

Schizophrenia and Psychotic Disorders

Robin Winkler
CLINIC
Department of Psychology



THE UNIVERSITY OF
WESTERN AUSTRALIA

What is Schizophrenia?

Schizophrenia is a disorder of the mind that involves disorganisation of normal thinking and feeling. It occurs equally as often in men and women. Nearly three-quarters are between the ages of 16 and 25. About 170, 000 Australians suffer from schizophrenia with a further 600, 000 involved in their care. Nevertheless, it is poorly understood. People with schizophrenia do *not* have split personality. Second, people with schizophrenia are not necessarily dangerous. Rather schizophrenia involves:

Delusions - are false beliefs or feelings that things are under outside control. Some feel others are plotting against them, can read their mind, or feel they have extraordinary powers. Usually delusions are held with unshakeable conviction.

Hallucinations - commonly involve hearing imaginary voices, but some people experience seeing, feeling, smelling or tasting things that do not exist. To the sufferer, the sensations are real. Sometimes individuals hear voices reporting what they're thinking or telling them to do things.

Disorganised Thoughts - people with schizophrenia often have mixed-up thinking and can lose track of what they are saying. It can become hard to organise thoughts and sometimes disorientation and confusion can occur. Some become preoccupied on one thought or small detail to the exclusion of others, so they lose sight of the bigger picture.

The above symptoms are the 'positive' symptoms of schizophrenia as they are *added* to normal experience. The following symptoms are 'negative' symptoms, because they represent a *loss* or *decrease* in normal experience:

Loss of Emotions - Sometimes people with schizophrenia respond inappropriately, for example laughing on sad occasions or become indifferent to everything. They may seem hard to reach and it may feel like you cannot get through to them.

Apathy - the motivation to get on and do things is reduced. Sometimes this is noticeable in work and home duties. The person may also neglect their appearance. These changes may be accompanied by depressed or anxious feelings and it may seem as if the person's personality has changed. Sometimes there is deterioration in the social life and they may become withdrawn, staying in bed for a long time, losing interest in activities they previously enjoyed.

Symptoms vary greatly between individuals and tend to change over time. The main symptoms are usually present for at least 6 months. Sometimes the individual may not realize fully that there is something wrong and this lack of insight may lead to problems with not taking medication. This is difficult for families who want to offer support, but feel helpless and frustrated that the person will not acknowledge their illness and seek help.

There are five types of Schizophrenia. These are: **Paranoid** – featuring delusions or auditory hallucinations; **Disorganised** – where the main features are disorganised speech or behaviour and an absence of, or the inappropriate expression of emotions; **Catatonic** – where physical movements are disturbed leading to rigidity or immobility; **Undifferentiated** – in which some symptoms are present, but not those of the previous three types; and **Residual** – which features no prominent delusions, hallucinations, disorganised speech or grossly disorganised behaviour, but does include flattening of emotions.

Schizophrenia usually proceeds through four stages. The first is the *prodromal* phase, when a person may show social withdrawal, neglect of hygiene, and some strange behaviour. This is followed by the *active* psychotic phase when delusions and hallucinations become prominent and persist for at least a week. The *residual* phase follows this active period with impairments to functioning and some less severe symptoms. Finally, the person returns to comparatively normal functioning and is in *remission*.

Other Psychotic Disorders

Schizophreniform Disorder: This is similar to Schizophrenia, except for its duration is shorter. Approximately 1/3 of patients recover and the remainder will go on to develop Schizophrenia.

Schizoaffective Disorder: in addition to symptoms associated with schizophrenia a person may experience long bouts of depression or mania (extreme feelings of elation).

Delusional Disorder: involves a persistent false belief. These beliefs last at least a month. Usually disruptions to normal living are not associated with this disorder.

Brief Psychotic Disorder: is the sudden and brief onset of a positive psychotic symptom, often after a trauma. Afterwards the person returns to how they were before.

Shared Psychotic Disorder: Develops in individuals in a close relationship with someone with delusions. Usually the partner with the original disorder is the more dominant and imposes the delusional beliefs. Symptoms disappear if the relationship is ended.

Psychotic Disorder Due to a Medical Condition or Drugs: Delusions and hallucinations may be due to a general medical condition. Sometimes medications or drugs can bring on psychotic episodes. The symptoms appear quickly and last a relatively until the effects of the drug wear off.

What Causes Schizophrenia?

