THE HISTORICAL DIMENSION AND APPLICATION OF COGNITIVE-BEHAVIORAL THERAPY IN THE TREATMENT OF SCHIZOPHRENIA

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ABSTRACT

This article aims to demonstrate the historical progression of madness and the applicability of Cognitive-Behavioral Therapy (CBT) in schizophrenic patients. This is a narrative review comprising articles published on electronic databases: Scientific Electronic Library Online (Scielo), Periódicos Eletrônicos de Psicologia (PePSIC), PubMed, Research Portal and Redalyc, dated between 2000 and 2019. When launching the descriptors: (cognitive-behavioral therapy AND schizophrenia), (cognitive-behavioral therapy AND psychosocial therapy), (psychosis), (history of madness AND psychiatric reform) in the databases cited, 153 works were found, which, based on the exclusion and inclusion criteria, resulted in a total of 27 materials to make up the theoretical framework of this work. Based on history, the article presents the different meanings attributed to madness, bringing with it the process of deinstitutionalization and its respective developments in the implementation of public health policies in Brazil. In addition, we searched the literature for empirical studies that reported both the employability of the Cognitive-Behavioral Therapy (CBT) interventional method and the results obtained in terms of symptoms and quality of life for these individuals. Thus, we conclude that psychotherapy is beneficial in terms of alleviating symptoms and improving overall functioning. At the same time, the effectiveness of psychoeducation for family members is also highlighted.

Keywords: *Schizophrenic, Psychology, Quality of life, Psychoeducation.*

1 INTRODUÇÃO

Schizophrenia is defined by the American Psychiatric Association - APA (2014) as a psychotic disorder marked by alterations in thinking, emotions and behavior. Its symptoms are perceived through delusions, hallucinations, changes in memory, motor movements, disorganized speech and affective dullness. These symptoms can manifest themselves under different contents, depending on the experiences that

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make up the individual's cognitive and subjective fields.

The purpose of this article is to infer the efficacy of Cognitive Behavioral Therapy (CBT) combined with the use of conventional medication in the treatment of schizophrenia.

For centuries, the main form of treatment for schizophrenia was antipsychotic medication and asylum confinement, which contributed to the stigmatization of madness and social exclusion. However, the 1970s saw the establishment of the guidelines arising from the Psychiatric Reform[1], which was political, economic and social in nature and mobilized civil society as a whole in its demands.

Moving from an exclusively hospital-centered model to welcoming and psychosocial intervention, this study highlights the main CBT techniques linked to conventional treatment, developed in individual and/or collective sessions at Psychosocial Support Centers (CAPS), showing positive results in the overall functioning of patients, as well as bringing families closer together and psychoeducating them, who are now responsible and active in the treatment of schizophrenics, with a view to promoting health and quality of life.

1.1 CONCEPTUALIZATION THROUGHOUT HISTORY

Madness is one of the oldest psychological phenomena described throughout history. Until the end of the Middle Ages, the figure of the leper represented the pinnacle of divine punishment; thus, in order to obtain a cure, it was necessary to repent of a sin, because God, the holder of both the disease and the cure, was the only one capable of casting out demons and other evil spirits that tormented the sick (Santos, 2015).

As contextualized by Reis (2000), it was from the 18th century onwards, with the institution of the philosophical and scientific current of the Enlightenment, that madness came to be seen as an object of study for medicine, which ended up breaking the sacral view of cause and effect between sin and illness. Through the method of scientific research, which begins the delineation and classification of

[1]Psychiatric Reform was the term used to designate the process of practical and theoretical transformation in the field of psychiatric care. Started in Brazil in the late 1970s, the movement was influenced by experiences developed in Europe and the United States (US) after the Second World War, based on criticism of the classic model of the psychiatric paradigm focused on hospitalization (KINKER, 2020, p. 11).

mental pathologies, the definition known today as schizophrenia, was previously known as “dementia praecox”.

According to Reis (2000), this term, early-onset dementia, was formulated by the Frenchman Benedict Morel (1851-1853), gaining strength and structure with the German doctor Émil Kraepelin (1856-1926), at the end of the 19th century, who, in the 6th edition of his Treatise on Psychiatry, described it as a severe nosological entity, of endogenous origin, occurring in early adulthood (Reis, 2000).

It was characterized not by a set of typical symptoms, but by its chronic and deteriorating course. Furthermore, according to Reis (2000), Kraepelin was responsible for differentiating it from Alzheimer’s and manic-depressive psychosis. He therefore determined that this illness could manifest itself in three different forms: hebephrenic, catatonic and paranoid (Valença; Nardi, 2015; Reis, 2000).

