

Mental Health and Society
Seminar 4 Week 17 (beginning 20/1/2014):
Cognitive behavioural therapy in Schizophrenia

This session is intended to get you thinking about some aspects of psychological therapy for schizophrenia. A few weeks ago in class we talked about schizophrenia so this will help consolidate some of the ideas in this session. As you will remember from when this was first mentioned in class, there has been a growing interest in Cognitive Behavioural Therapy and related psychotherapeutic interventions for schizophrenia. Mostly, this has happened in the UK, but the Americans are catching on too. In the reading for this tutorial we can see the application of these techniques in some detail. The reading is:

Bradshaw, W. (1998) Cognitive behavioural treatment of schizophrenia: A case study, *Journal of cognitive psychotherapy*, 12 (1) 13-25. This, as usual is available in the online materials <http://www.brown.uk.com/brownlibrary/bradshaw.pdf>

In reading this and in discussing it you might want to think about some of the following issues:

How did the therapist get rapport established with the client? You might want to check out how 'genuineness', 'respect' and 'accurate empathy' (p.3 on our copy) might be performed – these are often found as techniques of client centered or Rogerian therapy.

Why are these sorts of things important in therapy? To what extent would it be possible to do therapy without 'genuineness', or 'empathy'? How might therapists have managed before these concepts were 'invented' in the 1950s?

In Bradshaw's article there is a 'socialization phase' there is (fairly typically) some emphasis on 'educating' the client and telling them a standard introductory textbook story of schizophrenia - biological vulnerability plus environmental stress. Why tell the client this kind of story? What would happen if clients were told other kinds of story, such as a spiritual one? What other kinds of story *could* one tell to help people live with 'schizophrenic' symptoms?

Carol, like many people with long term mental health difficulties, spent time in bed, smoking and watching television. Why does this happen?

You might want to think about some of the following:

It's a part of the 'illness'

Drug side effects

Stigma when you do go out

Lack of money

Reduced expectations from other people

It's part of the sick role

To what extent might these be true? You might want to think also about ways in which psychologists (or indeed, nurses, social workers, care assistants, volunteer helpers etc.) could help; with this.

What other factors are there that restrict some sufferer's social and occupational lives?

In this paper they mentioned monitoring the client's stress levels. Why might it be useful to do this?

There are some activities mentioned which were part of Carol's rehabilitation e.g. painting by numbers, macramé. Why do you suppose they were using such highly structured tasks? What would happen if more creativity were demanded?

Why is it desirable to give people an 'internal locus of control' as they appear to have done with Carol?

Would this be better than an external one? Why?

Why would social activities be a problem for someone in Carol's position? Why does this happen in 'schizophrenia'?

The author says that individuals with 'schizophrenia' have 'exceptionally negative appraisals of themselves and events' (our page 6). To what extent is this a realistic perception? Think about the people in Herman & Musolf's paper in one of the earlier seminars too. To what extent did they fit this pattern? Is it possible to make people's perceptions of themselves more positive? Or do we need to change society and reduce the stigma attached to the condition?

Why was 'termination' of therapy gone into so carefully? What could go wrong if it wasn't?

Is it possible for people to become dependent on therapy or their therapist? If they do, can they become independent again?

Is the therapy really 'cognitive behavioural' or are they just making it up as they go along?

You might wish to compare the therapy which has been attempted for schizophrenia with the material about therapy for depression which is reviewed in text books.

To what extent does the therapy need to be cognitive behavioural in order to have a beneficial effect?

Would other kinds of therapies be effective? Would other activities have the same effect, like pottery classes or reading children's stories aloud?

As a result of reading this, and the material we have covered in the lectures, what can we conclude about the effectiveness of this kind of therapy with people who are 'schizophrenic'?

To what extent could it replace medication? Or is it always going to be an adjunct?

As a result of thinking about and discussing these issues you will be beginning the task of becoming a critical reader of reports of therapy. Generally, when I read about therapies I'm asking questions like Why are they doing this? What would happen if they didn't? How does it fit in with what I know about other people with similar problems? Is it the therapy that helps or is it just the attention? Are they really addressing the symptoms or just making her a bit more socially normal? What's so great about going out and getting involved in things anyway? In this way it is possible to evaluate the significance of therapeutic interventions.

Bradshaw's paper is getting quite elderly now but it does succeed in showing in some detail what a therapeutic programme of this kind might work out in practice. Among the materials available to you at <http://www.brown.uk.com/schizophrenialist.htm> , there's a case study of enhancing a client's metacognitive skills (Buck and Lysaker, 2009), a study of enhancing family relationships via family therapy techniques (Carter, 2011) and the issue of navigating a complex social world when suffering from schizophrenia (Hooley, 2010).

References

- Buck, K.D. and Lysaker, P.H. (2009) Addressing Metacognitive Capacity in the Psychotherapy for Schizophrenia: A Case Study, *Clinical Case Studies*, 8, (6): 463–472
- Carter, D.J. (2011) Case Study: A Structural Model for Schizophrenia and Family Collaboration, *Clinical Case Studies*, 10, (2): 147–158.
- Hooley, J.M. (2010) Social Factors in Schizophrenia, *Current Directions in Psychological Science*, 19 (4): 238-242