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PREFACE

The authors of this book are from the Department of Personality, Evaluation and Psychological Treatment at the University of Almería (Spain). They are members of the research group "Clinical and experimental analysis of disorders within the schizophrenic spectrum" funded by the Autonomous Government of Andalusia (Spain), led by Dr. Adolfo J. Cangas (tenured university lecturer recently qualified as university professor). The group has participated in various research projects focusing on the continuity of hallucinations between the clinical and normal population, metacognitive beliefs related to the origin of auditory hallucinations, sociocultural variables involved in the onset of hallucinations, and the application of third generation psychotherapies in psychotic symptoms. The results from these projects have been published in diverse journals such as the *International Journal of Social Psychiatry*, *Behaviour Research and Therapy*, *British Journal of Clinical Psychology*, *International Journal of Clinical and Health Psychology*, and *Philosophy, Psychiatry, & Psychology*. The research group itself has published several manuals on the etiology and treatment of schizophrenia: *Advances in the etiology and treatment of disorders within the schizophrenic spectrum* (2003), *Schizophrenia: New perspectives in research* (2006), *Social skills for living independently: Module of family participation in mental health services* (2009), and *Treatment of the severe mental disorder* (2010).

Chapter 1

INTRODUCTION

Hallucinations are very dramatic behavior that today is considered to be a distinguishing characteristic of a group of serious mental disorders, as is the case of schizophrenia. Despite the seemingly bizarre nature of this type of behavior, it should not be misconstrued that hallucinations hold no functionality for the person experiencing them or that they cannot be understood through different psychological or social mechanisms (Layng & Andronis, 1984).

To study this behavior, is it not only worthwhile to analyze people that suffer from schizophrenia, it is also useful to involve people with other disorders who experience voices (such as mood, dissociative and personality disorders, and posttraumatic stress) (Altman, Collins & Mundy, 1997; Dhossche, Ferdinand, van der Ende, Hostra & Verhulst, 2002; Romme & Escher, 1989; Ohayon, 2000; Tien, 1991), or even individuals within the normal population that may have similar experiences (Baker & Morrison, 1998; Cangas, Langer & Moriana, in press; Morrison & Wells, 2003; Serper, Dill, Chang, Kot & Elliot, 2005).

The study of hallucinations has also garnered significant interest from the classic works of Bentall, Jackson and Pilgrim (1988) and of Person (1986), who showed the utility of focusing on specific symptoms (rather than general syndromic characteristics such as schizophrenia), given that they are better related to etiological variables, can aid in the study of the continuity of psychotic symptoms, can improve reliability, etc.

The reality today is that the symptom of hallucinations is sufficient for a diagnosis of schizophrenia. However, its significance in diagnosis has not always been as it is in present times. In fact, for Bleuler (1911) (who introduced the term "schizophrenia"), hallucinations were a secondary symptom of other more basic disorders (the famous four As: changes in Association, Affection, Autism and Ambivalence). It would be later in history, particularly under the influence of Kurt Schneider and the propositions of formal diagnostic systems that sought to offer a more reliable system of classification, which would lead to the dominant role that hallucinations have today.

Since the 1960s a fundamental problem of psychopathological diagnosis was its low grade of reliability. To site an example, the famous *United States-United Kingdom study* (Cooper, Kendell, Gurland *et al.*, 1972) found that there were numerous discrepancies between the diagnoses made in the U.S.A. and those made in England after an analysis of psychiatric interviews that were recorded by professionals in both continents. These differences were attributed to the diagnostic systems used that were seen as too generalized or vague. It was also in this same period that the famous Rosenhan (1973) study took place when group of students who pretended to hear voices were admitted to a psychiatric institution. What is notable about this case is that, once inside, the group of people stopped pretending the original behavior but continued to be held in the center for six months, and when they were discharged the diagnosis that had been given to them was "residual schizophrenia."

