With the remaining time, the writer taught Linda the basics of cognitive behavior therapy for psychosis, which she assimilated well. Subsequently, Linda was also taught progressive deep muscle relaxation techniques (16 major muscle groups), developed by Bernstein and Borkovac (1973), and another homework assignment was introduced: completing the relaxation techniques formally three times per day (i.e., AM, PM, evening). The writer discussed Linda’s array of delusions, which included the TV, telephone, and other inanimate objects (e.g., chair) telling her to complete various activities, some of which were socially unacceptable. Other delusions included her belief that closing the top of a water bottle would disallow her ability to breathe. At this point, the writer had Linda test the delusion by tightening the water bottle and allowing her to see that she could still breathe. The writer encouraged Linda to ‘challenge’ other delusions and demonstrated role playing a ‘challenge’ for an obvious delusion: the television talking to her directly. Linda understood the intention of the role playing exercise as the initial stage of her learning to confront delusional messages, with the knowledge that professional support was available via telephone if urgently required.

Linda’s parents arrived to pick her up and were given 15 minutes of feedback regarding the content of this particular session, the strategies learned and their rationale, and the parents’ role at home to ensure their daughter felt safe and able to complete the treatment tasks assigned.

Session 3 (December 22, 2007)

Linda arrived on time and stated that the medication made her drowsy. She stated that she was currently receiving fluoxetine 12.5 mg; risperadone 3 mg; and was no longer taking the anxiolytic, alprazolam. Linda stated that she experienced visual hallucinations during the past week, 30% of which she firmly believed were “real” and 70% she thought were “fake.” We reviewed the previous session’s homework assignment of progressive deep muscle relaxation. Regarding her tendency to stay at home, the writer suggested a structured daily activity plan of walking independently to her choice of a number of locations (i.e., shopping mall, theater, store, park, community center).

The writer introduced systematic desensitization (exposure therapy) regarding Linda’s fears of walking to and entering a

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Cognitive Behavioral Therapy (CBT): A Summary

Cognitive Behavioral Therapy (CBT) is an empirically supported treatment that focuses on patterns of thinking that are maladaptive and the beliefs that underlie such thinking. For example, a person who is depressed may have the belief, “I’m worthless,” and a person with a phobia may have the belief, “I am in danger.” While the person in distress likely holds such beliefs with great conviction, with a therapist’s help, the individual is encouraged to view such beliefs as hypotheses rather than facts and to test out such beliefs by running experiments. Furthermore, those in distress are encouraged to monitor and log thoughts that pop into their minds (called “automatic thoughts”) in order to enable them to determine what patterns of biases in thinking may exist and to develop more adaptive alternatives to their thoughts. People who seek CBT can expect their therapist to be active, problem-focused, and goal-directed.

Over the past 10 years, CBT for schizophrenia has received considerable attention in the United Kingdom. While this treatment continues to be in its infancy in the United States, the results from studies in the United Kingdom have stimulated considerable interest in therapists in the U.S., and more therapists are conducting the treatment now than just a few years ago. In this treatment, patients are encouraged to identify beliefs and their impact and to engage in experiments to test their beliefs. Treatment focuses on thought patterns that cause distress and also on developing more adaptive, realistic interpretations of events. Delusions are treated by developing an understanding of the kind of evidence the person uses to support the belief and encouraging the patient to recognize evidence that may have been overlooked that does not support the belief. Furthermore, the assumed omnipotence of “voices” is tested, and patients are encouraged to utilize various coping mechanisms to test the controllability of auditory hallucinations.

CBT’s focus on thoughts and beliefs are applicable to a wide array of issues. Because CBT has excellent empirical support, it has achieved wide popularity both for therapists and consumers. Those who may receive CBT training include psychologists, psychiatrists, social workers, and psychiatric nurses. Those seeking treatment using a CBT approach are encouraged to ask their therapist what CBT training they have had or to contact a Center for Cognitive Therapy and request a referral in their geographical location.

Reviewed by Debbie M. Warman, PhD and Aaron T. Beck, MD, June 2003

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