

# ONE

## What Is Schizophrenia?

Schizophrenia has been problematic in terms of causation and classification since it was first described over a century ago, initially as dementia praecox. It has also become a very stigmatized and misunderstood condition. Schizophrenia can now be diagnosed reliably using criteria developed over the past few decades and is recognized as a diagnostic entity by international classification systems. However, the diagnosis covers a very diverse group of individuals who present in a variety of ways and require a wide range of therapeutic approaches—indeed, Bleuler (1911), when he first used the term, referred to it as “the group of schizophrenias.” As a result of the diversity of presenting symptoms, Persons (1986) and Bentall and colleagues (1988) have argued the case for focusing on individual symptoms such as hallucinations, delusions, and thought disorder rather than on diagnosis. There is also an intermediate position that considers possible clinical subgroups within the overarching schizophrenia diagnosis (described in detail later in this chapter). Schizophrenia can therefore be viewed from three vantage points: disorder, subtype, and symptom.

These approaches can be considered complementary:

- The broad diagnostic category “schizophrenia” has been useful for communication, education, and research purposes. Information about research into characteristics of people with schizophrenia (e.g., age of onset) and their outcomes with treatment is given in this and the next chapter.
- Subgroups provide a way of unifying symptom clusters to further guide therapy where the condition is so diverse in presentation. For example, hallucinations can occur in different circumstances and be linked to different symptoms. They may be abusive and very distressing and require direct work on the effects of trauma. Alternatively, they can support a systematized set of paranoid delusions (e.g., voices attributed to “the CIA”), and the primary focus will then be on dealing with the beliefs underlying the delusional system rather than much direct work on the voices.
- A focus on individual symptoms is also valuable. Identifying symptoms is relatively straightforward. Therapy focused on symptoms is simple to understand and can be used in psychological management based on an individualized case formulation.

This chapter describes:

1. The characteristics of schizophrenia, including symptoms and demographic information
2. The cognitive model of schizophrenia, which draws on vulnerability–stress conceptualizations of schizophrenia involving the interaction between
  - Biological, social, and psychological vulnerabilities and
  - Individual stresses or stressful circumstances
3. Clinical subgroups of schizophrenia with illustrative cases
4. Ways of understanding psychotic symptoms

## CHARACTERISTICS OF SCHIZOPHRENIA

The course of schizophrenia is reasonably well understood but unfortunately has changed little over time. New treatments, both pharmacological and psychosocial, may be beginning to have an impact on this, but it is too early to be demonstrable. Of those who develop the illness, traditional teaching has been that approximately 20% make a full recovery, 20% have relapses with no intervening deterioration, 40% have relapses with some deterioration, and fewer than 20% remain chronically ill and show little recovery. There is some evidence (presented below) that this may be a gloomier picture than the reality. However, there is no question that the clinical presentation of schizophrenia to clinicians is a variable one that hinges strongly on the stage of the disorder and the mixture of symptoms.

### Symptomatology

People with schizophrenia tend to experience a variety of psychiatric symptoms, including certain types of hallucinations (particularly auditory, visual, and somatic—i.e., causing physical sensations), delusions, thought disorder, and loss of insight. These symptoms usually coexist with negative symptoms (alogia, affective blunting, poor motivation, and social withdrawal; see the definitions and explanations later and in Chapter 12), which can be either primary or secondary to depression or medication side effects. Cognitive deficits—interference with thinking—such as disturbed attention, impaired short-term memory, and poor recognition of facial expressions also occur and lead to or perpetuate poor coping abilities and social isolation.

Schizophrenia has been defined by the presence or absence of specific symptoms. A combination of these symptoms and a measure of duration is necessary to make the diagnosis, according to criteria established by the *International Classification of Diseases* (10th edition; ICD-10; World Health Organization [WHO], 1992) and the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; American Psychiatric Association [APA], 2000). ICD-10 requires one very clear-cut schizophrenic symptom or two less clear symptoms to have been present most of the time for a duration of 1 month. DSM-IV-TR requires one characteristic symptom to have been present for a significant proportion of time for a 1-month period or two less characteristic ones (see APA, 2000, for further details).

Symptoms used for diagnostic purposes include:

- Hearing his or her own thoughts spoken aloud.
- Third-person hallucinations (voices talking about him or her).
- Hallucinations in the form of a running commentary on what he or she is doing or thinking.
- Somatic hallucinations (experiencing feelings that are believed by the person to originate externally but to others do not appear to do so).
- Delusions of thought withdrawal or insertion (beliefs that others can remove thoughts from, or put them into, a person's mind).
- Delusions of thought broadcasting (the belief that his or her thoughts are broadcast to others).
- Delusional perception (when the person sees or hears the same thing as other people but attaches a meaning to it that is delusional, i.e., not shared by others).
- Delusions of passivity ("made" acts, thoughts, or emotions—when the person is convinced that he or she is being made to do, think, or feel things by an external force or by other people when this does not appear to be the case).

Negative symptoms and the medium-term course of the disorder are included in the diagnostic criteria of DSM-IV-TR but not ICD-10. The introduction of such classificatory systems has improved reliability, but the validity of the diagnosis remains in question. In other words, it is now possible to get good agreement on whether someone has signs and symptoms that characterize schizophrenia, but there is still uncertainty about how meaningful a diagnosis (or group of diagnoses) it is in terms of putative causes, prognosis, or treatment response. Prior to the advent of stricter criteria during the 1970s, schizophrenia was diagnosed much more often in the United States as compared to Europe. With the introduction of agreed-upon criteria and major international studies, it has become clear that the incidence of schizophrenia is much the same throughout the world, although there are a small number of groups who do have higher rates (Boydell et al., 2001).

Many other symptoms occur as well as those that are used in diagnosis, and these may be as distressing and disabling, or even more. These include psychotic symptoms such as abusive or command hallucinations (in the second person—e.g., "You're useless" or "Kill yourself") and thought disorder—where the train of thought is very difficult to follow—and nonpsychotic symptoms such as depression, anxiety, obsessions, compulsions, social phobia, and agoraphobia.

### **Demographics**

Of the general population, 0.5–1% will develop schizophrenia at some point in their lives, although the rate of onset of schizophrenia is quite low (10–20 cases per 100,000 population per year). There is no difference in rates between men and women, but women have a mean age of onset 3–4 years later than their male counterparts. The rate of incidence is higher in urban than in rural areas. Social outcome in developed countries, as opposed to that in less developed countries, has generally been conceived as poor, with episodic relapse or chronic deterioration and heightened suicide risk. People with schizophrenia have a higher-than-expected mortality rate, owing to a number of different causes, with suicide accounting for some of the difference. Young men with relapsing schizophrenia and evidence of repeated self-harm are particularly at risk.

Schizophrenia is arguably the most debilitating psychiatric disorder—psychologically, financially, and socially. It is the 13th most expensive illness in terms of health expenditures, according to the World Bank. The traditional view has been that people suffering from this disorder are seldom employed, are unlikely to develop meaningful relationships, and have a tendency to drift down through the social classes into living in isolation or even on the streets. But this negative view has been repeatedly challenged. A study of people who had been diagnosed as having schizophrenia recently showed that approximately 50% of them, at 15-year and 25-year follow-up, had favorable clinical outcomes (Harrison et al., 2001). Whatever the long-term perspective, much of the workload of community mental health teams involves working with people with schizophrenia and related diagnostic categories (schizoaffective disorder, bipolar disorder, and delusional disorder).

### THE COGNITIVE MODEL OF SCHIZOPHRENIA

Models used to explain schizophrenia have been based on biological, social, and psychological conceptualizations (see Table 1.1). Biological models have emphasized physical causes for the disorder, including abnormalities in structure and function caused by, for example, genetics, birth injury, abnormal development, or viral influences. Social models have focused on environmental influences, including poverty, influences of the inner city and culture, and family and societal pressures. Psychological models have taken a variety of perspectives, often considering complexities in interpersonal relationships.

None of these models has found universal acceptance since all of them have limitations in explaining the available research findings or in being substantiated by them. As a result, models incorporating elements of each have been proposed—based on the interactions between vulnerabilities and stress. These vulnerabilities may have a biological origin (e.g., genetic predispositions), may be inborn psychological characteristics, or may result from social circumstances during intrauterine or early development. Stresses also can be biological (e.g., infection or drug intoxication), psychological, or social. Cognitive models of delusions have recently been set forth by Garety and col-

**TABLE 1.1. Vulnerability–Stress Model of Psychosis**

---

Psychotic symptoms, including those of schizophrenia, arise from a combination of *vulnerabilities*:

- Biological, including genetic
- Social, including living in an urban environment
- Psychological, which may include:
  - An externalizing bias
  - A tendency to “jump to conclusions”
  - Difficulty in “taking the role of the other”
  - Negative or confusing underlying beliefs about the self

with *stress* that is *significant to the individual* because of its type, severity, associations, or possible implications and that may be amplified by a fear of “madness” and stigmatization.