In 1959, Kurt Schneider was interested in finding what was specific about schizophrenia, that is, what symptoms might be pathognomonic of this disorder or what behaviors would indicate a case of schizophrenia and not another type of disorder. His interest was not in looking for the etiology of psychosis, but in finding its distinctive characteristics. That was how he came to differentiate between first-rank symptoms and symptoms of second rank. The first rank would be characteristics of schizophrenia and would include diverse types of hallucinations and delusions such as voices arguing, experiences of somatic passivity or delusional perceptions. In contrast, the second-rank symptoms, such as confusion, depressive or euphoric states, and feelings of emotional impoverishment, could be present in many disorders. This proposal is

what finally prevailed in the diagnostic systems of our current times (ICD and DSM).

It should also be taken into consideration that, since the 60s, antipsychotic medication has acted specifically against hallucinations and delusions, eliminating or alleviating their effects in a significant percentage of cases (about one half of patients). The existence of a drug that acts against these behaviors is therefore more likely to become *essential.*

We must also take into account the spectacular and dramatic nature of hallucinatory behavior, which is why it is a cause of great concern. Hallucinations are configured as a fundamental behavior in current Psychopathology; but what is their origin? In the next section we will focus on the social aspects involved in their origin and maintenance.

Chapter 2

SOCIAL FACTORS ASSOCIATED WITH THE ORIGIN OF HALLUCINATIONS

Drawing from the introduction, it appears that hallucinations may be consequences of very basic situations (as previously noted by Bleuler). In this sense, social components will take a leading role. Clearly then, to analyze this behavior, cultural variables must first be taken into account. Schizophrenia is a disorder specifically of modern times. Even though in other epochs there have been cases of hallucinations, their significance, origin and consequences are markedly different from the cases of schizophrenia in the present times and therefore should not be likened. For example, the visions of mystics in the Middle Ages are very different from the voices of schizophrenics today (Cangas, Sass & Perez, 2008; Sarbin & Juhasz, 1967), not only because in the Middle Ages it was more common that people experienced visions and today it is the auditory hallucination that predominates, but because of the very different consequences present in each historic period (in the Middle Ages one could increase their social status by associating the hallucinations with a religious origin, while in present times hallucinations represent a significant social stigma associated with mental illness). In times past, a person's life was not paralyzed, whereas today, the experience of hallucinations represents an obstacle to basic life projects (studies, family, etc.).

Today, a central aspect of our society is the "medicalization" of any behavior that is considered "abnormal." It is from the nineteenth century forward that hallucinations acquired this particular character (Berrios,

1996). In other times and in other cultures hallucinations were closely related to religious or mystical activities and were not regarded as they are now.

Coexisting with the medical concept of psychopathological behavior is the social role of the mentally ill. The existence of hallucinations in a person often produces stigma, fear or rejection in others, which in turn affects the very way that person feels about him or herself. When someone begins to manifest this kind of behavior they are likely to think: am I going crazy? – which then contributes to an ever-accelerating emotional reaction (Cangas, Garcia, López & Olivencia, 2003).

It is also important to take into account that in the western world we are less familiar with the internal events that are related to feeling different, behaving in different ways, or having intense emotional experiences; unlike some Eastern traditions which are more embracing of these types of experiences (Al-Issa, 1977, 1995; Wahass & Kent, 1997a, 1997b). Thus, to the extent that our society is increasingly "rational" it rejects experiences that are not strictly within this construct, fostering the need to explain everything in a rational way (the logic possibly being that for people the "thought" is first and then the "emotion"). This means that hallucinatory experiences in our society, different than in other cultures, provoke an intense emotional reaction, a desire to control those experiences, and a different way of confronting them.

