A Therapists Conceptual Journey from Anxiety to Psychosis

James M. Claiborn Ph.D. ABPP ACT

First let me thank Dr. Scrimali for the honoring me with the invitation to address this esteemed group.

Slide 1

I am going to talk today about my own conceptual journey from understanding anxiety to understanding psychosis. I have worked with a range of individuals over the years from those diagnosed with schizophrenia to those with anxiety disorders and have worked in a range of settings from state and Veteran's hospitals to outpatient clinics and private practice. My early experiences in work with psychotic patients were rather unsatisfying. While my orientation has always been based in cognitive behavioral work when I was working with psychotic patients I would find myself returning to behavioral approaches and a conceptual model with roots in animal learning. I was involved in implementing a token economy and trying to use principles of conditioning to shape behavior. In effect I was conceptualizing people as a sort of black box. I could control stimuli in their environment, at least to some extent, and hope to alter frequencies of emitted behaviors. If I could get a psychotic patient to say fewer things that I judged delusional then I was successful.

Slide 2

Unfortunately this approach only works when the therapist has significant control over the contingencies of reinforcement and while it may change target behaviors it doesn't seem to address the internal process that we think of as representing psychosis and more importantly doesn't seem to address the suffering of the individual involved. The word therapy means to cure or nurse. Psychotherapy is the application of psychological methods to mental disorders in effort to cure or nurse which would be to reduce suffering. If the methods available to the therapist don't accomplish these goals then they are of little value. Reduction in suffering may be accomplished by reducing dysfunction in life or by reducing internal states of distress. While a behavioral approach would seem to have potential in the former, in reality it falls short in practice.

Slide 3

The alternative would be to approach therapy with psychotic patients with some form of verbal psychotherapy. My own training and interest led to following the work of cognitive therapists. Early on this was primarily Albert Ellis and later Aaron Beck. I recall a conversation I had with Ellis where I asked him about what I thought was a particularly intriguing problem. His rather dismissive response was that such individual were psychotic and by implication attempts at therapy were a waste of time. Indeed the zeitgeist at that point was that psychotherapy was useless in treating psychotic disorders. I was aware of a small number of psychoanalytic therapists who claimed that schizophrenia was the result of some misdirected attachment of libidinal energy as a result of some early experience and that schizophrenic patients could be cured via psychoanalysis. Their claims were dismissed even by the majority of mental health professionals most of whom were trained in and subscribed to psychodynamic models. Even Beck seemed to overlook his own work. He published a case of successful therapy with a man with chronic schizophrenia and delusions based on his emerging Cognitive therapy in 1952. Despite this result the consensus among cognitive therapists was that therapy was not likely to make any important contribution to treatment of schizophrenia. While I don't have data to address the question I would argue that most mental health professionals in the US would still argue that therapy has little to offer for the psychotic patient. The prevailing belief is that psychotic disorders are biologically based and therefor any meaningful intervention must be biological as well.

Slide 4

Based on my own personal experience working with psychotic individuals and the prevailing culture of the field I came to understand that I had little to offer psychotic patients so I directed my attention elsewhere. When I had a choice I would I would decline to see such patients, I would advise them that therapy had little to offer and they would be better off seeking medication management.

I dabbled in a variety of activities including family therapy, couples therapy and invested time in working with problems like chronic pain and substance abuse treatment. Through out this time I remained faithful to my cognitive behavioral orientation. I ran across one of the early books on a cognitive behavioral therapy for schizophrenia. Shortly there after I tried to apply what I had read to work with a psychotic patient. It was a crashing failure. I continued looking for an area where I could see meaningful benefit in my patients and where I could look to a supporting body of research supporting the effectiveness of the work I was doing. While the research is clear that cognitive therapy is as effective as medication for depression I personally found working with depressed people draining. This led me to specialize in anxiety disorders. I learned the protocols that were proven effective for phobias and panic. To me the most fascinating of the anxiety disorders was obsessive-compulsive disorder or OCD.