---

leagues (2001) and Beck and Rector (2002), and of hallucinations by Morrison (1998). These syntheses are based on a biopsychosocial model and attempt to include and explain recent research findings.

### **Biological Vulnerabilities**

Schizophrenia certainly has a genetic component in terms of vulnerability. This may be due to a small number of genes acting independently on a “multiple-hit” basis with an additive effect. Evidence of a genetic contribution, or predisposition, to schizophrenia derives from studies of identical and nonidentical (monozygotic and dizygotic) twins. The risk of developing schizophrenia is nearly 50% among children both of whose parents have schizophrenia. One influential follow-up study of twins found that both developed schizophrenia in 36% of the cases where the twins were identical, while for nonidentical twins the figure was 14%. This confirms the importance of heritability in schizophrenia, but since only just over a third of those who are genetically identical develop the disease there must also be an important environmental component to etiology. Confirmation of a genetic proclivity also derives from adoption studies, where it has been demonstrated that twins bought up in different environments have similar (i.e., higher-than-normal) rates of schizophrenia to those bought up together. There are some problems with these studies, in part attributable to other linked factors—for example, a tendency for mothers with schizophrenia to receive poorer antenatal care and a lack of reliability in diagnoses in studies. Twins are also clearly unusual in many ways, and their identity issues in particular may affect their susceptibility to schizophrenia. Viewed from the other direction, 89% of people with schizophrenia will have parents who do not have schizophrenia, 81% will have no affected first-degree relative, and 63% will show no family history of any kind of the disorder. So, the current consensus is that there is a genetic vulnerability in some people with schizophrenia that is probably due to multiple genes acting independently, with an additional environmental component.

Schizophrenia also carries a biological predisposition linked to birth trauma and maternal viral infection. Geddes and Lawrie (1995) estimated that complications in pregnancy and delivery may increase the incidence of schizophrenia by 20%. More specifically, Verdoux and colleagues (1997) found that subjects with onset of schizophrenia before age 22 were three times more likely than those with onset at a later age to have had a history of abnormal presentation at birth and 10 times more likely to have had a history of complicated cesarean birth. The risk of developing schizophrenia for people with obstetric complications, such as prolonged labor (which can cause oxygen deprivation), is four times greater than those who have none, and a history of such complications has been found in 40% of those with schizophrenia. A complicating factor here is that those with schizophrenia have an increased likelihood of obstetric complications due to psychosocial factors.

There is also a seasonal effect: People who develop schizophrenia are more likely to have been born in the late winter or spring. Epidemics of viral illnesses such as measles, influenza, and chickenpox have been shown to correlate with an increase in the numbers of births of people who later develop schizophrenia. The increased risk of developing the illness in this way is probably very small. However, these risk factors may

combine with genetic risk to create significant vulnerability to schizophrenia. Individuals with schizotypal personality traits (eccentric behavior with anomalies of thinking and affect) are overrepresented in the families of people with schizophrenia, possibly showing that these personality traits may be markers of an underlying vulnerability or independent risk factors. Findings of brain changes in groups of people with schizophrenia, such as increased ventricular size, may also manifest themselves through increasing vulnerability.

Yet many individuals with schizophrenia appear to have no obvious biological or genetic predisposition. In such cases, personal, social, or psychological vulnerability linked to early life traumas or disturbance may be linked to the development of schizophrenia in later life.

### **Social Vulnerabilities**

Schizophrenia is commoner in cities than in rural areas, and this seems to hold true even when a tendency for people who become ill to move from the country into cities is taken into account. Other vulnerabilities, as mentioned previously, are most likely to develop in inner-city areas where there is limited access to or use of obstetric facilities. Such areas also tend to have high levels of deprivation and abuse of various types, leading to increased stress and possibly the formation of negative schemas (e.g., related to paranoia), which tend to perpetuate psychotic symptoms. These are also the very areas where there is easier access to hallucinogenic drugs, which can likewise activate and perpetuate symptoms. Finally, inner-city areas are often inhabited by new immigrant peoples and asylum seekers, who have a higher incidence of schizophrenia. This particularly occurs in second-generation immigrants, possibly because of their struggles in relation to cultural conflicts, alienation, racism, and limited support.

### **Psychological Vulnerabilities**

Certain psychological vulnerabilities that may predispose individuals to schizophrenia have been described over the past decade. Processes leading to cognitive distortion may be present, such as tendencies to externalize praise for good events or blame for negative events, and to personalize that praise or blame to one individual or group (Bentall & Kinderman, 1998). Externalization and personalization are linked to "theory of mind" deficits. Basically, these deficits involve a pervasive problem in empathy (i.e., an inability to take the role of other people and understand their perspectives). They may also be "self-serving," in that paranoid thinking may be defensive or functional (effective) in reducing discrepancies between the "actual self" and the "idealized self." Persons with schizophrenia may protect self-esteem by making external causal attributions for negative events (Bentall & Kinderman, 1998)—that is, blaming others for things that go wrong, rather than themselves. Some people with schizophrenia may have a propensity to develop delusions or hallucinations as a way of protecting against unbearable affect or loss of self-esteem (Turkington & Siddie, 1998), rather than, for example, becoming anxious or depressed. Delusions may be marked by systematization and often grandiosity, which protect the persons against underlying beliefs such as "I am worthless," "I am damaged," "I am unlovable," and "I am evil."

Comparisons have been drawn between intrusive thoughts in panic and obsessive-compulsive disorders on the one hand, and psychotic symptoms on the other (Morrison, 1998). In both instances, intrusive thoughts are unwanted or unacceptable to the persons experiencing them and are perceived as uncontrollable. The essential difference between hallucinations and obsessions is that the former are attributed externally (i.e., are seen as coming from outside the mind), while the latter are attributed internally (Kingdon & Turkington, 1998). Morrison (2001) argues that positive symptoms can be conceptualized as intrusions into awareness, and that a vulnerability to misinterpretation of these causes the associated distress and disability.

People with certain paranoid delusions display typical cognitive distortions. These typical distortions include making arbitrary inferences (drawing conclusions from inadequate information) and holding those conclusions more firmly than others would (Garety & Freeman, 1999). Such delusions are formed as attempts by people who are suffering from symptoms (e.g., voices or physical symptoms of anxiety) to make sense of them in an absence of knowledge about them. They are typically much more culturally syntonc (e.g., alien abduction, satellite control, torment with lasers).

Chadwick and colleagues (1996) have also described a tendency for different groups of clients to view themselves or others negatively—as illustrated by the terms “poor me” or “bad me.” These psychological characteristics may be genetically determined vulnerabilities, but it is also possible that they are the results of specific stressors or circumstances in earlier life or a combination of these. It is certainly the case that the circumstances in which persons find themselves, and the prevailing cultural beliefs, both influence the content of the persons’ own beliefs and the degree of conviction with which these are held.

### **Stressors**

Stressful life events and circumstances can take a variety of forms. These can be obviously distressing (e.g., bereavements and other losses) or less so (e.g., changing from the day shift to the night shift, or moving away to college). They can include the effects of hallucinogenic drugs and alcohol as independent and contributory stressors. Some people may be particularly sensitive to these stresses at certain times during their lives or because of life circumstances or previous significant events.

People with critical and abusive auditory hallucinations with linked depression and low self-esteem often disclose during therapy that they have been the victim of childhood sexual abuse or adolescent trauma, including bullying. Early trauma has been linked to hallucinations in schizophrenia (Heins, Gray, & Tennant, 1990) and specifically to diagnostic symptoms of schizophrenia (Ross et al., 1994). In such cases it may be a further negative life event that triggers abusive voices. Such hallucinations may also exist for many years before the person presents for services, but eventually they become intolerable or the person makes a decision that the time has come—sometimes even because he or she is only now strong enough—to deal with them. These voices are often the voice of the abuser or, for example, people who have strongly criticized or bullied the client, and often there are linked visual hallucinations or imagery.