Another aspect that is characteristic of modern times is "hyperreflexivity" or exaggerated self-consciousness of processes that usually go unnoticed (Pérez, 2008; Sass, 1992). Both positive and negative symptoms in psychosis can be understood as an excess of hyperreflexivity, of being trapped in thought processes that generally the person cannot distance him or herself from. This aspect is related to studies that have focused on the analysis of metacognitive beliefs, that is, the ideas that people have about their own thoughts and thought processes. Findings from these studies have showed that patients who hear voices score higher than the normal population in: low cognitive confidence (e.g., "I don't have much memory"); negative beliefs about the controllability of thoughts and the risk involved in not controlling them (e.g., "when I start to worry I can't stop"); positive thoughts about the act of worrying ("I need to be worried in order to stay organized"); and cognitive self-awareness ("I am aware of how my mind works") (Baker & Morrison, 1998; Morrison & Wells, 2003). Though, above all,

it is the superstitious beliefs about mental events that are of fundamental importance (García, Pérez, Soto, Perona & Cangas, 2006; García, Pérez, Sass & Cangas, 2008). It is common for patients with psychosis who hear voices to inbue them with great power, a power established by chance or biased associations: "because they were able to foretell the death of my father," "because they know everything about me..." There is an important fusion between thought and action, that is, a person believes that having a certain type of thought will provoke that thought in the form of action (García, Pérez & Cangas, 2006).

Hyperreflexivity in psychosis is also associated with another essential factor, the "loss of common sense" (Sass, 2003; Stanghellini, 2004), which means, to the extent that a person questions every-day, commonplace processes, it is likely that they will distance themselves from common ways of behaving. For instance, if a person is continually asking: "is this world real?", "am I the only one who sees the supernatural beings that are invading us?", "why do we have to have relationships with other people?", etc. (questions that could indeed make sense, but that we generally do not pose to ourselves), it may be a form of social "paralysis," the experience of seeing difficulties in a unique way and feeling "different" than other people.

Where does this hyperreflexivity or loss of common sense in schizophrenia come from? Its emergence is related to the social factors that begin during key evolutional moments in our society, such as adolescence. At this stage, the person not only changes their ways of behaving (leaving behind the infant world), but also begins to frame their future as a person (in the workplace as well as within emotional and social spheres). During the stage of adolescence (which is relatively long in our society) new roles appear that the person has to assimilate, such as the need to have greater autonomy outside of the home (although, paradoxically, they may be required to remain dependent or compliant within the sphere of the family). It is a stage of new activities: the first romantic relationships, sexual discovery, and the first heartbreaks. This also corresponds with a greater critical capacity, with the realization of the many inconsistencies in the "adult world," and with awareness that the rules that had previously governed behavior are now changed and more complex. These are the multiple processes that can contribute to an adolescent's "unhappiness-in-the-world." Difficulties of adaptation can spawn feelings of not fitting in with the ways of everyone else, with

other people's values, with the desires of others, etc. This, in turn, produces a constant questioning of common behavior and ways of seeing things. Using the words of Laing (1960), in psychosis the person would feel as if they have been "swallowed" by the world. Hence, subjectivity now plays an important role, or, from the writings of Sass (1992), "the external world, supposedly objective, becomes subjective and de-realized, while the inner self, which is supposedly subjective, becomes objective and deified" (Sass, 1992, p. 338).

In this new stage it is crucial to look at how the personality has developed, which has, in part, been modulated by processes of family dynamics. In schizophrenia, the influence of high expressed emotion as a predictor of relapse has been emphasized, though it is also important to recognize that this type of emotion may be an influencing factor in the very origin of this disorder together with other communication disorders within the family network (Read, Seymor & Mosher, 2004). From childhood, through interactions with others (family relationships of course playing an important role), the personality is taking shape, which will then determine ways of being, ways of meeting demands, and ways facing social difficulties. In this regard, it is well documented that people who have develop schizophrenia have previously shown signs of having a vulnerable personality with schizotypal or schizoid personality components. It is common for these people to describe their childhood as more solitary than the rest of their companions and characterized by strange behavior or by different types of behavior than that of the other boys and girls of their age (Parnas & Handest, 2003; Stanghellini, 2004b). There are more difficulties in dealing with people as well as difficulties in social adjustment. Also, studies that have investigated the personality of people most prone to hallucinations found that they scored higher in emotional instability and avoidance components (Barrett & Ehteridge, 1994).