From 1908 onwards, there was a reformulation of the construct established *a priori* at the annual meeting of the Psychiatric Association in Berlin, where the word schizophrenia (schizo = split, phrenia = mind) appeared for the first time, developed by the Swiss psychiatrist Eugene Bleuler (1857-1939, apud Elkis, 2000), who focused on the typical symptoms, such as hallucinations and delusions, thought and speech disorders, disturbed emotions and affect, cognitive deficits and avolition (Elkis, 2000).

At the same time that science was advancing in the production of knowledge and the classification of subjects, the social rejects, or mental institutions, began to emerge. Based on a logic of abandonment, their function was to manage, control and apprehend all subjects who deviated from the expected concept of normality. Institutional conditions were precarious and many did not actually have a diagnosis. The inhumane practices commonly applied were defended under eugenicist thinking, which was characterized by “social hygiene”, removing from society those subjects who did not fit in, considered despicable and with undesirable behaviors. Within this segregation, homosexuals, epileptics, alcoholics and prostitutes were also sent to mental institutions (Figueirêdo; Delevati; Tavares, 2014).

Decades passed and the exclusionary treatment of the mentally ill had no prospect of being updated, until, in the 19th century, Philippe Pinel (1745-1826), a doctor and zoologist, influenced by the pillars of the French Revolution: liberty, equality and fraternity, advocated moral treatment for the alienated and unchained the insane in Paris, bringing diagnosis implied in prolonged, rigorous and systematic

observation of the patient's biological, mental and social transformations (Alves *et al,* 2009).

Throughout the unfolding history of madness, described by Alves *et al.* (2009), it can be inferred that, even with such advances in the field of mental health, Pinel did not remove the stigma of madness from that subject. The diagnosis accompanied by the idea of a cure was unified as a mark that sentenced the individual to institutional imprisonment for their entire life, because many of the pathologies presented had no effective cure and it was not up to psychiatric knowledge alone to carry out the treatment.

1.2 PSYCHIATRIC REFORM IN BRAZIL

In Brazil, the psychiatric model has been a constant target of criticism, both in discourse and in hegemonic practice. From the very beginning, Machado de Assis (1839-1908), one of the greatest writers of Brazilian literature, when he wrote "O Alienista", used irony as a social critique, questioning the scientism of the 19th century. In this work, the protagonist doctor, in an authoritarian manner, collected from the bosom of society all those he called "crazy". Backed by scientific discourse and protected by unquestionable medical knowledge, he masked his particular obsession with labeling and socially excluding anyone he deemed outside of normality (Lima, 2019).

In the 19th century, madness became a "problem" of social order for the Brazilian authorities. With the number of alienated people growing daily, the mental institution began to play the role of "catcher" of distressed families bringing their relatives in crisis. In a paternal and authoritarian way, the hospital took the sick member away from them and locked them up, using everything that psychiatric science has produced in more than two centuries of existence, including the use of electroshock (Kinker, 2020). This same author, while working on the intervention of a psychiatric hospital in the interior of the Northeast, an institution disapproved of more than once by the Federal Ministry of Justice, discusses the unsanitary conditions of the infrastructure in which the patients were confined:

> The smell of urine and feces dominated the confinement spaces. In the courtyard there was a cubicle, perhaps very close to a concrete stable, where

> the inmates had to urinate and defecate. There were no toilets and no right places for them, the whole cubicle was a flat, floor-standing toilet. Naked bodies surrounded by flies were a constant sight (Kinker, 2020, p. 26).

For Yasui (2010), with the military coup of 1964, psychiatry acquired the status of a mass care practice. This was the beginning of the commodification of madness and the capitalization of health. It should be emphasized that the transformation of health into a consumer product was not exclusive to psychiatry, but part of a broader project to implement a medical-welfare model.

Consequently, the Italian psychiatrist Franco Basaglia (1924-1980) implemented the idea of Democratic Psychiatry, in which he proposed a new way of looking at the phenomenon, emphasizing the importance of transgression of the institution for social reintegration. It changed the parameters of an ideal cure and brought madness into the picture as inherent to the human condition, postulating that an attempt to remove the pathological condition from the subject would be tantamount to erasing their subjectivity, since pathology is part of being, present in their otherness and psychic constitution (Couto; Alberti, 2008; Yasui, 2010).

