

Beck Comes Full Circle
A review of
Schizophrenia: Cognitive Theory, Research, and Therapy
A.T. Beck, N. A. Rector, N Stolar and P. Grant
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Beck (1952) described successful treatment of an individual with delusional guilt using individual therapy. While his early work and training was psychoanalytic, Beck gradually evolved whole new approach to psychotherapy that he called “Cognitive Therapy” (Beck 1997). His genius can be described with a paraphrase of a quote from Yogi Berra who said “You can observe a lot just by watching”. What Beck did was learn a lot by listening to his patients. In the 1953 case the conceptualization was based in psychoanalysis but, looking back, the therapy included asking the patient to evaluate evidence by doing things like asking him to describe the FBI agents he believed were watching him. Beck foreshadowed an approach that would later develop into cognitive therapy. Beck began to call his approach cognitive therapy in 1964 when writing about thinking in depressed patients.

Over the succeeding years when asked what cognitive therapy would not work for, Beck would give what he describes as a cavalier response that cognitive therapy would not work for schizophrenia. He gave this answer not because it was something he believed but because there was no evidence that cognitive therapy would work with this population. When evidence began to accumulate Beck stopped saying cognitive therapy wouldn't work for schizophrenia (Hole, Rush & Beck 1974). It was not until much later, however, that the idea of applying cognitive therapy to schizophrenia began to be seriously researched. The bulk of the work developing cognitive therapy for schizophrenia was done in the UK and that began in earnest in the 1990s. Garety et al (1994) published a pilot study of a CBT approach reflecting the development of ideas which can be traced back to work in cognitive therapy for disorders like depression (Beck et al, 1979). The approach starts by adapting familiar methods for dealing with distorted thoughts that had been applied successfully to depression and using them with the distortions embedded in the thinking exhibited by schizophrenic patients.

This new book completes the circle. Beck and colleagues leap frog the British contributions and provide a comprehensive volume that is a guide to learning and applying cognitive therapy to schizophrenia. This fills a critical gap. Therapists setting out to learn cognitive therapy in most applications may have a range of options including a large number of books and workshops by master therapists. Students may find courses readily available. However most of this training will cover mood and anxiety disorders. While there are now several books on CBT and schizophrenia, they are often hard to come by, and other training in this area is scarce. Beck and colleagues begin this book with an overview of schizophrenia. This sounds like a logical beginning but assumes a unified concept of the disorder.

The concept of schizophrenia dates from Bleuler who coined the term which was the successor to Kraepelin's dementia praecox. Most of the newer work on cognitive therapy for schizophrenia has been symptom focused and efforts are directed at dealing with hallucinations, delusions and to a lesser extent other symptoms. Since these symptoms occur in a range of people who are not diagnosed with schizophrenia and the focus of treatment is often focused on

the distress associated with positive symptoms rather than the occurrence of symptoms it is not clear that the concept of schizophrenia is central to the conceptual model or therapy for psychotic symptoms. The early chapters of the book struggle with this problem and review models from a variety of sources. After a careful review of several models they reach the conclusion that:

“schizophrenia has not revealed itself to be caused predominately by any single physical malfunction, genetic disturbance or environmental event... schizophrenia is a cluster of symptoms that may turn out to be one disease or a group of related diseases.”

As others have suggested we don't have a good model for what schizophrenia is and may never find one. It may not be possible to build such a model since the symptom cluster does not hang together well. The disjunctive approach to diagnosis from the DSM-IV leads to many ways to diagnose schizophrenia with no overlapping symptoms. A more practical approach is to address a model of symptom formation and treatment. While the book sets out to describe cognitive therapy for schizophrenia, the text would seem to be better described as cognitive therapy for psychosis.