It is important to add to this picture the specific circumstances of an individual's development that may contain components of social isolation or stress. One might recall the famous studies on sensory deprivation where students without psychopathological problems were put into chambers void of any type of stimulation, and after a time, began to experience hallucinations. In patients with psychosis, as mentioned before, it is very common that there are difficulties in interacting with others. It might be argued that hallucinations in some way "supplant"

natural speech; to the extent that there is little interaction with others, there is a greater presence of thoughts in the form of dialogues. Hallucinations can be seen as "breaking the silence of the inner dialogue" (Stanghellini & Cutting, 2003).

It is also common that the onset of hearing voices is linked to experiences of stress. Romme and Escher (1989) identified six triggers, most of them having to do with the themes discussed in this section, such as intolerable or adverse situations (divorce, job loss, etc.), recent trauma especially when not expected (e.g., the death of a loved one), conflicting aspirations (goals that are not met), threats, childhood trauma, and the denial of emotions.

We must nevertheless take into consideration that hallucinations are not merely a "passive" reaction to adverse situations; they are also a compensatory mechanism or attempt to overcome the adversity. Clearly, hallucinatory behavior is probably not the best solution; furthermore, it can be reinforced behavior – which, in fact, helps to keep it going. Hallucinations may very well alleviate the feeling of discomfort, ease the responsibility for having certain thoughts, help to recognize a specific sensation, contribute to feeling special, etc. This is why many patients (especially in the early stages of the disorder) have commented that hallucinations provide them with company or help them to make a decision, and so on (Knudson & Coyle, 1999). Recently it has been postulated that a fundamental aspect in the explanation of this behavior is experiential avoidance, where the person does not engage or enter into contact with aversive subjective elements (thoughts, images, feelings) because of the suffering they generate. This obviously offers the person the advantage of alleviating the initial stress, but it also paralyzes that person from participating in and realizing activities that could be valuable to them (Veiga-Martínez, Pérez-Álvarez & García-Montes, 2008).

Hallucinations may also contain components of positive reinforcement, though these may be more difficult to detect. In this case, as proposed by Layng and Andronis (1984), to understand hallucinatory behavior we must bear in mind the array of possible behaviors available to a person, and recognize the instances when hallucinations are probably the "least bad" of the possibilities and when the reinforcers cannot be easily identified (because of being delayed in time, for having to do with

forms of personal avoidance, for being controlled by different audiences, etc.).

In the explanation of hallucinations is important to differentiate between the variables involved in the onset, or origin, of the experiences and those that have a function in their maintenance; at the first stage, one set of variables may be involved, and in a subsequent stage, there may be other variables. For example, high stress situations can be key in the onset of hallucinations, but once the hallucinations are established, lesser degrees of stress or more common adversities can serve as triggers.

In sum, in the emergence of hallucinations, multiple social factors are involved. Together with contributing components of today's society – an emphasis on the medical, little familiarity with internal events, the presence of social stigma – the person who hears voices is likely to be in a situation of significant social isolation and likely to be affected by personality characteristics such as avoidance and schizotypal components, and emotional disorder. In this context, when subjected to different key stressors, it is likely that one's behavior (thoughts, feelings) is interpreted incorrectly and is considered not to be one's own or not self-generated (this would be, then, the hallucinations). This behavior would have a number of important repercussions in the form of either positive or negative reinforcement. Later in time, the presence of intense stressors or difficulties is no longer necessary for this behavior to be maintained given that a habitual way of acting will have been established in relations (or the lack thereof) with others.

Chapter 3

PSYCHOLOGICAL TREATMENT OF HALLUCINATIONS

From the previous section we can see the importance that different social aspects can have, not only in the etiology of hallucinations, but also relating to the types of interventions used for this behavior. Although the principally known treatment for hallucinations (and of widespread use in the western world) is pharmacological treatment, psychological intervention, which has shown clearly favorable results, is also essential. Moreover, it is important not to refer to the relationship of the psychological to the pharmacological as merely complementary, because where pharmacological treatment has failed to reach, psychological intervention has had an affect (Cuevas-Yust, 2006).