Another figure to corroborate the movement was Nise da Silveira (1905-1999), a doctor, psychiatrist and psychoanalyst, who directed the Occupational Therapy Section at the Pedro II Psychiatric Center in Rio de Janeiro, and was extremely important in rethinking the hegemonic policy of the time. Their work was groundbreaking in allowing the internal world of schizophrenics, full of dissociations, deconfigurations and psychic conflicts, to be transposed through art, through expression in the most different shapes, colors and sizes in the paintings and sculptures they created (Silveira, 2015).

It was from the reflections and provocations developed by these figures, especially Basaglia, together with the climate of persecution and repression of demonstrations opposing institutional policies, that the Psychiatric Reform broke out, above all from the mobilization of workers, who made visible the segregation and violence of psychiatric institutions (Hirdes, 2009; Couto; Alberti, 2008).

The Psychiatric Reform in Brazil began to be debated in the 1970s and was consolidated as a government policy at the end of the 1980s, enabling a historic leap forward in the treatment of mental illness and becoming a central milestone in the country's mental health care policy. The theoretical perspective of

deinstitutionalization[2] brought by Basaglia could “question the role of the psychiatric hospital in maintaining relations of domination, the role of the staff (between caring and controlling through segregation) and the ideology of psychiatry as a producer of knowledge” (Kinker, 2020, p. 14).

New guidelines have been created and instituted in the way mental health is conceived. After the Psychiatric Reform, they began to aim to replace asylum internment, changing to services that welcome and work in a flexible and dynamic way, focusing on a greater investment in people (not just drugs as containment), mobilization of all the actors involved (society, technicians and family), promotion of self-help and autonomy, emphasizing temporary services, as well as valuing professionals, training them and valuing continuous training in knowledge and techniques (Hirdes, 2009).

Leaving the asylums and moving towards the community, the Psychosocial Care Centers - CAPS, today are points of care that provide open and community health services, made up of a multi-professional team that works from an interdisciplinary perspective and primarily provides care to people with mental suffering or disorders, whether in crisis situations or in psychosocial rehabilitation processes (Santos, 2016).

Some of the sections in Ordinance No. 3.588, of December 21, 2017, assigning CAPS the role of being able to provide urgent and emergency psychiatric care; working with open doors, with daily reception and treatment shifts, ensuring access for referred clients and effective accountability for cases; individual care for routine and emergency consultations; psychotherapeutic and counseling care, offering assisted and dispensed medication; group care for psychotherapy, operative groups and social support activities, stimulating the protagonism of users and family members, promoting participatory activities and social control (MINISTÉRIO DA SAÚDE, 2017).

2 SCHIZOPHRENIA ACCORDING TO THE DSM-5

Today, according to the 5th edition of the Diagnostic and Statistical Manual of

[2] Seen as a deconstruction of knowledge, practices, cultures, and values rooted in illness/dangerousness, it requires overcoming modes of knowledge, forms of relationships and violent practices, as well as institutions and mechanisms of asylums and objectification of individuals within the terms of a psychiatric diagnosis (KINKER, 2020, p. 14).

Mental Disorders (DSM-5), schizophrenia is defined by abnormalities in one or more of the following five domains: delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behavior (including catatonia) and negative symptoms. The symptoms presented by the individual involve a range of cognitive, behavioral and emotional dysfunctions. Individuals with schizophrenia may exhibit inappropriate affect, dysphoric mood taking different forms, presenting as depression, anger or anxiety; disturbed sleep pattern and a lack of interest in eating (APA, 2014).

The positive symptoms of schizophrenia are those in which additional behaviors occur at times of psychiatric crisis (acute crisis) such as delusions, hallucinations, changes in speech and behavior (catatonia, movement disorders, among others). Despite the nomenclature “positive”, they are not characterized as something beneficial to the patient. It is also believed that the presentation of positive symptoms, especially delusions and hallucinations, is closely related to the specificities of each individual, and the contents of hallucinations and delusions begin to communicate their fears and impulses (Gabbard, 2016).

Negative symptoms, on the other hand, are those in which there is a loss of function, characterized by a decrease in motor and mental activity, as well as emotional manifestations, exemplified by dulled affect, anhedonia, poor speech and social isolation. These symptoms can also occur due to secondary causes of the illness such as environmental deprivation, depression, anxiety and the side effects of antipsychotics. There are also neurocognitive deficits, such as deficits in working memory, attention and executive functions (Gabbard, 2016).

