

# Effects of Metacognitive Therapy on Schizophrenia, and Possible Improvements

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*Imagine yourself projected into this scenario:*

It's a cold, gloomy day. You peek out of your apartment window through the blinds to make sure everything is safe before you exit the building to go to work. Everything seems to be fine, so you venture out of your apartment deliberately, but cautiously. However, in the back of your mind, you have a strong, overpowering feeling that someone is watching you. As you walk down the street, you hear footsteps behind you. You quicken your pace. The footsteps quicken as well. You break out in a run towards a more crowded street. When you get to the street, you quickly glance behind you to see who was following you. No one is to be found. With a shiver down your spine, you continue on.

When you get to work, you can hear your co-workers talking about you. They are conspiring against you to try to get you fired by telling your boss that you're always late to work and not fulfilling the required duties. They are always whispering behind your back, and you can always hear their negative comments playing over and over in your head. They say things such as, "You are not going to last another month in this job" or "You are a total failure." Although you try to explain to your boss what's going on, you are unable to make the words come out properly.

It becomes even worse when you go to the grocery store after work. Passing by each aisle, people turn to look at you apprehensively. When people see you, they quickly turn and walk the other way. You can hear their voices echoing throughout your head saying, "We need to get away from you before you curse us with your mere presence!" or "Who would even want to look at you, you complete failure!" Their voices seem to overpower you and become louder and so intense that you run out of the store and back to your apartment where you sit in your house,

unable to move, trying to evade the voices echoing in your head.

This experience is not at all pleasant. It would be terrifying and stressful, to say the least. The scenario just presented is an example of what life might be like for one who has untreated schizophrenia. Because of the severity of these untreated symptoms in some people, it is imperative they be provided with highly effective treatment with effects that are long lasting. A treatment plan using regular cognitive behavioral therapy (CBT) sessions and supplemented by metacognitive training (MCT), in addition to regularly taken anti-psychotic medications, might prove to be the most effective treatment regimen for schizophrenia. While MCT is effective in helping clients cope with their delusions, it fails to address a very significant component of schizophrenia experienced by some people: auditory hallucinations. In order to understand why and how CBT and MCT treatment plans work, and where they are deficient, one needs to acquire some background knowledge about schizophrenia and the development of CBT and MCT treatment protocols.

## LITERATURE REVIEW

Schizophrenia affects about 1% of the population worldwide (Williamson, 2006). The DSM-IV (2000) is currently utilized in diagnosing the disorder. While many aspects of the disorder can be lessened or eliminated by taking antipsychotics, other methods, such as Cognitive Behavioral Therapy (CBT) and, most recently, Metacognitive Therapy (MCT), are being studied as comparable alternatives or supplements to these medications. CBT can provide skills to those who are resistant to taking medication and help improve everyday struggles for

people with schizophrenia such as having trouble at work and developing relationships with others (Morrison, 2009). In 2010, psychologists in the United States and Great Britain were surveyed to gather their views on CBT in relation to schizophrenia to determine their views regarding the efficaciousness of this fairly new treatment (Kuller, Ott, Goisman, Wainwright & Rabin, 2010). The UK rated CBT the best treatment for schizophrenia, while the United States rated medicine the best form of treatment. This difference, as the article stated, could be due to the differences in the types of health services offered in both countries. Clinical trials testing Cognitive Behavioral Group Therapy (CBGT) have also been introduced in past studies (Lawrence, Bradshaw, Mairs, 2006).

Metacognitive Training (MCT) is a more recent treatment developed to treat schizophrenia. Metacognitive Training (MCT), a new treatment for schizophrenia developed by Steffen Moritz and Todd Woodward, can help people with schizophrenia to become more attuned to illogical thinking patterns associated with their illness (Woodward 2009). A variation of CBT, this approach targets positive symptoms, delusions in particular (Kumar et. al., 2010). Since then, a review of the current findings in MCT has been written (Moritz, Vitzthum, Randjbar, Veckenstedt, & Woodward). The article concludes that MCT can now be seen as a complement to regular therapy sessions. Testing this idea, a recent study conducted in 2011 in France proved that MCT is a method of treatment well received by the clients it serves (Favrod, Maire, Bardy, Pernier & Bonsack, 2011). MCT was also seen in this study to further clients' knowledge, understanding and response to delusions.