Generally speaking, people who develop schizophrenia have a built-in *vulnerability* that may be *genetic*, that is, a predisposition to the disorder that is inherited, or *environmental*, such as a viral infection in the mother during pregnancy, or *biological*, such as abnormalities in the brain. It is thought there is an imbalance of the brain chemical, dopamine, that causes thought patterns and interpretation of experiences to become distorted. Any one of these vulnerabilities may be affected by life events,

particularly within the family, which in turn may be triggered into malfunctioning due to some stressful event. Once the psychotic disorder is expressed, it may recur during the due to further stressful life-events. Thus, the combination of genetic, biological, and environmental vulnerability, along with stressful life events, helps explain how a person may develop schizophrenia, and how it may continue.

Schizophrenia runs in families, so there is a 10% chance you may develop schizophrenia if you have a parent who has it (or 90% you will not). However, surroundings, living conditions and life events also play a role. Again, these factors do not mean you will develop schizophrenia, only that when combined with the genes, the chances increase.

What Treatments are Available?

The major treatment is medication, but some people fail to respond fully, others have severe side effects, and others are unwilling to take medication. Recent approaches have therefore included psychological therapies. Goals and strategies vary according to the stage and severity of the disorder, as well as past history and frequency of past episodes. When possible, treatment should involve the patient and family in active collaboration using medication and psychosocial interventions. Many patients need lifelong comprehensive and continuous care. The treatments include:

Medication: Schizophrenia is treatable with “neuroleptics” which target the brain chemical, dopamine. Conventional neuroleptics (haloperidol and chlorpromazine) reduce “positive” symptoms (delusions and hallucinations), but may be less effective in treating the “negative” symptoms (apathy and emotional disturbances). Side effects include muscle rigidity, tremor, and facial grimacing. Newer, “atypical” neuroleptics (clozapine) have fewer side effects.

However, medication alone is not always enough. It does not help with social, relationship, and occupational difficulties. **Psychosocial treatments** can also help.

Psychosocial Interventions

Cognitive-Behaviour Therapy Techniques

Cognitive refers to thinking, and cognitive-behaviour therapy is a new set of techniques that address the disordered thought processes that can lead to distress and to impairments in behaviour. Some techniques show promise in reducing distress associated with disordered thought.

Content Approaches - focus on changing hallucinations and delusions. Techniques include *coping strategy enhancement* to build on natural coping strategies, such as listening to music to help with auditory hallucinations. Another strategy has been *retribution-enhancing techniques* in which patients focus on the characteristics and meaning of hallucinations and reattribute them. Another successful approach has been *verbal challenge and reality testing*. The aim is to challenge beliefs by questioning and looking for alternative explanations. Reality testing involves carrying out experiments that check out a delusion or hallucination.

Cognitive Rehabilitation -The goal is to adjust memory, vigilance, and conceptual abilities and prevent relapse by addressing problems in thinking. Treatments have been successful by focussing on single problems such as attention, as well as on clusters of problems such as communication skills, interpersonal problem solving, and social skills training.

Early Intervention

Another successful approach is intervention in the first episode of psychosis. Low dosages of neuroleptics are administered and cognitive-behaviour therapy is used for challenging and coping with symptoms.

Rehabilitation

Aims to improve social, vocational, educational, performance. Social skills training is offered, as is vocational rehabilitation.

Family Interventions

These involve education to provide families with information on the disorder, its origins, treatment, and future prospects as well as strategies for managing common problems. Families are taught how to identify signs of relapse, manage stress, express emotions appropriately, give advice, what expectations to have, how to communicate and solve problems. Family interventions assist patients and their relatives and reduce vulnerability to relapse.

Some Useful Books

- Torrey, E.F. (1995). *Surviving Schizophrenia: A Manual for Families, consumers and providers*. Harper Collins.
- Schizophrenia Fellowship of Victoria. (1994). *Psychosis. What is it? An Introduction to Psychotic Illness in Everyday Language*. Heppell Taylor: Victoria.
- AFAFMI (1992). *About Schizophrenia*. W.A. Health Dept.
- Jones, S. & Tallis, F. (1994). *Coping with Schizophrenia*. London: Sheldon Press.
- Deveson, A. (1991). *Tell me I'm here*. Ringwood.: Penguin.

Robin Winkler
CLINIC
Department of Psychology

**Robin Winkler Clinic, Department of Psychology
The University of Western Australia
10-12 Parkway, NEDLANDS WA 6907
Telephone: (08) 9380 2644 Fax (08) 9380 2655**

This information pamphlet is not medical advice and should not be relied on without taking professional advice.