paranoid beliefs may help deal with the discrepancy between perception of ones self and status vs ideal self or status.

Normalization

- An important aspect of a cognitive approach to dealing with psychotic symptoms is normalization.
- This takes the form of discussions with the patient about how their experiences are in fact similar to and understandable as variations of “normal” experiences.
- In the case of delusional beliefs this means a discussion of how one might come to believe the delusional idea based on past experiences, context etc.
- In the case of hallucinations this means a discussion of how perceptual experiences can be deceiving, or how normal experiences are similar to hallucinations.

A moment in therapy

- The patient reports an incident that “made” him mad.
  - While walking on the grounds a person looked at him and then spit on the ground.
  - Then a few minutes later the same person held a door open for the patient and smiled.
    - The patient interprets the spitting as the individual intending to be insulting and the door holding as unexplainable.
  - Using guided discovery the patient was able to recognize
    - The first explanation given to an event may not be accurate.
    - Others behavior may not be related to the patient at all.
    - The alternative explanation of the spitting behavior as unrelated to the patient is plausible and not distressing.