### **SCHIZOPHRENIA**

While each person experiences schizophrenia differently, there are a few

specific universal characteristics that define it. However, not all of these characteristics have to be present in a person for them to be diagnosed with schizophrenia. According to the DSM IV, two or more of the following characteristics need to be present in order for a diagnosis of schizophrenia to be made: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, and negative symptoms such as a flat affect. These symptoms usually appear during adolescence or early adulthood for males with a possible extension by a few years in females (DSM IV, 2000). Delusions are false beliefs accompanied by strong convictions despite obvious disapproval by evidence. Thus, in the previously described scenario, the delusions would be that the person believed he or she was being followed and watched, conspired against at work, and hated by everyone in the grocery store. Therefore, despite the fact that a simultaneous occurrence of these events is not probable and also regardless of anyone telling him or her different, the person experiencing this scenario would most likely continue to believe this was happening to him or her. It is difficult to convince someone that what he or she had just experienced was not real because it was extremely real to him or her. Hallucinations, on the other hand, are false/ distorted sensory experiences that seem to be real. Auditory hallucinations, or illusory perception of sound/ voices, are the primary type of hallucinations experienced by those with schizophrenia. Contrary to common conceptions, visual hallucinations are relatively rare. Disorganized speech patterns occur because the person has disorganized thought patterns. These disorganized thought patterns can manifest themselves in speech patterns as well. A person with schizophrenia may have trouble communicating with others because his or her speech patterns can be jumbled or in

some cases, unrecognizable. In the scenario previously presented in the introduction, the person had difficulty communicating with her boss. Another possible symptom of schizophrenia, grossly disorganized behavior, is when the given behavior is inappropriate for the setting in which it occurs. An example of this could be exhibiting sexual behavior that is not appropriate in a public setting. Catatonic behavior, in comparison, can involve either the inability to move or respond to outside stimuli or behavior that is strangely hyperactive. This was represented in the introductory scenario toward the end in which the person was faced with the inability to move. Lastly, those with schizophrenia can experience blunted affect, which is characterized by one's inability to have emotional reactions. Blunted affect can often be seen in one's facial expressions. Out of all these symptoms associated with schizophrenia, the most common and perhaps one of the most difficult to overcome are delusions. New advancements in treatment have been found to heighten understanding and decrease the effect that delusions can have on those with schizophrenia.

### **COGNITIVE BEHAVIORAL THERAPY**

Discussed by Aaron Beck in 1952 but not fully realized until quite recently was the use of Cognitive Behavioral Therapy (CBT) in the treatment of people with schizophrenia. The approach first became widely accepted in Britain where clinical trials were and are conducted on a regular basis. The United States did not do as much research to start out with because of the differences in medical services offered. Britain has the National Health Service that guides the mental health programs, while the United States is made up of many private practices that have some flexibility in how they approach treatment (Kuller, Ott, Goisman,

Wainwright & Rabin, 2010). Those who study CBT believe that "Cognitive behavioral therapy is based on the idea that our thoughts cause our feelings and behaviors, not external things, like people, situations, and events" (NACBT, 2010). Also, CBT promotes the idea that anyone can change his or her behavior to cognitively, not always realistically, make the situation better. There are many techniques practiced in CBT. Attention switching, attention narrowing, increased activity levels, social engagement and disengagement, modification of self-statements, and internal dialogue are some commonly used techniques in CBT (Tarrier & Haddock, 2004). The following is a CBT scenario: a client with schizophrenia goes to see a therapist who practices CBT because he is convinced that his neighbors are plotting to kidnap and kill him. A therapist who practices CBT would go about helping the client by allowing him to look at the situation with a reasoning point of view. Some questions such as "Why would these people be plotting to kill you?" or "Does this seem probable?" would probably be asked to further examine this delusion the client is having. The client would work closely with the therapist to figure out what is really going on and why what they are thinking is irrational. Eventually, the client will be able to catch negative feelings that he or she has and challenge these with logic instead of merely responding out of fear or emotion. CBT has also been tested in groups with schizophrenia, but primarily in Britain and not the United States. However, the competency of therapists who usually practiced CBT alone with the client and not with a group came into question. A newer variation of CBT, called MCT, has now been introduced by Steffen Moritz and Todd Woodward. This type of treatment specifically targets the delusions that are among the main symptoms of schizophrenia.

