Our group has repeatedly replicated the “jumping-to-conclusions bias” in patients with schizophrenia (Moritz & Woodward, 2005; Moritz, Woodward, & Lambert, 2007a), which demonstrates that not only acute but also remitted patients share a tendency to make hasty decisions, even when confronted with delusion-neutral events. In subsequent studies we could substantiate those findings with alternative paradigms. People with psychotic-like-experiences sought less advice from others before making a decision (Scheunemann, 2018) and patients with psychosis rated multiple interpretations of a situation as plausible despite having little information (Moritz & Woodward, 2004). As a possible explanation for this cognitive bias, we assume a lowered decision threshold in people with schizophrenia as an indication of liberal acceptance (Moritz, Scheu, Andreou, Pfueller, Weisbrod, & Roesch-Ely, 2016; Moritz, Woodward, & Hausmann, 2006; Moritz, Woodward, Jelinek, & Klinge, 2008). In another study in which patients were repeatedly surveyed over several days, we were also able to show that the tendency to jump to conclusions is variable and precedes fluctuations in paranoid symptoms over the course of the day (Lüdtke, Kriston, Schröder, Lincoln, & Moritz, 2017).

Incorrigibility, that is, the maintenance of an opinion or attitude despite counter-evidence that most would find convincing, is a core feature of delusions. In a series of studies conducted in cooperation with Prof. Todd Woodward (Moritz & Woodward, 2006a; Veckenstedt et al., 2011; Woodward, Moritz, & Chen, 2006; Woodward, Moritz, Cutler, & Whitman, 2006; Woodward, Moritz, Menon, & Klinge, 2008), we confirmed that people with schizophrenia, especially those with acute positive symptoms, show a decreased ability to integrate disconfirmatory information in their decisions (this is known as ‘bias against disconfirmatory evidence’, or BADE). This response style, along with the aforementioned jumping-to-conclusions bias, may represent a pivotal mechanism in the formation and maintenance of schizophrenia. Additionally, we have investigated a hypothesis put forward by Bentall and Kinderman (1994) claiming that people with paranoia tend to personalize failure, which in turn reflects an underlying decreased implicit self-esteem and perhaps a stronger self-serving bias (success is due to one’s own efforts, whereas failure is due to others or circumstances). Although we indeed found evidence for decreased implicit self-esteem (Moritz, Werner, & von Collani, 2006), the results do not support the idea that there is a stronger self-serving bias in this disorder. However, through this work, we found another interesting deviation, which is that people with acute psychosis expressed less control and personal involvement with regard to both positive and negative events (Moritz, Woodward, Burlon, Braus, & Andresen, 2007b). In comparison to healthy and psychiatric controls, they attributed the causes of positive and negative events significantly more often as being outside their control. We also found evidence of mono-causal attributions in individuals with psychosis (Randjbar, Veckenstedt, Vitzthum, Hottenrott, & Moritz, 2011).

Research Collaborations

In cooperation with Prof. Tania Lincoln from the University of Hamburg, we investigated whether the cognitive biases discussed above are further aggravated under stress (e.g., Lincoln, Peter, Schäfer, & Moritz, 2010; Moritz et al., 2010), and in collaboration with PD Dr. Daniela Roesch-Ely from Heidelberg, we have assessed the role of cognitive biases for symptomatic and functional outcomes in schizophrenia (Andreou et al., 2013, 2014). Additional studies deal with other cognitive biases in schizophrenia, such as attentional distortions (e.g., Moritz & Laudan, 2007) and the illusion of control (Moritz, Thompson, & Andreou, 2014).

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References