As described in the DSM-5, around 5 to 6% of individuals with schizophrenia die by suicide; around 20% attempt suicide on one or more occasions, and many have suicidal ideation. This behavior comes from the commands of hallucinations, causing self-destructive behavior and can be harmful to those around them as well. The risk is especially high in males, but it is observed throughout the life cycle in both sexes (APA, 2014).

3 INTERVENTION OF COGNITVO-COMPORTAMENTAL THERAPY

In the early 1960s, Aaron Temkin Beck (1921-2021), then an assistant professor of psychiatry at the University of Pennsylvania, started a revolution in the

field of mental health (Beck, 2014). As a psychoanalyst and fundamentally a scientist, he has always dedicated his studies to the empirical validation of psychoanalysis. However, through his experiments he identified negative and distorted cognitions (mainly thoughts and beliefs) as the primary characteristic of depression, the mental disorder he studied (Beck, 2014).

Moving away from psychoanalysis, the treatment that emerged in the early 1960s was called Cognitive-Behavioral Therapy (CBT). The cognitive model of CBT is based on three fundamental premises: cognitive activity influences behavior; cognitive activity can be monitored and altered; and changes in cognition determine changes in behavior. Aimed at cognitive restructuring and problem-solving, she will work in an educational, structured and focused way to manage false beliefs, automatic and dysfunctional thoughts (Almeida; Marques; Queirós, 2014).

Regarding the use of this therapeutic approach for the treatment of psychotic symptoms in schizophrenia, studies have empirically demonstrated the effectiveness of CBT in the treatment of schizophrenia by corroborating a significant reduction in positive, negative and depressive symptoms, being efficient for the remission of psychotic symptoms (Mota; Silva; Lopes, 2017; Zimmer *et al,* 2007; Almeida; Marques; Queirós, 2014; Morrison *et al.,* 2004). In This Sense, Beck (2014) states:

> Cognitive Behavioral Therapy has been widely tested since the first scientific studies were published in 1977. To date, more than 500 scientific studies have demonstrated its effectiveness for a wide range of psychiatric disorders, psychological problems and medical problems with psychological components (Beck, 2014, p. 25).

Furthermore, it is worth highlighting the study by Morrison *et al.* (2004), because while 6% of people treated with CBT developed a psychotic disorder, the percentage in the group treated without this psychotherapy rose to 26%; there was also: a reduction in the prescription of medication, a reduction in the likelihood of meeting diagnostic criteria for psychotic illness in the DSM-IV and significant improvements in positive symptoms.

Rodrigues, Kraus-Silva and Martins (2008) also showed, based on a systematic review, that family intervention based on Cognitive-Behavioral Therapy was effective in reducing the likelihood of relapse in patients with schizophrenia by around 60% and reducing the incidence of relapse in the first year of treatment by 30%.

The study by Zimmer et al. (2007) was carried out in southern Brazil involving 56 outpatients aged between 18 and 65, 95% of whom were diagnosed with schizophrenia and 5% with schizoaffective disorder. The researchers concluded that the results were more favorable for the group belonging to the Cognitive-Behavioral Program (CPB) than those submitted to the usual treatment (UT), showing an improvement in global functioning, as well as verbal memory, social adequacy, affective withdrawal, social and occupational functioning.

Cognitive-Behavioral Therapy for Psychosis (CBTp) is a frequently used intervention for patients with schizophrenia, enabling greater adherence to pharmacological treatment, supportive counseling for the family and effectiveness in relation to positive and negative symptoms. It seeks to systematically teach patients to analyze, challenge and change thoughts, attributions and beliefs underlying disturbing psychotic symptoms, low self-esteem and perceptions of interference in achieving functional goals (Almeida; Marques; Queirós, 2014).

A study carried out in an inpatient unit showed that the CBTp skills learned are very useful and patients continue to use them even after a month of discharge. Applying the group approach saves resources and responds to the needs of more people at the same time, promoting greater socialization in a population that is usually socially isolated and excluded. In addition, groups allow experiences to be shared, which can help to restructure irrational beliefs. Furthermore, the notion of a group creates a safe space for people to talk about their psychotic symptoms without being judged, discuss evidence for and against their beliefs with peers and improve their coping strategies (Almeida; Marques; Queirós, 2014).