## **METACOGNITIVE THERAPY**

Metacognitive Training (MCT) is the most recent method developed to help people with schizophrenia learn to deal with the delusions they may experience. It is the best approach to treating schizophrenia when supplemented by regular visits to a therapist and, depending on client preference, medication as well. MCT is conducted mostly in group settings, which is much more cost effective and able to help a larger number of people with schizophrenia. One of the main things that makes MCT different and perhaps better than CBT is the fact that the therapy sessions are conducted in a group setting. Group settings have been shown to help clients develop a means of support, something which is often weak or non-existent in their life. This could be caused by a lack of family or friends because of the disease. Since many people with schizophrenia experience delusions often resulting in distrust of certain individuals, this can lead him or her to estrange themselves from others. So assuming, people with schizophrenia may have a difficult time forming relationships outside of therapy. Interacting with others in a group setting where trust can be built and experiences can be shared yields exceedingly positive results. In MCT, the group is taken through training sessions extending over a certain number of weeks, depending on the frequency of meetings. During these sessions, the therapist or therapists working with the clients present the following core subjects: attribution, jumping to conclusions, changing beliefs, theory of mind, memory, self-esteem and mood. These subjects are separated into sections called modules. Each module addresses one of these common illogical thinking patterns and goes through exercises that can help clients to avoid them. The modules are presented in ways that are easy to understand and interactive. The clients are

encouraged to talk about these patterns of thinking and consider their own experiences relative to the patterns of thinking. Being presented in a group setting allows clients to feel less pressure than being one-on-one with a therapist and helps them understand that they are not the only one who feels a certain way and experiences schizophrenic symptoms. The sessions also are fun and entertaining for clients because they show pictures to illustrate how common misconceptions of thought can occur. For example, the jumping to conclusions module uses a card trick to show clients how people can automatically believe that the card trick is not just a trick, but "magic." Therefore, MCT is very new, but extremely promising.

The only downfall associated with MCT is that it primarily addresses delusions; it does not address auditory hallucinations in much depth. While medication can lessen this symptom or eliminate it altogether, what is it like for people who do not wish to take medication? Some cultures and religions even guard against the use of medications or prohibit it. These are ethical considerations one must note when working with people of various cultures and ethnic backgrounds. Specific training targeting hallucinations could make a large impact in cases like this. Medication can also produce unwanted symptoms that are not favorable to some clients. For example, clozapine, a regularly prescribed drug for some patients with schizophrenia can have negative effects on the immune system. Various people who have taken clozapine for schizophrenic symptoms have suffered decreased immunity. This could definitely be an unwanted side effect that could result in many serious problems. Other antipsychotic drugs can cause publicly uncomfortable symptoms such as Tardive Dyskinesia, or unintentionally repeated movements of the body or face.

Since MCT is already being tested and producing positive results for delusions, can't something be done to help clients with the auditory hallucinations they might experience? Although there is no real cure to make hallucinations go away, there could be another component added to MCT to make it more effective in targeting the auditory hallucinations as well as the delusions. Apart from cultural or personal preference to not take medication to treat schizophrenic symptoms, there are other factors to consider. Medication availability could be a large factor as well. What if someone were unable to get a prescription for his or her medication on time due to personal or financial reasons or forgot the medication and didn't have immediate access to it at the precise time it was needed? A program that clearly addressed hallucinations would be extremely beneficial to anyone with schizophrenia who experienced hallucinations in case one of these things were to happen. Auditory hallucinations, when a person has false auditory perceptions, are very common to schizophrenia. People with schizophrenia often report how auditory hallucinations are like voices in their head telling them to do things. Some people have even said that the voices tell them to hurt or kill themselves. People with schizophrenia have occasionally

followed the instructions of their voices as well, which could be as minor as opening a window or as serious as committing suicide. If this is the case, auditory hallucinations should definitely be addressed in these MCT sessions and not ignored. While delusions are important to address in the sessions as well, there should be an addition to these sessions that discusses auditory hallucinations. A possible solution to this problem would be to implement a module into the MCT therapy that primarily provides psycho-education about hallucinations and steps to get through them if they happen to occur. This would definitely be something to explore more in depth to find other possible solutions.

Since MCT is a fairly new practice, there are not many articles discussing potential deficiencies in its practice. Many articles only define MCT and talk about its practices. Others merely give accounts of the successes of MCT during various clinical trials. The approach outlined here makes the claim that although there are many positive applications of MCT, there are some components that can be improved. Hopefully, this concept can be expanded upon in the future by suggesting possible detailed implementations that can be used to address hallucinations in future MCT sessions for clients with schizophrenia.

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