There is often strong avoidance of inquiry and disclosure and avoidance of working with the traumatic material by both the client and the clinician. The increased

arousal of the traumatized state worsens the hallucinatory experience, as does any linked sleep deprivation. Both of the above can lead to the emergence of obsessional thoughts often with linked compulsive rituals. In such cases a systematic guided formulation linked with the abuse-congruence of the psychotic symptom content will often allow the person to begin the process of reevaluating the trauma and of working with the linked distress through the beliefs involved—for example, shame, anger, and unworthiness. People with such distressing symptoms may have repeated readmissions, suicidal attempts, and high suicide risk due to the combination of critical and command hallucinations and linked depression. Trauma can also follow the experience of psychosis through additional personal victimization. Many of our vulnerable clients are targets for muggings, beatings, and sexual assaults and repeated abusive relationships (Walsh et al., 2003). Again, these are often not elicited or disclosed but act to exacerbate hallucinations, persecutory delusions, and negative symptoms.

Perhaps the most powerful maintaining factor is the person's belief about the psychotic symptoms amplifying any distress intrinsic in the stressful experience itself. People who believe that their voices are omniscient or omnipotent, as is often the case (Birchwood & Chadwick, 1997), tend to activate particularly poor coping strategies. This includes especially those who believe that the voice is that of a powerful spiritual being such as God or Satan. On the other hand, Romme and Escher (1989) showed that optimal coping was linked to much less threatening explanations, for example, "repressed voices from my childhood," "part of my personal development," "a parapsychological gift . . . like a medium." Biological explanations are helpful to some people who feel less ashamed and more in control when they have an "internal/medical" explanation. Many people, however, feel disempowered, alienated, and depressed by holding this belief. The crucial thing is to work with the client's beliefs about symptoms if they are dysfunctional and, if need be, to work toward a new belief that best suits the individual.

### **Vulnerability–Stress Model**

The vulnerability–stress hypothesis of schizophrenia simply states that vulnerabilities and stresses combine to produce the symptoms characteristic of the disorder. The precise symptoms (e.g., voices or delusions) and combination of symptoms (e.g., any of the clinical subgroups described later) that are produced will be determined by the nature of the vulnerabilities and stresses experienced. People with vulnerabilities from genetic weighting, poor obstetric care, and negative schemas may become psychotic through the occurrence of environmental stressors such as drug use, trauma, or the accumulation of social problems. The negative schemas, lack of support, use of hallucinogens, and generally impoverished social environment with victimization then act to maintain psychotic symptoms.

In addition to such background factors, fear of the experience of psychotic symptoms can exacerbate stress. The experience of transient psychotic symptoms such as paranoid ideas and auditory hallucinations is surprisingly common in apparently healthy community samples (Johns & Van Os, 2001). Such "psychotic" symptoms are as common as obsessional thoughts and are usually interpreted in a similarly negative manner. This is particularly so in Western culture, where such symptoms are perceived in a highly stigmatized way. A person who develops pseudohallucinations due to sleep

disturbance linked to pressure of work could interpret the transient symptoms as follows:

"I'm sure I heard someone speak just now . . . It seemed to be calling my name . . . Am I starting to go nuts? . . . If I have a breakdown, I will lose my job . . . What will people think of me? . . . Maybe I will be put in a mental hospital . . . I will be locked up and injected . . . Life will be unbearable."

This sequence of increasingly anxious interpretations of the original experience can lead to increased anxiety and further sleep deprivation. This process can act to maintain and exacerbate the hallucinatory experience. The person can begin to become convinced that he or she is fundamentally different from others—"schizophrenic," "mad"—and this can then be reinforced by others' responses. Normalizing (see Chapter 8) provides information about circumstances where such experiences occur—for example, to people under extreme stress, such as hostages—and is understandable as related to those stressful experiences. The people experiencing such circumstances are different in terms of the distress they are undergoing but not fundamentally different "as people." The message is that given sufficient or specific types of stress, most individuals—maybe everyone—could develop the symptoms the person is experiencing.

There is therefore a clear rationale for the use of normalizing explanations (Kingdon & Turkington, 1994) as an early strategy in engagement and therapy with the psychotic person. Normalizing leads to reduced anxiety and improved collaboration. It can also lead to an early success experience due to reduction in hallucinatory intensity by reducing the anxiety that can be acting as a maintaining variable. Other psychotic symptoms (e.g., thought insertion and ideas of reference) are often the subject of similar catastrophization and can be helped through normalizing explanations.

Instead of (or as well as) catastrophizing about psychotic and panic symptoms, people can also become actively involved in pursuing "safety behaviors" in each of these disorders, especially with voices (Morrison, 1998). These are designed by the person to reduce the impact of the symptoms he or she is experiencing, but as these behaviors tend to use avoidance primarily, they can instead lead to their increase or at least persistence. The symptom is interpreted in these circumstances as a danger signal. The person will not engage with or take ownership of the experience and will avoid any situation where the voice might occur. If hearing the voice tends to occur in social situations, then the person will strenuously avoid social contact. When safety behaviors are deployed in this way, the hallucinations never have the opportunity to be extinguished and are actively maintained by the coping style of the person. When there is exacerbation of the experience of the psychotic symptoms by catastrophization and the use of safety behaviors, intense and disabling psychotic experiences can develop. The safety behaviors are only stopped when more functional coping strategies have been collaboratively developed and have shown efficacy in symptom management when used in graded homework exercises or during the session itself. Normalizing explanations and the use of voice diaries that encourage engagement and the gradual dropping of safety behaviors can then be effectively used together.

Change may therefore occur through the client's understanding the way in which his or her vulnerabilities and the stresses he or she has experienced interact. This sense of understanding has two effects:

1. It draws meaning from confusion, which is reassuring and destigmatizing: “I’m not that different from everyone else,” “now I understand why I feel so bad.”
2. It provides the basis for specific interventions that can alleviate the distressing and disabling symptoms, for example, problem solving, coping with voices, and testing out strong beliefs and working with their consequences.

## CLINICAL SUBGROUPS

Crow (1985) described positive and negative syndromes (Type 1 and Type 2) of schizophrenia and suggested that different neurological mechanisms might underlie the two syndromes. Prominent negative symptomatology at the time of the first episode that does not resolve during the index admission has been shown to predict a poor outcome (Carpenter et al., 1988). Barnes and Liddle (1990) posited a three-factor model of chronic schizophrenia involving perceptual distortion (i.e., the presence of delusions and hallucinations), disorganization (i.e., thought disorder), and negativity. Bleuler (1911) initially described a “group of schizophrenias,” and sporadically since that time subgroups have been delineated, such as simple, paranoid, hebephrenic, and catatonic schizophrenias, but such distinctions have had little impact on clinical practice.

Cognitive therapy involves careful investigation of initial episodes, and it has become apparent to us over the past few years that there are at least four common presentations that seem to require similar individual management plans, though with distinctions from one group to another (Kingdon & Turkington, 1998, 2002). Validation of these groups has been through review of clinical cases and discussion at many workshops and lectures; participants have generally agreed that the descriptions of these groups are clinically recognizable and fit with aspects of people with schizophrenia with whom they have worked. More formal research into the groups is currently being pursued. They are described here, with case examples, and used throughout this manual to help clarify the management of a complex heterogeneous group of people.

### Sensitivity Psychosis

People with sensitivity psychosis—who tend to present as adolescents or young adults—experience gradual onset, usually over a period of a year or more, in which they seem to have increased difficulty in managing events that they find to be stressful, for example, social situations, academic study, leaving home, or breakdowns in relationships (see Table 1.2). Sometimes they have been quite successful at school, although perhaps a bit solitary, or they may in contrast have had serious problems coping previously but remained in normal education or low-grade work. There have, however, been changes that they have experienced as stressful, for example, changes in jobs or in their educational setting.

Psychotic ideas emerge, sometimes transiently, with personalization of events being common, or presenting with beliefs that he or she is being spoken about by others or on radio, TV, or in musical lyrics (delusions of reference). The episode leading to presentation may be quite florid with thought disorder, hallucinations, and paranoia, but often this settles to leave a residuum of negative symptoms. Understandably, families and other caregivers can become very concerned about such symptoms and the dis-

**TABLE 1.2. Features of Sensitivity Psychosis**

- 
- Often relatively solitary or shy.
  - Gradual onset in teens or /early 20s.
  - Relatively minor stress (e.g., leaving home for college, starting work) precipitates episodes.
  - Caregivers usually very involved.
    - High expectations (based often on client’s past performance)
    - Encouraging and supportive
    - May be “trying too hard”
  - Feels under pressure but at a standstill.
  - Ideas/delusions of reference and thought broadcasting especially frequent—particularly when overstimulated.
  - Prominent “negative” symptoms.
- 

abling effect they have, and tend to try very hard to help the person. These efforts, however, can be counterproductive (as discussed in Chapter 12).