Slide 5

One feature of OCD that seemed particularly appealing was that a very clear method of treatment based in a behavioral model was proven effective. This was true in spite of the fact that the underlying conceptual model was less than satisfactory. I began to focus much of my work on people with anxiety disorders especially OCD. I pursued training in treatment of OCD and the majority of what was presented involved the behavioral work and deemphasized or even dismissed a more cognitive conceptualization. At this same time I began to acquire what I would call capsule conceptualizations of various anxiety disorders which were based in cognitive therapy. As an example I learned to describe panic disorder as a catastrophic misinterpretation of a normal sensation. Individuals with panic disorder believe that their panic symptoms are dangerous. They believe that a panic attack will lead to death, insanity or a horribly embarrassing outcome involving loss of control. Conceptualizing an individual with panic at a global level becomes a matter of filling in the blanks. What is the stimulus the individual is reacting to? What is the predicted consequence? What are the safety behaviors that serve to maintain the problem. Conceptualization of the individual is of course some what more complex. It would involve trying to understand how they acquired the problem beliefs, what experiences have they had with reinforce the danger, how have the safety behaviors functioned to prevent their learning that the danger is exaggerated. The therapy follows logically from the conceptualization. It makes sense to expose the individual to the anxiety while inhibiting safety behaviors and allow them to learn that it doesn't lead to the dreaded consequence. Simultaneously we can work on understanding the cognitive model. The individual can learn that it is not the stimulus event such as pounding heart that is the problem but the interpretation of the event that is the source of the problem. They can learn that they can first identify and then modify their beliefs.

Slide 6

We can move conceptualization to a more sophisticated level by understanding the metacognitive dimension. Here I am especially indebted to the work of Adrian Wells who has developed and explained a metacognitive model of emotional disorders. Wells defines metacognitive knowledge as knowledge about their own cognitions and task factors that affect it. He defines metacognitive regulation as executive function such as allocation of attention and detection of errors in processing.

These more sophisticated cognitive models didn't yet extend to OCD at least in my experience. Indeed many of the major sources on OCD disputed the validity or even the need for a cognitive model of the disorder or the extension of more cognitive methods into therapy for the disorder. After all the use of exposure and ritual prevention works well. Admittedly the conceptual model is limited but who cares. Apparently Jack Rachman cared. He wrote about how the traditional conceptualization of OCD fails to explain the origin of obsessions and the anxiety associated with them. Although not describing it as such Rachman offered a metacognitive model of OCD.

Slide 7

The modern cognitive model of OCD begins with an understanding of intrusive thoughts as normal events. Research by Rachman and others has found that 90% off individuals responding to surveys report intrusive thoughts. I tell my patients that there is an interesting question about what is going on in the other 10%. I offer two alternatives. One is from Freeston who conducted one of the studies. He suggested that the other 10% figured out that they didn't have to fill out the rest of the questionnaire if they denied the experience and were simply lazy. The second alternative is that those who deny intrusive thoughts are simply liars. The intrusive thoughts found in non-clinical populations are indistinguishable from those reported by patients with OCD. What then explains the difference in experience.

If virtually everyone has intrusive thoughts indistinguishable in content from those that trouble people with OCD what accounts for the disorder being found only in 2% of the population. The model argues that the difference is in the interpretation of the thought and the reaction to the thought. In other words it is the metacognitive response to the intrusive thought. The capsule summary I would offer for OCD is that the individual experiences an intrusive thought which is a normal event. However they activate beliefs about the event or thought that lead to problems. This begins with the evaluation of the thought as meaningful or important. If the thought involves some perceived risks then the risk is seen as realistic and high probability. The reasoning seems to be since I thought of something that could go wrong it is likely to go wrong. The next step is to assess responsibility for the expected event. The reasoning is since I thought of it and it is likely to go wrong I am responsible for preventing it. Finally they need to be certain that they have prevented the adverse outcome they have predicted. However certainty is elusive and the individual repeats the safety behavior in a futile search for it. As a corollary of the belief about importance of thoughts we find people with OCD hold themselves responsible for having the thoughts and believe they need to control them. This leads to efforts to try to suppress thoughts. When discussing this point with patients I suggest they try not thinking about polar bears. It is well established that attempts to suppress thoughts leads to an increase in frequency. This same effort to suppress intrusive thoughts leads to their increased experience. The individual with OCD is then prone to make the error that this increased frequency is evidence of importance. People with OCD engage in the circular logic that the thought is important because I have it and I have it because it is important.

