

# Cognitive Theory Applied to the Treatment of Delusions of Schizophrenia

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This article reviews theory regarding cognitive interventions in schizophrenia, focusing particularly on the treatment of delusions. The cognitive theory of psychopathology is first introduced and the specific goals of cognitive therapy are then presented. A range of philosophical and etiologic perspectives on the nature of delusions are explored, including the cognitive perspective. Specific stages and techniques of therapy are discussed with theoretical underpinnings and suggestions for incorporation in advanced practice psychiatric nursing.

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**D**ELUSIONS, a cardinal symptom of schizophrenia, present a difficult challenge in the treatment of persons with serious and persistent mental illness. Certain delusional processes can seriously inhibit the adequate function and community adjustment of the seriously mentally ill. When delusions are resistant to treatment by the newer pharmaceuticals, clinicians have few alternatives for effective treatment. One treatment alternative is cognitive therapy, which has shown effectiveness with other mental illnesses, particularly depression. Cognitive therapy is gaining recognition as a possible treatment for the delusions of schizophrenia. This article reviews the literature related to cognitive interventions in the treatment of schizophrenia and suggests strategies for incorporating this modality in clinical practice.

A number of clinical reports and research studies address cognitive therapy in schizophrenia. Perris (1989) and colleagues report the development of an operational community-based cognitive model in Sweden for the support and treatment of those with schizophrenia. Beck has reported recent efforts exploring the use of cognitive therapy for the symptoms of schizophrenia (Alford and Beck, 1994; Hole, Rush and Beck, 1979). Other reports are increasingly showing the effectiveness and treatment potential of this intervention model (Alford and Correia, 1994; Chadwick and Lowe, 1990,

1994; Himadi and Kaiser, 1992; Milton, Patwa, and Hafner, 1978; Watts, Powell, & Austin, 1973).

This article presents the cognitive theory of psychopathology to provide the rationale for cognitive intervention in treating delusions. Delusions are not well understood and present unique treatment challenges. A range of philosophical and etiologic perspectives on the nature of delusions, including the cognitive perspective are explored. Specific stages of treatment and applicable techniques are presented primarily as an example of theory application rather than step-by-step instructions. This application of theory to practice can be useful to advanced psychiatric nursing practice.

## COGNITIVE THEORY OF PSYCHOPATHOLOGY

Cognitive therapy has a long history of treatment success with depression, and is now gaining recognition for its use in anxiety, panic, and eating disorders (Beck, 1993). Cognitive interventions are also being tested for use in obsessive-compulsive and bipolar disorders, sexual deviance, and post-

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traumatic stress disorder (Alford and Beck, 1994). More recently, cognitive therapy is being considered to address the delusions and hallucinations associated with schizophrenia. Underlying the cognitive model of psychopathology is the perspective that our behavior and actions are directly determined by the way in which we structure the world on a cognitive level (Beck, Rush, Shaw, & Emery, 1979). The cognitions of cognitive theory are of three types: cognitive events, cognitive processes, and cognitive structures (Perris, 1989). These distinctions provide the basis for the application of cognitive therapy for delusions.

Cognitive events are the images, fantasies, dreams, and thoughts that occupy much of our mental activity. Specifically, these are automatic thoughts (Beck et al., 1979). They are automatic because they are repetitive, occur spontaneously, and resist our best conscious efforts to rid ourselves of them. Their automaticity suggests that they occur below the level of conscious awareness, but can be brought to conscious awareness (Robins and Hayes, 1993). These thoughts represent one's subjective experience of life events, not objective experience (Robins and Hayes, 1993). The form of one's automatic thoughts frame one's experience of the world. Negative automatic thoughts produce negative subjective experience of one's world.

Cognitive processes are the pathways by which "errors in the recognition and in the processing of information" occur (Perris, 1989, p. 22). These are the processes with which one appraises events. These distortions form the link between automatic thoughts and schemata or structures, the third cognitive type. The following examples of faulty cognitive processes have been adapted from Beck et al. (1979) and Perris (1989). Subjective abstraction is the process by which one takes pieces out of the whole of an event. The individual interprets the event based on the fragment instead of considering the whole event. Arbitrary inference includes suppositions of the meaning of an event, with evidence either directly in opposition to this supposition or without any evidence of support or denial. Overgeneralization implies the application of assumptions from one event to a broad range of events, without attention to how this assumption relates or not to these events. Magnification and minimization are gross misjudgments regarding the importance of an event. Personalization assumes one is central to events without any basis of support for this assump-

tion. Its most blatant manifestations are persecutory delusions and delusions of reference. Dichotomous, polarized thinking is the tendency to interpret personal behaviors in extremes, that is, all good or all bad.

These faulty cognitive processes are not indicative of any particular mental illness. In fact, the reader likely recognizes having experienced at least one of these processes. They are best described as occurring on a continuum in every individual (Perris, 1989). Those considered to have seriously disordered cognitive processing probably suffer from multiple processing dysfunctions, and are less able than most to correct these problems (Perris, 1989).

Cognitive structures or schemata are the third category of types of cognition. These are learned over time through experience and form the basis of beliefs on which one understands his or her world. Schemata are fundamental, largely unchanging "systems for classifying stimuli" that are applied across a broad range of experience and events (Perris, 1989, p. 23). Perris (1989) likens schemata to that which defines the self. Those with disordered cognitive structuring perceive events in terms of threats to the self, such as loss or danger. Schemata are difficult to change, being more amenable to assimilating confirmatory information rather than accommodating and making room for new schemata.

It is important to identify the schemata, or cognitive structure, at the heart of an individual's self, called core schemata (Robins and Hayes, 1993). Features unique to core schemata are that they operate across a broad range of events for the individual and that they can be recognized across different people. Commonly recognized core schemata are low self-esteem and loss. When core schemata are operating, the therapist can recognize obvious changes in affect. Lastly, core schemata can be identified by exploring areas in therapy where the client did not respond, had a particularly difficult time, or was resistant to exploration or change.

The development of these three types of cognition imply active participation on the part of the individual. As open systems striving toward equilibrium, we create our personal worlds over time through receiving, assimilating, and accommodating information according to what we already know and to what we are willing (consciously or not) to

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