### **CASE 1: GORDON**

Gordon, a quiet young man of 18, was referred to see a psychiatrist, presenting with depression after leaving school. He was living with his father, a recently retired attorney, age 66, and his mother, a teacher, age 57. His brother, a police officer, age 24, was described as having “effectively dropped out of school” and now lived in a city 70 miles away with his girlfriend. He knew of no family history of mental illness. He experienced no developmental problems and after going to a local primary school went away to private secondary school as a boarding resident at age 12. He was happy for the first 4 years and did well at his initial public examinations, then started more advanced studies in chemistry, physics, and psychology.

He returned to school after the first year of these studies and felt that he “didn’t fit in.” He said that he couldn’t communicate with the other students, he was ruminating about them, and that their background was more privileged. When he initially became depressed, he had trouble going to sleep. He described “analyzing people’s lifestyle and background.” He felt inadequate, considered suicide, and indeed deliberately walked over railway bridges, thinking of throwing himself off. He felt he was “in tune with others’ thoughts”—that he “could pick them up.” He was referred by the school to see a psychologist, who noted his “great difficulty functioning in terms of motivation,” but Gordon did not disclose his psychotic symptoms.

He began to experience visual hallucinations of colorful patterns and felt in some way that he was “able to detect other people’s characteristics through these patterns.” He also began to hear female voices criticizing him. He could not continue at school and left to live at home, where he undertook a local college course in media studies. He remembers that he felt that he “got on well with other students” but had problems with the academic work. He used cannabis occasionally from the age of 16 but not during the 6 months prior to psychiatric referral.

When seen for psychiatric examination he was noted to be spontaneous, with

a “pseudophilosophical quality” to his speech, and expressed openly the belief that he was picking up people’s thoughts by the characteristics of their voices. He was also considered to be showing blunting of affect and, with his difficulties with work, lowering of motivation, that is, the possible emergence of negative symptoms. This was considered by the psychiatrist assessing him as likely to be a poor prognostic factor.

His parents were seen and disclosed that a paternal uncle had died of suicide 25 years earlier. They described Gordon as previously strong, determined, and thoughtful. However, over the preceding 2 years, he had become increasingly introspective, distant, and irritable, and complained about hearing voices to his mother. His father expressed a very negative view of psychiatric care but was concerned about his son. Medication was commenced—chlorpromazine. He was at this stage referred for cognitive therapy to the psychosis service in Southampton for psychiatric and therapeutic intervention.

He was seen over the next few months as an outpatient. He was noted to be becoming depressed, particularly exacerbated by an incident where he had a minor car accident when driving. His father became very critical, harshly blaming him for the accident, and the home atmosphere became very tense. He was prescribed an antidepressant but discontinued chlorpromazine, an antipsychotic that he had agreed to take. He was continuing at the local junior college, and initially his results were quite good, although he was quite negative about them. His plan was to apply to a 4-year university. However he was going to bed in the early hours of the morning and getting up late, meaning that he was missing lectures.

After a summer vacation he began to miss appointments and his classes. When questioned he said that he had decided to take a year off, but then he changed his mind. His friends had almost all moved away, and so he was seeing them only occasionally and beginning to shut himself off from the world. He missed a few more appointments, and then his family doctor re-referred him, as his parents said that he was refusing to see anyone. His mood was “strange, with inappropriate thoughts and ideas.” Fortunately he came to the next interview, being persuaded by his brother and mother. He described serious difficulty completing work at college: “It seems whatever I am thinking about, they can hear my thoughts or know what I am thinking about.” He restarted medication, “which helped clear the jumble out,” and then dropped out of college altogether for a while. He was confining himself to his room when not taking medication, and his “parents [were] at the end of their tether.” He did continue intermittently at college but got very poor grades. He was actively hallucinating, hearing sarcastic comments.

Following the assessment above, we developed a model of his symptoms based on the idea of “sensory overload” that prevented him from functioning; he agreed to take an antipsychotic drug, risperidone, in the morning as a way of “buffering against this stress.” His parents were seen together, and the model of negative symptoms was described (see Chapter 12). It was agreed that the best way forward was to reduce pressure and expectation—aim to convalesce. All agreed that he should “take a year off.” His mood immediately improved. He still had the “feeling of waves of energy between people” and “I still think I can hear myself thinking out loud and others thinking out loud” (thought echo/broadcast-

ing) with occasional voices. He had not been claiming welfare benefits, so this was initiated.

Over the next few months, he met with the therapist and chatted, working on understanding the thought broadcasting and also “made actions”—deliberately diverting his eyes, which he felt were out of his control but which increased with stress. His father “backed off,” and his mother remained supportive, although occasionally she became the subject of Gordon’s verbal frustration. His brother visited occasionally and after a few months took him to a rock festival, which was a severe test of his ability to cope with the thought broadcasting, which increased even with small crowds. He also visited other events, for example, the local boat show.

Gordon then decided that he was ready to visit the local job center to make an appointment to see the Disability Resettlement Officer, who could offer him support in looking for suitable meaningful employment. This took a number of weeks of discussing exactly where he needed to go, what he needed to do, and to judge when he felt able to cope with this. Having made the appointment, on leaving the center, he believed that a couple of young men across the road knew what he was thinking and were laughing at him. Fortunately he could talk objectively about this, although he retained a strong degree of conviction that this was what occurred; he was prepared to go to the interview that was eventually scheduled for him, and he attended. This subsequently led to his being offered a place in a residential course on computer programming for a month, which he successfully completed. Since then, he has started part-time work in an office of a friend of his mother’s. He is gradually becoming less isolated and is cautiously making progress, as described later in this manual.

## Drug-Related Psychosis

The key diagnostic factor with drug-related psychosis is that the first occurrence of psychotic symptoms coincided directly with taking a hallucinogenic drug (see Table 1.3). Cocaine, amphetamines, or ecstasy seem the most common, but high levels of cannabis may also have this effect. Continual use of these drugs may produce further episodes but over time the psychotic symptoms may occur independently of drug usage and other events (e.g., a TV program about drugs or meeting an old friend can cause it, or

**TABLE 1.3. Features of Drug-Related Psychosis**

- 
- Drug-induced psychosis at initial presentation (hallucinogens—amphetamine, cocaine, LSD, heavy use of cannabis).
  - Recurrence or perpetuation of symptoms when drugs not present (on testing).
  - Initially may be given diagnosis of personality disorder or drug misuse (only).
  - Hallucinations/paranoia—replay of original psychosis.
  - Onset usually in teens or 20s.
  - May have “rebellious” personality.
  - Frequently from a disrupted family.
  - Caregiver often very uncertain how to help and may therefore give confused messages to client.
  - Frequently poor cooperation with services.
-

the symptoms may simply persist in the absence of any hallucinogen). This can occur following only one episode of drug-precipitated psychosis. Persistence of symptoms may develop but can readily be tracked back to the initial drug-taking experience. These symptoms tend to be a replay of the original psychosis, at least in part. Work with families and other caregivers is necessary and needs to emphasize consistency, but it may prove difficult as they are often having to deal with quite chaotic and sometimes hostile behavior. Gaining the client's cooperation for treatment, at least during the earliest stage of involvement, can be a major problem.

### **CASE 2: CRAIG**

Craig, a tall, athletic young man with long hair, presented with symptoms that he described as "flashbacks" twice a week. He had suicidal ideation and behavior and had recently taken a large overdose of medication but was fortunately found before serious damage was done. He also was frequently banging his head in response to voices and had considered hanging himself with a wire flex.

He was born in a countryside village. He has two older brothers and a mother who was said to have been unable to cope with them after his birth. She seems to have suffered from postnatal depression, so Craig spent a lot of time with his grandparents. His parents split up when he was 8, and he moved to Nottingham to live with his father, although he continued to have holidays with his mother. He describes a happy childhood despite this and relates well to his family. He did well academically at school up to the age of 17, gaining good passes in basic examinations and commencing advanced studies despite having developed positive signs of schizophrenia. He has no relevant medical history.

He commenced taking cannabis at age 14, followed by LSD and occasional use of heroin. He says that he has generally avoided illicit drugs since developing his illness but remains occasionally vulnerable to friends' influence. He had a number of girlfriends before becoming ill. He has not worked except for assisting his father occasionally.

He presented at age 17 with a 2- to 3-month history of voices, described as seeming to be outside of his head. They sometimes would repeat his thoughts or tell him to do things, including kill himself. He described being made to move in response to them and that his thoughts were withdrawn and possibly broadcast. He developed ideas that he was controlled by a foreign agency and occupied by two people who were influenced in some uncertain way by electronic fields. At the time of presentation he said that he had had no heroin or LSD for 4 months and no cannabis for 2 months. He was prescribed sulpiride, an antipsychotic, and improved over the next few months. He started college but had persistent thought broadcasting and described significant perplexity. He stopped medication because of sedation and started experiencing additionally thought insertion, somatic delusions, and audible thoughts. However, he continued attending college and got a part-time job. He was seen psychiatrically again because he had broken a television and compact disc player in response to voices. Risperidone was used, but he showed erratic compliance.