The authors build a general cognitive model of the positive symptoms, hallucinations and delusions, then build a model of negative symptoms and formal thought disorder. Cognitive models of hallucinations and delusions have been described and developed over the last decade. The book has chapters devoted to integrating research and synthesizing a cognitive model that is both comprehensive and practical in leading to a conceptualization of symptoms which can be shared with patients and be used to guide therapy. Positive symptoms can be understood as representing experiences that are actually much more common than most of us were taught. Delusional beliefs are not qualitatively different from normal beliefs but lack consensual validation. They can be understood as the product of excessive use of selective attention and jumping to conclusions. Hallucinations are reported by an estimated 2.5-4% of the population, and most of these people do not have a diagnosable psychiatric disorder. Experiences such as sleep deprivation and stimulus deprivation will produce hallucinations in volunteers. It seems that people who are prone to experiencing hallucinations have an increased tendency to experience imagery as a sensory experience. What becomes critical in understanding hallucinations is the individual's thoughts about the experience. Beliefs about the source of voices, their relative social status, omnipotence, as well as biases and relative weaknesses in evaluating evidence lead to the problems associated with hallucinations. Hallucinations may be best understood as the result of misinterpreting the source of one's own thoughts.

While a cognitive model of hallucinations and delusions has been the subject of considerable research and development, negative symptoms of schizophrenia have been neglected until recently. In the current book Beck et al, provide a workable model. The person with negative symptoms is likely to endorse dysfunctional beliefs about their performance, likelihood of experiencing pleasure and generally have a pessimistic attitude about the future. They open their mental filters to allow in negative messages. This model of negative symptoms parallels the cognitive triad found in depression. The cognitive aspect of negative symptoms interweaves the cognitive model with observations about deficits in information processing that are part of the picture in schizophrenia. The individual's experiences are shaped by the deficits reinforcing pessimistic expectations.

Factor analytic studies of schizophrenic symptoms typically produce a three factor model. The three clusters are the positive symptoms (hallucinations and delusions), negative symptoms,

and disorganization. The book presents a cognitive model of formal thought disorder as representative of the disorganization cluster. The model holds that thought disorder results from inadequate executive function leading to failure to inhibit the spread of activation of associational nodes and the lack of attentional resources. The result is that speech is produced reflecting the unfiltered associational connections.

Having presented a cognitive model of schizophrenia the second half of the book provides a clear practical treatment manual. It begins with a chapter on assessment. The authors provide suggestions about clinical interviewing and use of various scales as a way to establish an understanding of the individual and begin the difficult work of establishing a therapeutic relationship. Interviewing a patient who may be paranoid or who is dealing with hallucinations presents a new challenge to the clinician who has traditionally worked with anxiety or mood complaints.

One of the common misconceptions about cognitive therapy is that it doesn't focus on the therapeutic relationship. The authors note that the sine qua non of cognitive therapy is establishing a therapeutic climate of mutual respect and trust. We are provided with experience based wisdom on how to accomplish this while understanding some of the obstacles working with someone who is experiencing psychosis.

With the understanding that assessment is an ongoing process the book includes chapters on assessment and therapy of the symptoms of psychosis following the earlier chapters on developing cognitive models. Thus there are chapters on delusions, hallucinations, negative symptoms and thought disorder. While there are many books that can serve as treatment manuals in the world of CBT this one is exceptional. First it is exceptional in that it is filled with clinical insights and suggestions based on experience. There is a recognition of the need to be extremely flexible and adjust to the rapidly changing and complex relationship that develops in therapy with schizophrenic clients. The book is also exceptional in its clarity and depth of coverage. When a cognitive therapist moves into a new area of work, they are likely to look for books and other sources representing the research and thinking of those who have made this journey before. Beck et al have provided a guide to that journey. They have led us full circle from a preliminary exploration into psychotherapy with a delusional man to the rich possibilities of cognitive therapy with schizophrenic patients. During the intervening decades American psychiatry has invested in psychopharmacology and biological models but not brought real hope to most of the people suffering psychotic disorders. This book will stand as a classic leading to a generation of therapists able to bring hope and clinically important help to those suffering from schizophrenia.

Beck and colleagues have completed the circle from a tantalizing case study over 50 years ago to a well formulated guide to understanding psychotic symptoms and applying cognitive therapy.

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