Slide 8

With this model we can both understand why behavioral treatment works for OCD but also understand how we can intervene at a cognitive level. This cognitive model is more satisfactory than the earlier behavioral model. Therapy can begin with a process of normalization. The therapist can explain that the thoughts are normal events, sample intrusive thoughts form non clinical populations can be provided, and experiments with suppressing neutral thoughts can be conducted, don't think about polar bears. Further we can explain that the human brain has a function I refer to as an idea generator. This function is an adaptive one as it aids in identifying and solving problems. It is

reasonable to assume that while this idea generator is always active and is responsible for intrusive thoughts it accelerates its output when the individual experiences threat or stress. This would account for increased obsessions when people are stressed. Although I was skeptical at first I have found that a cognitive approach to OCD is not only well accepted by patients but appears as effective as behavioral interventions. This later conclusion is now supported by emerging research.

Sometime life takes a turn we would never have anticipated. I had focused most of my work on cognitive therapy primarily with anxiety disorders and had established myself as something of an expert on OCD in particular. A series of events led me to take a part time position working in a hospital where the majority of patients were diagnosed with psychotic disorders such as schizophrenia. When I took the position I thought I would work there only until I could find an alternative way to support myself. After all may earlier experience working with people with psychotic disorders had been frustrating at best. I didn't see what I could bring that would make the work rewarding or meaningful. Indeed I offered to work on providing services to those suffering from anxiety which was agreeably an undeserved need in the psychiatric hospital setting.

Slide 9

Once I began working in an setting where most of the patients were diagnosed with a psychotic disorder I started reading about developments in cognitive therapy for these disorders. Let me describe the culture in most psychiatric settings in the US. To a large extent a medical or biological model is dominant. We use the DSM-IV to establish diagnoses and schizophrenia is described as a brain disease. Treatment centers on selecting the proper medication regime. Patients are told their experiences are not real, their beliefs are delusions and that this is a result of their brain disease. The patient is led to understand that their only hope is to take these medications and accept the illness. While psychotherapy of some type may in some way be a useful adjunctive treatment it is understood that it is not really going to make a big difference. At best it might facilitate acceptance of the medical model or improve compliance with medications. While treatment is provided by a team made up of staff from a variety of professional backgrounds the person in charge is a psychiatrist. Although standards for training of psychiatrists in the US include exposure to various schools of psychotherapy the vast majority of psychiatrists focus their practice on psychopharmacology. I needed to understand a reasonable role for a cognitive therapist in this culture.

Slide 10

My reading led to some startling conclusions. I learned that fully 60% of people diagnosed with psychotic disorders and fully compliant with medication will continue to experience positive symptoms such as hallucinations and delusions. Second I learned that there was a body of research on cognitive interventions with psychotic disorders. The research I found had been conducted outside of the US where a different culture seems to prevail. The material I was reading questioned the very basic assumptions about psychotic disorders and their treatment.

I had been taught that the thinking of people diagnosed with psychosis is qualitatively different from that of non-psychotic individuals. I had been taught that hallucinations were pathognomonic of psychosis. I had been taught that psychotherapy which engaged in discussion of delusions would be likely to make things worse. Despite the fact that different psychotic disorders don't seem to respond differently to psychopharmacology I was taught that the different diagnostic categories represent distinct disorders and that it was important to distinguish between them.