He was admitted to the hospital after being aggressive toward his brothers and threatening his father with a knife. He took an overdose and tried to hang

himself but fortunately was found before coming to serious harm. He also hit his 6-year-old sister in response to voices. He soon settled down in the hospital with medication, however. He then left the hospital and moved out of his father's house to live with friends but then started missing college since he was not getting up early enough. A few weeks later, he smashed a tape recorder and then fell through a window, possibly intoxicated with illicit drugs. His care coordinator arranged with him to move to a group home, and he agreed to see a psychologist but then changed his mind and again took an overdose.

Craig was readmitted to the hospital: he believed aliens were talking to him, telling him to kill himself or his friends. He said he believed the prescribed medication was cyanide and continued to have thought insertion and withdrawal. He improved in the hospital and left to live at a girlfriend's house, but this soon broke down and he went into another supported group home for a few months. He then had a period of 2 years living independently in a flat but became vulnerable to drug-using friends. A further admission occurred due to relapse from the use of illicit drugs and discontinuing antipsychotic medication. He was shouting, irritable, and unable to deal with an accidental fire in his room, causing concern for his safety. He also had delusions of reference about the television, so he had stopped watching it. He was hearing voices and had low mood with suicidal thoughts.

In the hospital, he started depot medication and was discharged to the group home again. He returned to college, but his father soon detected continuing illicit drug use. He became severely thought-disordered, and he was now also drinking heavily. Clozapine was offered, but he refused to continue it after feeling "pole axed" (severely sedated) when he commenced it and has refused to take it since. A fourth brief admission occurred because of friends "bullying" him. He was apprehended while running and screaming with a screwdriver in hand, making threats to his neighbors. There was a report of him using "crack" cocaine by a neighbor. He also threatened to burn his house down. On admission, however, a drug screen was negative. He abruptly left the hospital but was returned to it—he would not participate in a rehabilitation program, so he returned to the group home. Further admission was subsequently necessary after a serious and very large overdose, which interrupted his planned move into a more independent accommodation. Again, his drug screen was negative for illicit drugs. It was at this point that he was referred for engagement in cognitive therapy.

Over a period of 6 months, a formulation has been developed with him looking at the circumstances in which he developed symptoms and when he has relapsed. This has been done in an exploratory and nonjudgmental way, reviewing the reasons for taking illicit drugs as well as the problems they have caused. Attribution of current symptoms to these previous drug-induced episodes has been gradually accepted, and further work on them had been done, as described in subsequent chapters.

### **Traumatic Psychosis**

Posttraumatic stress psychosis (traumatic psychosis) is on a continuum with borderline personality disorder (BPD) and posttraumatic stress disorder (PTSD). Traumatic events—especially sexual abuse in childhood or early adulthood—seem relevant to the

symptoms produced (see Table 1.4). For example, the voice may be that of the abuser or, where termination of pregnancy has occurred, of the “unborn child.” These become psychotic symptoms because they are externalized by the person and attributed to external agencies, as opposed to PTSD or BPD, where they are recognized as phenomena originating from within. Diagnostic psychotic features such as thought broadcasting and paranoia also occur such that a diagnosis of schizophrenia is warranted. However, work with these clients has to embrace both psychotic symptoms (e.g., understanding voices) and work with borderline features (e.g., impulsivity, fear of abandonment and self-harm, or posttraumatic stress).

### CASE 3: GILLIAN

Gillian presented first to general adult psychiatric services at 31 years of age. She was admitted from the family home involuntarily, under the U.K. Mental Health Act, with the help of the police. At that time Gillian was dressed in a garish manner with excessive jewelry, very brightly colored and inappropriate clothing, and heavy makeup. She made reference to a “bionic arm” that was causing her problems at home. Examination revealed that she had severe alopecia (hair loss) due to repeated hair washing and bilateral conjunctivitis due to excessive application of mascara. There was evidence of affective incongruity and preoccupation with personal cleanliness. She appeared to be continually disturbed by auditory hallucinations. Although extremely distressed and extremely mentally unwell, she was deemed to be at low risk of suicide or of violence to others. There was evidence of increasing deterioration in her physical state due to the degree of psychotic preoccupation.

Gillian had a normal birth and development in childhood, though she gradually fell behind her colleagues in elementary school and needed one-to-one instruction. Despite this, she did poorly in examinations, and an educational psychologist made a diagnosis of borderline learning disability. Gillian spent almost all her time with her family. Her father was disabled with rheumatoid arthritis, and Gillian spent a lot of time caring for him up until the time of his premature death when she was only 22 years old. Gillian’s mother was a dominating figure who held the family together after her husband’s death and used to do the various

**TABLE 1.4. Features of Traumatic Psychosis**

- 
- Auditory hallucinations
    - Abusive, violent and/or sexual content
    - Second person (“you’re a [swear word]”)
    - Command (“Kill yourself,” “kill your children”)
  - Experienced as shocking and alien
  - Repetitive and distressing
  - Fluctuating insight
  - Blames self
  - Associated with
    - PTSD, especially sexual abuse
    - Depression; suicidal and depressive thoughts
  - Overlap with borderline personality disorder
-

household chores with Gillian's help. Gillian and her mother were inseparable up until the time of the mother's sudden death of myocardial infarction when Gillian was 29 years of age. By the time of the mother's death the two brothers and two sisters had married and were living away from the family home. This left Gillian alone at home with Jack, the eldest of the brothers, who was a heavy user of alcohol. Jack's friends, who visited the house for drinking sessions, behaved indecently toward Gillian and left money with Jack. Jack bought jewelry and inappropriate clothing for Gillian and coerced her into wearing makeup when his drinking friends were coming to the house. Gillian was effectively used as a prostitute and repeatedly sexually assaulted. Initially she became anxious and depressed with obsessional thoughts and rituals. This rapidly led on to the development of pseudohallucinations and increasing social withdrawal.

By the time she was seen by psychiatric services, Gillian was suffering from virtually continuous auditory hallucinations. These were second-person and command in type. Content included "You are useless," "Put the makeup on," "Don't you have any better clothes?," "You are a slut," and "You are dirty—wash your hair." Gillian believed that the voices were telling the truth but did not know what they were exactly. She reported visual images and at times visual hallucinations linked to the voice-hearing experience.

Gillian derived some benefit from antipsychotic medication, but the hallucinations and negative symptoms were little affected. Assessment revealed that, when prompted, Gillian was quite capable of undertaking a variety of tasks. She was referred for cognitive therapy with a diagnosis of schizophrenia due to failure of response to standard treatment including antipsychotic medication, occupational therapy, and supportive nursing. It was decided first of all to undertake a trial of clozapine for 6 months along with placement in a rehabilitation hostel. Behavioral therapy was used during this period in an attempt to cut down on her repeated hair washing and application of makeup. There was some evidence of minimal improvement on this regime, but at the next review it was decided that cognitive therapy should be attempted to see if Gillian could be more effectively engaged in working with her symptoms on the basis of a mutually understood formulation. Work done with her and her progress are described later in this manual.

### **Anxiety Psychosis**

When anxiety (and, sometimes, depression) increases, often it is in response to stressful circumstances, although these are frequently not recognized as such (see Table 1.5). A "delusional mood" may develop—that is, a feeling that something significant is going to happen that may seem spiritual, magical, or parapsychological. Then a point is reached, often quite abruptly, when the person "knows" the answer that explains what has been happening to them—why they feel the way they do. Often they are isolated and unable to check out such concerns with anybody they trust and whose views they respect. "It is because I am being poisoned by my neighbors—they've never liked me" or "It is because I am descended from the Queen of Scotland and they are all jealous of me." There may then be other symptoms that develop consequent to this, but the key presenting issue is a very strongly held belief for which evidence is lacking—although

**TABLE 1.5. Features of Anxiety Psychosis**

- 
- Onset
    - Acute: it builds up over a few days or weeks
    - Generally later in life: late 20s onward
  - Stress-related (e.g., work pressure)
  - Anxiety relieved by crystallization into a “meaningful” explanation for distressing feelings
    - Delusional perception or delusional conclusion (e.g., “the neighbors are responsible” or “I’m persecuted because I’ve been sent to save them”)
  - Isolation common
    - Geographic (e.g., living alone or working away from home)
    - Interpersonal (e.g., relationships broken down)
  - Usually delusions present—may be grandiose or persecutory—developing into a delusional system
  - Further episodes in response to stress
- 

there may be features of the belief that in themselves are true or at least understandable but do not fully support the conclusion that is so strongly held.