Various therapeutic strategies have been designed that are specific for the treatment of the positive symptoms of schizophrenia. Among them, the most consolidated proposals are the cognitive behavioral techniques for hallucinations and delusions. The early procedures employed the basic principles of behavior analysis, such as positive reinforcement of incompatible behaviors, extinction, or punishment procedures such as time-out (e.g., Lindsley, 1959; Haynes & Geddy, 1973). Subsequently, standard procedures in the treatment of anxiety and depression have been used and adapted to this population, procedures such as systematic desensitization, detection of thought, self-monitoring, or counterstimulation (Chadwick, Birchwood & Trower, 1996; Farhall, Greenwood & Jackson, 2007). According to Slade and Bentall (1988), the variability of these proposals can be reduced to three essential

elements: focusing on or centering on a person's own voice, with the help of the therapist, in order for it to reclaim its effect in that person's own experience (not that of external agents); anxiety reduction techniques, such as systematic desensitization; and, distraction (such as counterstimulation techniques, or as Slade and Bentall propose, the reinforcement of incompatible behaviors).

In general, the results of these procedures have been positive. However, there are also a number of limitations, such as the fact that many of these works are case studies, or that several of the studies (especially the earliest research) were realized within an institutionalized population (where, for example, it is easier to control the contingencies), or the lack of analysis of the significance of the different components introduced. But perhaps even more important is that when the results of these interventions were compared with other psychosocial treatments such as social skills training, family intervention or assertive community treatment, no significant differences were found. It may be the non-specific factors contained in all psychological interventions that explain such results (Cuevas-Yust, 2006; Gaudiano, 2005).

More recently, what are known as third-generation interventions are being used. The therapeutic goal here is not to eliminate the symptom, but that it affects the person in a different way and therefore does not paralyze his or her life. The basis of the idea is that trying to deliberately suppress private events such as feelings, thoughts, and images, can paradoxically produce an increase in this type of activity. Within this philosophy different techniques of acceptance have been used. Procedures for achieving mindfulness techniques, for example, make the person aware of cognitive and emotional processes, but without trying to change them, merely letting them "flow." The results show that when using these techniques patients improve in the post-treatment evaluation, although differences are not significant when compared with the control group (Chadwick, Hughes, Russell & Dagmar, 2009).

Acceptance and Commitment Therapy also seeks the acceptance of private events (which are being avoided) by using metaphors and a series of experiential exercises. The intent is that the person does not fight the symptoms, but that they change the socio-verbal framework within which are they are generated. Furthermore, the idea is no longer to merely accept the symptoms, but to act according to what can be valuable to the person. This is indeed an essential aspect of the therapy

and particularly important in the area of psychosis. Schizophrenia is usually characterized precisely by a marked apathy and anhedonia. Unraveling valuable aspects that are important for the person and then directing behavior toward these aspects is key. This activity is not only effective for the positive symptoms but also for the negative symptoms of schizophrenia (García-Montes & Pérez-Álvarez, in press; Pérez-Álvarez, García-Montes, Perona & Vallina, 2008).

The two randomized studies that exist to this date on the effectiveness of Acceptance and Commitment Therapy (Bach & Hayes, 2002; Gaudiano & Herbert, 2006) found that there were fewer re-hospitalizations in the people that received this type of treatment, although they did not show a reduced frequency of hallucinations (which, as has been discussed, is not the objective). After this procedure people became more active and engaged, the voices were not paralyzing the people's lives in the same way that had been previously experienced. This can be seen as an important change in people's relationship with these symptoms. The assumptions made about this intervention are also consistent with the idea that sometimes it is not necessary to focus directly on hallucinations in order to modify them and that other related behaviors can be treated (behaviors related to mood states, social isolation, etc.) to diminish their effect.

The favorable data drawn from the results of third-generation psychotherapies are beginning to glean importance. Although more randomized studies are still needed, there seems to be an opening of new perspectives, not only related to the usefulness of these therapeutic techniques, but also related to the explanation of various processes involved in hallucinatory behavior.

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