Interventions on the negative symptoms of schizophrenia should be based on progressive and gentle planning for patients, using a slower and more cautious model to encourage behavioral changes on issues such as social isolation and lack of initiative. Among the possible interventions present in CBT, the ones that have shown the most effective results are: The Modules Technique, the Coping Strategies Reinforcement Technique, Normalization and Psychoeducation. In addition, the indication of successive tasks, behavioral testing and skills training can also be used (Soares, 2019; Barreto; Elkis, 2007).

Module technique: It consists of five stages to be followed:

1: Setting up the therapeutic alliance and evaluation.

2: Application of strategies to manage the case, symptom control, emotional

responses and impulsivity.

3: Discussion of how his experiences come about.

4: Strategy for managing the positive symptom: hallucinations (here comes the Socratic method of questioning and cognitive restructuring).

5: Evaluation of beliefs and presuppositions they have about themselves and others, which guide them (Barreto; Elkis, 2007).

Normalização: The key point of this theory is to understand what forms and maintains the psychotic phenomenon. We propose linking the delusional and hallucinatory content to the patient's real life story, making it possible to identify vulnerabilities and triggering events. This leads to a reduction in stigma, the creation of a therapeutic alliance by valuing the patient's discourse and the active participation of the subject in identifying and analyzing the factors that can trigger or intensify their condition (Barreto; Elkis, 2007).

Technique of reinforcing coping strategies: It seeks to understand the symptomatic interaction between emotional components and the environment. Emotional reactions can then be manipulated with cognitive restructuring methods, behavioral experiments and reality tests. Here, the patient is reinforced to maintain certain attitudes that are effective in controlling symptoms, which they already adopted even before therapy. With the help of the psychologist, coping strategies are developed to deal with psychotic events (Paloski; Christ, 2014; Barreto; Elkis, 2007).

Psychoeducation: A way of improving the patient's and family's understanding of the disease, understood as providing information about the symptoms, the etiology, the treatment and the way of life to be readjusted. This constantly encourages the family to play an active role in the health-disease process. Given the constant outbreaks and conflicts she faced at the beginning of treatment, she became subjectively ill. It is therefore necessary to bring family members closer to the therapeutic process so that they feel supported and equipped with the skills to cope effectively (Santos, 2016; Soares, 2019).

The work of the CBT to control hallucinations aims to make the patient accept a more rational and plausible explanatory paradigm for the origin of these phenomena, as well as developing strategies to control their consequences for the subject. Therefore, Candida *et al.* (2016), states that when treating auditory hallucinations, it is important for the clinician to pay attention to certain characteristics such as frequency, volume, number of voices, location and probable triggers, which

will provide the basis for the interventions applied.

In this way, Wright, Basco and Thase (2008) describe as effective strategies for controlling these phenomena the encouragement to distance themselves from the voices and analyze the incorrect claims they make, putting together a list containing actions that silence them or make them less intrusive and controlling. In this way, with the help of the therapist, they can create a behavioral repertoire to increase the emission of useful actions and minimize behaviors that amplify the power of the hallucinations.

Cognitive-behavioral interventions enable adherence to drug treatment and the choice of effective procedures to produce cognitive, emotional and behavioral changes. As an adjunct to pharmacological therapy, it is essential to think about the health-disease process not by obtaining a cure, but by alleviating symptoms, and, in this psychopathology, to enable a weakening of delusional beliefs - false beliefs held with conviction by the individual, to increase understanding and *insight* into psychotic experiences, maintaining gains and preventing relapses (Mota; Silva; Lopes, 2017).

CONCLUSION

The study shows that the concept of the clinic and of the pathological condition of the subjects has been transformed by the social-historical context. Thus, the exchanges that take place today in psychosocial centers provide a space for encounter, expression, welcoming and active listening, transposing the biomedical model, centered on healing and the organic approach, to the biopsychosocial model, aimed at comprehensive care and health promotion.

As we have seen, after the Psychiatric Reform and the emergence of CAPS, the family was gradually included in the treatment, which is directly related to psychoeducation, which enables them to deal with the dysfunctional behaviors present in the family nucleus, promoting new behavioral repertoires to better cope with and manage the pathological condition of this family member.

However, despite its effects on reducing positive and negative symptoms, reducing the anguish and suffering resulting from the psychotic experience, minimizing relapses and promoting a welcoming family environment, CBT is still little studied in Brazil as an effective form of treatment (Soares, 2019).

Thus, the ideas listed here are only intended to be a tool for reflection for potential readers who are researchers. It is hoped, therefore, to awaken new knowledge that deepens aspects not clarified in this reading. In view of this, further studies on this subject are suggested.

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