#### **CASE 4: PAUL**

Paul was seen at home at the request of his family doctor on an urgent basis. At that time he was 28 years old. His parents, one a judge and the other a barrister, were very concerned about his deterioration over the preceding 10 days. They noted that he seemed to be a bit upset a few weeks earlier after finding out that his ex-girlfriend had just become engaged to be married. Thereafter he had struggled, applying for jobs with very little success. He had a degree in fine art that had not opened up the job market for him as he had hoped it might.

Despite these problems, he had seemed quite well until 10 days before the referral. At that point his elder brother had informed the family that he had been promoted to the board of directors of an electronics company. This appeared to have triggered an anxiety reaction in Paul, which led to increasing insomnia and preoccupation. For the 72 hours before his referral he was reported to be extremely anxious, with palpitations, abdominal churning, and tremor. He became increasingly pale, guarded, thought-disordered, and perplexed, culminating in a period of virtually total insomnia for 48 hours. He reported the belief that he might be changing sex on the basis that he had previously enjoyed dressing in women’s clothes.

There was no history of substance misuse, and there was no family history of mental illness of any kind. There had been no birth trauma or any developmental problems, but his younger brother (Robert) had been taken into care as a baby when Paul was only 3 years old. He said that this was “a dark family secret which nobody ever talked about.” Paul had performed reasonably well at high school and then at college.

After admission to the psychiatric unit he reported that a videotape had been made of him when he was cross dressing in a shop and that he believed that the tape was going to be used to harm him in some way. As his agitation gradually settled, he reported the belief that he was turning into a woman and indicated that the

tape had contained material predating the massacre at Dunblane (an incident where a number of children at a school had been shot a few months before), which he believed had put the idea of committing the murders into the mind of the murderer. Consequently he believed that he was to blame for the deaths of the children and that he would shortly be arrested by the police and thereafter incarcerated and vilified. He also believed that he had written some successful popular songs that had been stolen by the artist in question, who had somehow heard the contents of the tape.

His delusional system proved impervious to antipsychotic medication, although his behavior would have been unmanageable without it. There was concern that he may have decided to attempt suicide—such was his degree of distress over the impending “prosecution” that he was convinced was going to occur. On medication his thought disorder, perplexity, and severe somatic anxiety symptoms had all settled, but the delusional system dominated his lifestyle to such a degree as to make his quality of life very poor indeed. In this setting of a treatment-resistant systematized delusion with concerns over suicide risk he was referred for cognitive therapy.

### **Other Possible Subgroups**

There may be other clinical groups, but generally people with a broad diagnosis of schizophrenia seem to fit into the foregoing categories—although some may possibly meet criteria for more than one category. We find them useful in considering management and also as terms that are often much more acceptable than “schizophrenia”—because they are more complete or accurate descriptions of their problems. “Psychosis” as a term can sometimes be troublesome to people—it can be seen as stigmatizing—but replacing it with “disorder” or “problem” (e.g., sensitivity disorder or severe anxiety disorder) is often an acceptable alternative to people experiencing these problems. Negotiating the language we use with people can improve communication, engagement, and eventually shared understanding.

Possible mechanisms for the development of the subgroups are illustrated in Figure 1.1. For each group, there would be expected to be differences in vulnerabilities and stressors that will also influence whether the person develops schizophrenia or other disorders such as depression, borderline personality disorder, or drug dependence, or no disorder at all. Stigmatization will have an amplifying effect, and a tendency toward an externalizing bias (attributing experiences, e.g., voices or things being experienced by the person, to others), which defines psychosis, will need to be present.

## **UNDERSTANDING SYMPTOMS OF SCHIZOPHRENIA**

Symptoms of schizophrenia have been described by influential psychopathologists such as Jaspers (1963) as “nonunderstandable”; however, much experience and research since that time has made them much more understandable. The cognitive model developed to understand delusions, hallucinations, thought disorder, and negative symptoms is discussed here. Part of the process of developing a formulation of a case involves developing a case-specific understanding of the causes, function, meaning, and factors maintaining symptoms.

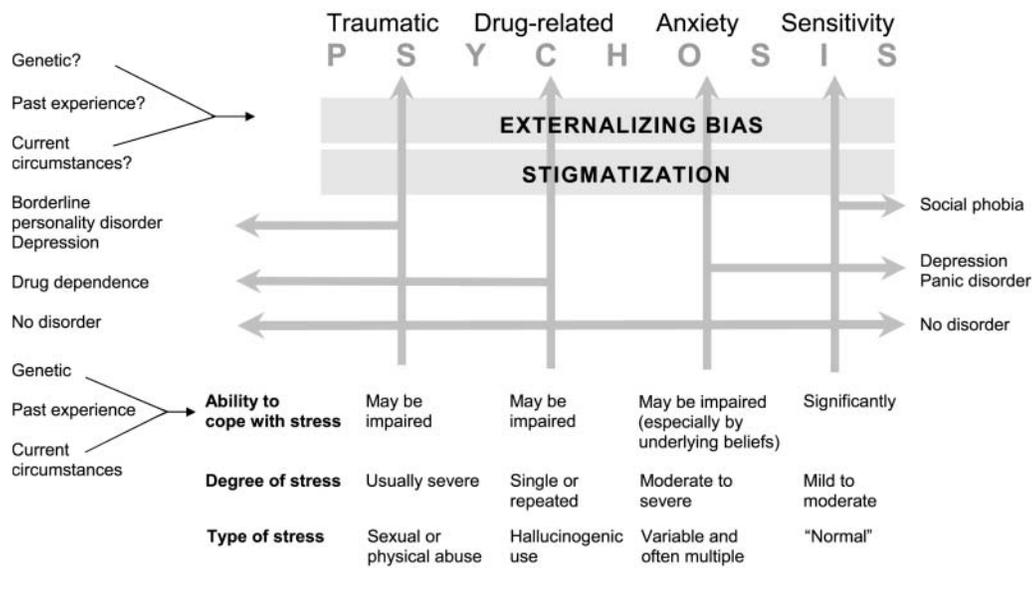


FIGURE 1.1. Theoretical model of subgroups.

## Delusions

Delusional beliefs are the core of psychotic symptoms, including hallucinations, as it is the beliefs about voices, visions, and the like that are fundamentally important rather than the experience of the phenomena themselves (see below). Similarly, thought interference and passivity (dealt with in Chapter 11) are special types of delusion. The term "delusion" is used as a shorthand term for strongly held beliefs that distress the person or interfere with his or her life by affecting important relationships with others. In addition, traditionally, it describes beliefs that are inaccurate, irrational, not amenable to reason, and inconsistent with the individual's culture. We would contend that categorical assumptions of inaccuracy, irrationality, and cultural inconsistency about these beliefs are problematic. In this manual we do not assume that strong beliefs, however strange they may seem, are inaccurate, nor that they need to be changed—but that they need to be understood and their consequences explored. One example where this was relevant involved a woman who had been admitted to the hospital with paranoid "delusions." These were centered around her husband, who she accused of trying to kill her. Her family disputed this, and her husband presented plausibly and appeared very concerned about her. She eventually accepted medication and returned home—only to be admitted to a general hospital a few months later as a result of her general practitioner's concerns. Investigation showed that she was indeed being poisoned. Her husband was arrested and later convicted of attempted murder. While such circumstances are rare, much more commonly bizarre or apparently erroneous beliefs are found to have some truth in them—or at least the reasons why the person believed them to be true become clearer as assessment and therapy progress.

Key elements in assessing and understanding delusions involve:

- *Strength*: How strongly is a belief held?
- *Context*: How unrelated is it to the person's situation?
- *Preoccupation*: How much time does the person spend thinking about the experience?
- *Plausibility*: How understandable is the belief?
- *Personalization*: How much does the person relate an experience to him- or herself?

The reasons for the development of delusions are multiple, and the reasons for the development of any strongly held beliefs apply. For example, such delusions may explain situations or relationships that are confusing to the person and give order and meaning to his or her life. They would be expected to be consistent with beliefs about the self. Social and cultural considerations may be very strong influences—the need to be accepted by family and peers may influence beliefs. It may be that grandiose beliefs in relation to the self (e.g., of special powers or position, such as royalty or divinity) compensate for a perception of lack of respect and a consequent need to impress (but this has yet to be effectively demonstrated). Paranoid beliefs may be related to a particular mood (e.g., depression), which they commonly accompany. They may explain circumstances (e.g., the loss of a job) that seem unfair and possibly allow the person an alternative explanation to one that attributes responsibility for the event to the person (e.g., missed time from work), or to chance circumstances (e.g., the person's area of expertise was no longer needed due to a change in market conditions).