Slide 11

I learned of a cognitive conceptualization of psychotic symptoms that overlapped with my understanding of OCD. We can return to the starting point that intrusive thoughts are a part of normal experience but that the reaction to them can lead to clinically important distress and dysfunction. If we look at diagnostic categories like schizophrenia and other psychotic disorders we find that the symptoms overlap and that the process of diagnosis is unreliable at best. The diagnostic system embodied in the DSM is less helpful than an approach that begins by looking at the specific symptoms and a model which explains these symptoms and leads to treatment. Recall I noted that the modern cognitive model of OCD starts with the normality of intrusive thoughts and the problem arising from the metacognitive interpretation of these thoughts. In the same way we can understand hallucinations and ideas of reference as the result of an adverse interpretation of an intrusive thought. Hallucinations can be understood as intrusive thoughts which are attributed to external sources. This is simply a metacognitive attribution that changes how the thought is experienced. It is also important to note that among individuals experiencing hallucination. This external attribution may contribute to continued experience of hallucinations by reducing cognitive dissonance or other distress associated with believing the thoughts originate from oneself.

Hallucinations are actually substantially more common experiences than most of us realize. Researchers working with people who report hallucinations report that the majority are not involved in treatment and often not diagnosed with any psychiatric disorder. Hallucinations can be be precipitated by ordinary experiences such as sleep deprivation. The result is that we can think of hallucinations as similar to normal experiences. It may well be that some individuals have are more likely to experience them and factors that influence this are may include some types of life experience and biological factors. It is also worth noting that hallucinations are not necessarily unpleasant and many people experience them report they value some of the voices. In cognitive therapy for anxiety we ask about an event that may include an internally generated sensation such as rapid heart beat or an external event such as a comment or action of another. Hallucinations can be understood as sensory events and like the individual with anxiety it is the thoughts about what the event means and metacognitions about the automatic thoughts and the event. The only thing that makes these experiences something we label psychotic is that they fall outside the range of experience we consider normal with in the specific subculture.

Slide 12

Individuals with OCD will often describe sensory experiences that support their obsessions. For example a person with contamination obsessions may describe feeling dirty after touching something they consider contaminated. This feeling often includes reported physical sensations suggestive of tactile hallucinations.

The distinction between hallucinations and delusions is somewhat arbitrary since the belief that the sensory experience such as a voice is external is one that would qualify as a delusional belief. Delusions represent beliefs that are interpreted by others to be unacceptable or inconsistent with the beliefs. Individuals with OCD typically have an understanding at some point in time that their beliefs are distorted in some way. It is interesting to note that this insight may fluctuate and some small percentage of people with OCD are described as having over valued ideas or poor insight which makes their beliefs indistinguishable from delusions.

There is one more important idea to complete the picture. We all want to make sense of our experience. We want to have a way of understanding and predicting our world. This effort to explain our experience and our world leads to the development of explanatory beliefs. These explanatory beliefs may be shared within our particular culture. When this is the case then the existence of

supporting evidence for the belief becomes irrelevant. However if the belief is in conflict with the culture it may be interpreted as an indication of a problem in thinking unless it is supported by substantial evidence. What we call delusions are simply beliefs generated to help the individual understand his world but which are inconsistent with what is accepted in our culture.

With these pieces we can construct a general conceptualization of psychosis. It is remarkably similar to the one that has been developed for OCD. People we call psychotic simply interpret and explain their world in a way that is inconsistent with the culture around them. They mistake intrusive thoughts for externally generated messages, and interpret events according to their conceptions of how the world works. To understand the individual we need to begin by accepting that they are doing what we are all doing. Trying to make sense of our experience. We can listen to their story and history and understand that they arrive at a model of the world by the same process the rest of us use making the same errors of inference.

My talk today has been about my journey to complex conceptualization of psychosis. In some ways I end where I began. I was trying to make sense of my experience and understand the people I was working with. I now know that the journey is a universal struggle and that as I understand my own I also understand those of my patients. As my personal experiences shaped my understanding so their experiences shape their understanding. Understanding psychosis begins with understanding ourselves.