Most important is that the formulation of the person's circumstances and symptoms, especially focusing on the initial episode, usually provides ways of finding meaning in delusional beliefs—especially where these are fixed and few in number or part of a delusional system. On occasion, delusions may be presented that are transient and held with less conviction, especially in cases where someone is highly psychotic. These may be less meaningful, but even these often reflect the current and past experiences of the person.

## Hallucinations

The cognitive model conceptualizes hallucinations as the person's own thoughts—which, to them, seem to come from *outside* their mind. The relevant belief is therefore that internal thoughts are externally generated phenomena. Traditionally they have been defined as vivid experiences with the quality of external reality in the absence of a stimulus to the sensory apparatus. Auditory, visual, and somatic hallucinations are therefore entirely internal cognitive phenomena that elicit powerful affective and behavioral responses, as they have all the implications of externally valid events. The beliefs about the hallucinations are fundamental. If the person does not recognize that the thoughts emerge from his or her mind—as is quite natural, given the convincing nature of the experience—this can be confusing and often distressing. One aim in developing “insight” will usually be to help the person explore alternatives to this belief.

Voices, the most common presentation of hallucinations, usually present as aversive phenomena: the person is distressed by them. It is widely assumed that voices are pathological—not just by psychiatrists and other mental health workers but especially by the general public. As has become clearer through the work of Marius Romme

(Romme & Escher, 1989) and subsequently the “Hearing Voices Network,” this is frequently, at best, a simplistic understanding of them and, at worst, an erroneous one. They have shown that many people hear voices that they value and view positively. For example, one rather isolated client heard the voices of two women chatting with him that he described as being very good company. Others may be ambivalent about them—the voices may at times have positive and at other times negative attributes. Certainly those who present to mental health services are more likely to experience negative effects, but even then positive effects can still exist. It is important to understand the impact of voices on the person and their view of them rather than assuming that they are wholly negative. This is so even where the presenting symptoms are abusive, unpleasant voices. Sometimes as voices recede, clients speak of increased loneliness and emptiness because so much of their time was previously occupied with combating them. While this would not usually be a reason for not working with the voices, it is an issue that deserves to be addressed in its own right.

Many people experience functional hallucinations in which the hallucinatory experience tends to be triggered by other perceptions. An example of this would be the person who developed accusatory auditory hallucinations when traffic noise became louder during the rush-hour period. In this case, it was agreed that the main caregiver would call a local window installer to have double glazing installed. The result was extremely effective. Such simple environmental interventions may not be considered because mental health professionals often do not consider such symptoms ever to be amenable to such simple measures. Assessment is limited, and so precipitants such as the traffic noise are not identified and interventions not suggested or tried. Many people also hallucinate in the presence of white noise—indistinct background auditory activity. For example, a client developed marked exacerbation of hallucinations when she heard a humming sound from the flat downstairs: This turned out to be the neighbor’s spin dryer. The neighbor was entirely agreeable to placing some foam rubber under the base of the dryer to diminish the noise in this case. Such simple maneuvers are often possible, although usually other measures are also necessary, but if successful, are seen as positive experiences allowing therapy to proceed. They encourage the person to further engage with their voice-hearing experience—focus on and work with it—and to further their understanding and range of coping skills. The person may not engage with the voices in such a constructive manner without a lead from the mental health professional. Engagement with the psychotic symptoms by the psychiatrist, psychologist, psychiatric nurse, occupational therapist, or social worker will often allow the person to emerge from stigmatized withdrawal and begin to take some control over the experiences.

Hallucinations are interesting cognitively, both in terms of their form and their content. In terms of form, the diagnostic hallucinations of schizophrenia are third-person hallucinations, a running commentary on the person’s actions, and a thought echo. Such symptoms often are “replays” of situations that have occurred or statements that have been made—usually in distressing or stressful circumstances (third-person voices and running commentary can resemble family discussions, e.g., “He’s not very good, you know.” “He’s walking out of the house again”; thought echo is the person’s own thoughts—but externalized). They would also appear to be very similar in type to the symptoms of obsessive-compulsive disorder (note the similarities and contrasts in the definition of obsessions, below).

*A definition of obsessions (as contrasted with hallucinations)*

- Ideas, thoughts, or images that are involuntarily produced (*as are hallucinations*)
- Occurring recurrently and persistently and experienced as senseless and repugnant (*as are some hallucinations*)
- Recognized as products of the person's own minds (*unlike hallucinations*)

Third-person hallucinations involve the same themes as obsessional thoughts (violence, control, religion, sexuality, cleanliness). This may involve the need to resist such themes by psychologically disowning them. The running commentary could be seen as an extension of obsessional indecision and thought echo of the obsessional fear that others will be able to detect these unsavory thoughts.

The failure to recognize hallucinations as one's own thoughts defines the difference between obsessions and hallucinations, although in practice these represent a continuum. This group of hallucinations therefore has overlap with obsessions and could be seen as lying on a spectrum with the symptoms of obsessive-compulsive disorder. If this is the case, then we might expect normalizing, exposure techniques, and work with linked schemas (e.g., control, responsibility, the thought-action link, and perfectionism) to be useful. These are techniques that are often used in working with hallucinations in schizophrenia.

Some hallucinations in schizophrenia do not have diagnostic implications, although occurring commonly. Examples include second-person and command hallucinations. These are often linked to visual imagery and at times to visual hallucination. These would appear to be a separate group of hallucinatory experiences that are commonly found in the setting of trauma. In the case of women who experience hallucinations long-term, around two-thirds have described having been sexually assaulted. These hallucinations are usually demeaning and derogatory and often comment on the worthlessness of the person or on sexual matters (often alleging homosexuality, pedophilia, or prostitution) and commanding actions usually of self-harm. The voice often resembles that of the abuser, and there can be linked somatic hallucinations (feelings of being touched, often intimately) and olfactory hallucinations (associated smells). In such instances, the hallucinations are usually best conceptualized and discussed as forms of flashback. The linked feeling is often of overarousal or varying degrees of distress and depression. In such cases the diagnosis of an emotionally unstable ("borderline") personality disorder may also be made—but additionally the person has psychotic symptoms, that is, his or her experiences may include hearing voices or thought interference.

## Thought Disorder

Formal thought disorder can be fascinating. It can allow us to explore the richness of language and the remarkable ways in which people can combine components to form new words and expressions—and it can also get both you and the person who is talking to you quite frustrated. The content of thought-disordered speech may be quite poetic in nature or simply garbled and seemingly nonsensical.

Essentially, the cognitive model of thought disorder views the term itself as a misnomer—what usually presents to us is not thoughts directly but speech that is idiosyncratic.

Not “thought disorder” but communications disorder. Often the person is striving to communicate but hardly managing to. The thoughts (or at least what they are trying to convey) beneath the conversation may be quite logical (once they can be understood), but their expression seems not to be. The person may speak very rapidly, with interweaving themes, using words that most people use with quite different meanings or words that are derived from others—either with unusual grammatical rules attached or as composite words made up of parts or the whole of words used in usual conversation. So, often people—family or staff—give up on them or humor them; this may mean that over the years they will receive little guidance or feedback to assist them in modifying, and thus clarifying, what they mean. They may appear, conversely, not to communicate much at all, or repetitively—with “poverty of content,” as it is described. This may be a lack of thoughts or it may be demoralization or simply a lack of much to say because of their social circumstances and the poverty of the environment around them.

People with active thought disorder, including knight’s-move thinking (that is, jumping around with just a tenuous connection—as a knight does in chess), fusion of themes, and neologisms (newly created words), are usually highly aroused by specific concerns (Harrow & Prosen, 1978). But they may have significant problems in discussing these issues and as they come closer to discussing them and become more agitated, so the thought disorder becomes greater and greater, interfering with communication. Proceeding slowly and patiently can help in clarification. There may be one core theme that drives the disorganization of thought, and if the person can be helped to focus on this, using thought linkage and explanation, increased coherence can result. By repeatedly but gently asking the person how he or she got from X to Z, the person begins to explain the Y connecting them together. Similarly, neologisms are questioned during speech, and explanations are requested. The underlying driving theme is usually one of threat, fear, or distress, and once this is identified a focus on relevant events and beliefs allows a reduction in arousal and increased coherence of speech. The underlying perceived dangers and threats have often been misperceived or magnified and can be gradually corrected during therapy (Turkington & Kingdon, 1991).

### **Negative Symptoms**

The term “negative symptoms” itself is disheartening, even though it is superficially accurate. What sort of symptoms are they? They are intended to describe absence—of expression, drive, emotion, and thought. But appearances, as elsewhere, may be deceptive. Under the surface, much may be happening in terms of contemplation and observation. Releasing the energy and potential that may be present but suppressed is an essential goal of treatment. All these symptoms have cognitive or behavioral components and so potentially are amenable to cognitive-behavioral approaches. Assessing them accurately assists in the development of a formulation-based treatment plan. Each of these symptoms may be understandable, as follows.

#### ***Affective Flattening***

The flattening of affect involves difficulty in communicating emotion or expressing feelings through facial expression and tone of voice, but it is worth exploring with the person why he or she appears to have such problems. There are a number of possibili-

ties, but it is wise to find out the individual's own assessment of the issue. You may need to approach the issue sensitively because the person may not have previously realized that this was how he or she was perceived, and it can potentially undermine one's social confidence. As with other symptoms, affective flattening may be biological in origin, in which case striving to change may prove ineffective. However, there are also possible psychosocial factors.

It may be that the person is effectively "in shock." This may be related to past traumatic events that he or she has failed to work through effectively, for example, bereavement. Alternatively, it may be appropriate learned behavior for the circumstances in which the person lived. For example, if shows of emotion (e.g., tears or disagreement) were disapproved of—as is the case in some families and cultures (typified by the British "stiff upper lip")—or punished, or triggered abuse, the absence of reaction—affective flattening—may be a natural reaction. When the early years of the parents of people with schizophrenia, or the persons themselves, have been difficult through poverty or repeated bereavements or other traumatic events, such emotional blunting may be an understandable reaction.

Affective flattening may be a direct reaction to abusive, derogatory voices or thoughts, and the "frozen" expression, a "front" to the world, may be an attempt to cope with seemingly overwhelming disturbance. Depression itself will present with affective flattening as a component of a broad depressive symptomatology. Medication can also contribute. Parkinsonian symptoms can be caused by antipsychotic drugs, especially the older "typical" drugs but also the newer ones in higher doses. These symptoms manifest themselves in a variety of often subtle ways, but reduction in emotional expression is particularly well recognized as a side effect.

### **Alogia**

What is alogia? It is described as slowness to respond, with the amount and content of speech restricted or interrupted. But is this a lack of thoughts or, rather, difficulty in communicating them? How can we know what someone else is thinking? There are suggestions from neuropsychological testing that cognitive deficits may underlie this symptom. But sometimes failure to express may have psychosocial sources. One reaction to criticism, real or perceived, can be to "shut up." Although this may have begun as a reaction to one individual—a teacher or domineering boss or family member—it can generalize and be reinforced by circumstances. Anxiety and perception of pressure certainly can impede communication, causing interruption, even cessation, of thoughts ("thought block"). A couple of embarrassing times when the person "dries up" and is unable to continue can do major damage to confidence and may contribute to apparent alogia.

### **Avolition**

Absence of drive and motivation is possibly the most disabling of symptoms associated with schizophrenia—"My get up and go has got up and gone." It is certainly one of the most frustrating symptoms. The person seems "lazy," "bone-idle," and "never going to get anywhere in life," but perhaps a better description is "driven to a standstill." The effect of stress may impair attention and concentration, and the more effort applied the

more pressured the person feels and the worse their attention and concentration become. Impaired attention leads to difficulty in remembering what is said, and when recall is needed, for example, to perform a new task, it cannot be done. Positive symptoms may also develop and worsen matters. Very often it emerges that lack of effort may now seem the problem, but this has certainly not always been the case. People with a wide range of abilities and achievements may present with avolition, but prior attempts at achievement are not usually the issue. A drop-off in performance is common, and a subsequent discussion will often spotlight the failure to achieve the expected results, with additional pressure and anxiety surrounding this. A vicious circle develops in which the more they try, the less able they are to complete tasks successfully, so the more frustrated and demoralized they become; as they repeatedly experience failure, they lose hope for succeeding in the future and gradually try less and less. Others around them may inadvertently contribute by encouragement, which manifests itself as pressure. Society may also increase pressures, for example, to get a job, a partner, and a family. For many people with schizophrenia, this is not an unreasonable long-term goal, but it *is* a short-term nightmare.

For a few people with schizophrenia, getting a job or partner may, however, be unreasonable even long-term, depending on their general functioning—particularly for those with borderline intellectual capacities. If they were slightly less able, they might be excused from such demands, as they would be viewed by those around them as being intellectually, mentally, or learning-disabled. As such they would receive special schooling and other support. In such circumstances, getting a job and the rest would be seen as an achievement in its own right—as a bonus rather than an expectation. However, because some individuals with schizophrenia and limited functioning have managed to struggle through normal schooling, expectations may be unrealistically high. Goals need to be reviewed, one on one, and adjusted on an individual basis.

### **Anhedonia**

What is anhedonia all about? It denotes a feeling of emptiness and reduced interest in activities and relationships. It is differentiated from depression and so is considered a negative symptom rather than primarily an emotional symptom, but such distinctions are not easy to draw. It is not the same as affective flattening, although you would expect an association between the two. It may be related to demoralization, hopelessness, or feeling numbed and because of the potential overlap with depression is viewed by many commentators as not being a *core* negative symptom. Depression, and possibly anhedonia, is very understandable in a disorder with such a stigmatized reputation and one characterized by such distressing and disabling effects.

### **Attention Deficit**

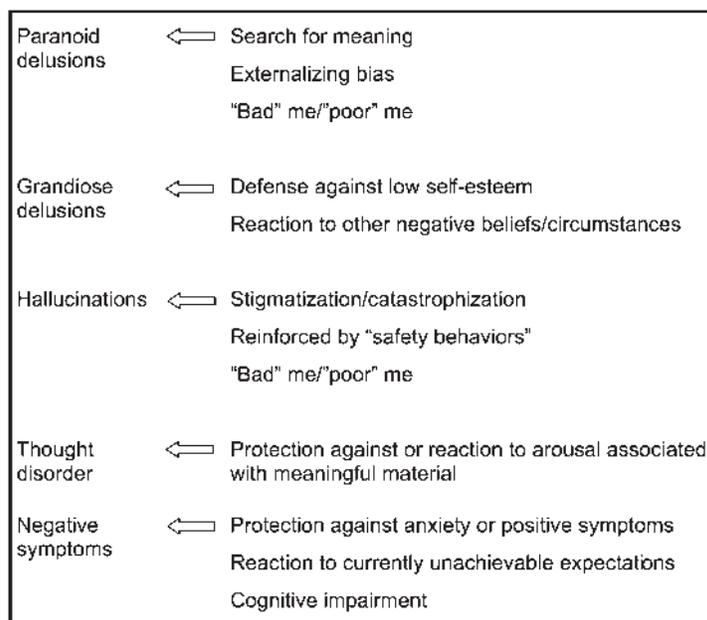
There is certainly good evidence for poor attention and concentration in schizophrenia. Anyone spending more than a few minutes with someone going through an acute episode of schizophrenia will notice that he or she, the therapist, is often functionally alone, with the client's mind elsewhere. Is this due to neuronal interference in the brain? Perhaps—there is certainly good evidence that people with schizophrenia do

more poorly on psychometric testing than normal controls. Such reported impairments include effects on executive functioning, attention, global working memory, and spatial working memory. Cognitive impairment predicts long-term outcomes and may be the most important predictor of vocational outcomes. It is also important to take into account the attendant preoccupation with and distraction by hallucinations, especially when these are vivid and intrusive, and also other thoughts, either delusional, obsessional, or simply very worrisome or even interesting, to the person. Certainly if you think the police are coming to get you or the world is ending soon, it is quite likely that your mind will be preoccupied with that rather than therapy, assessment, or psychometric testing. It is possible that the more the person tries to attend, the more overstimulation may contribute to and increase his or her attentional deficit—that is, the more these thoughts about thoughts (“God, aren’t I useless”) may interfere.

**Social Withdrawal**

Withdrawal may be a way to cope with overstimulation. Social overstimulation may be a particularly noxious source of stress. Reducing stress or increasing capacity to cope with it may be needed before direct work with the social withdrawal.

The cognitive model of negative symptoms based on these ways of understanding negative symptoms involves consideration of the protective functions that they may have, how they may be a response to currently unachievable expectations, as well as the effects of overstimulation (e.g., concentration difficulties) in a person who may have a biological vulnerability to stress. (This is discussed further in Chapter 12.)



**FIGURE 1.2.** Symptomatic explanations.