Clinical Psychology

A MODULAR COURSE

Schizophrenia

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SCHIZOPHRENIA

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In memory of Elaine Birchwood
and Gary Jackson

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Contents

What is schizophrenia? 1

In this first chapter schizophrenia is defined and what it is like to suffer from the disorder is explained. Some of the controversies and difficulties surrounding the concept of schizophrenia are also discussed.

The experience of schizophrenia

> . . . I sat down at home and my mother said I just started talking a load of utter rubbish . . . I was examined very thoroughly, but the doctors could not find anything wrong physically and put it all down to "nerves" . . . I avoided going out because people on the street could read my thoughts. My mind was transparent . . . I complained of hearing voices telling me to do different things, which I felt compelled to do . . . I felt everyone was against me, even the nurses and doctors . . . I did not clean my teeth, wash myself or comb my hair for the first two months . . . I just existed till I felt better when I gradually started to look after myself again. I used to sit all by myself and would hardly say anything to anyone . . .
>
> (Joe, a 22-year-old man diagnosed with schizophrenia)

> Schizophrenia is a disorder of thinking where a person's ability to recognise reality, his or her emotional responses, thinking processes, judgement and ability to communicate deteriorates so much that his or her functioning is seriously impaired. Symptoms such as hallucinations and delusions are common.
>
> (Warner, 1994, p. 4)

> . . . I saw the cross, and then God spoke to me. With this certainty my thoughts then took control. They were religious thoughts . . . and I began to hear an intermittent voice. Just prior to my acute admission, I announced to my aged father, who was in bed, Satan in the form of the Loch Ness Monster was going to land on the lawn and do it for us if we both remained together in the house. By this time, I heard the voice pretty constantly . . . the voice continued for four months. One day I was sitting listening to it when it suddenly said . . . . . "This is the final transmission: over and out". I have never heard it since . . . again . . . my thoughts took control; it was a period of wildly erotic sensations, lack of sleep, being out walking at any time from 1.00am onwards, marked tiredness, and frequent ideas of reference. Messages were being transmitted by car registration numbers and many written sentences had messages hidden in them in code . . .
>
> (Errol, 26-year-old man with schizophrenia)

Delusions represent beliefs which are not shared by the individual's cultural peer group. In schizophrenia these tend to be of three main types. In the first, the individual may believe (and feel) that his or her behaviour is being influenced or controlled by some external force (delusions of influence or control). In the second, the person may believe he or she is being watched, followed or persecuted in some way (delusion of persecution). Finally, the individual may believe he or she has lost his sense of identity or purpose and may believe he or she has powers or abilities out of the ordinary (delusions of identity). The following description vividly portrays the experience of delusional identity and the acute distress that accompanies the lonely feeling of a delusion of persecution. This 23-year-old man worked as a storekeeper in a department store:

> . . . In my flat I began to get delusions. I was a storekeeper at the time. I wrote out a "supreme new plan", a system of life which I had worked out for myself . . . I wrote out notebooks full of plans. I kept thinking the Mafia were after me, and the FBI were protecting me, ready to send me away to be trained. I kept thinking my parents were Jews. I would ask my landlady, in my loneliness, if I could watch their television and I would cry all the way through the programmes. Finally, I tried to get away to my aunt

> Mary's: all I had with me was a suitcase with a bible in it. The Police picked me up and I made a false confession of murder so that they would incarcerate me and protect me from the Mafia . . . my doctor said I needed a rest. Sometime the next day, the medical superintendent and my mother came to certify me at the flat. A Social Worker took me to hospital. I didn't resist; I thought it was all part of the plan . . .
>
> (Mark, 23-year-old man with schizophrenia)

There is no doubt that people who are diagnosed with schizophrenia undergo a major change in mental and social functioning. For some these changes are transient, but in the majority of cases the changes are episodic or permanent.

Perhaps the greatest costs to the person affected by these experiences are the social and psychological consequences. It may, after all, be argued that there are many in society whose behaviour is statistically abnormal, yet who do not bring themselves, or are not brought by others, to public attention (Peters, Day McKenna, & Orbach, 1999). It is when such behaviour leads to a serious deterioration in the quality of life or results in danger to the well-being of the individual or others that the person concerned, his or her family, and society in general, feel a need to respond. Unemployment, social drift, social adversity, loss of confidence, drive, and even loss of the skills of independent living are among the most serious of these social and psychological effects. Once again, this is best illustrated by some actual case examples.

> . . . Colin works as a general labourer in a factory making garden tools. At nineteen years of age, he was living with his mother and sister in a council flat in a deprived area of the city. He had always been a quiet person with few friends. His interests were predominantly solitary (fishing, gardening) although he occasionally spent evenings out with his brother. One summer, after visiting a fortune teller at a local fair, Colin felt convinced that she had cast a spell upon him and that she exerted almost total control over his behaviour and thoughts. Colin became increasingly withdrawn and started to absent himself from work. He became suspicious of people, including his relatives that he thought were agents of the fortune teller. His mother reported that he spent much of the day in his bedroom

talking and laughing to himself. It was discovered that Colin was hearing voices which he thought was an attempt by the fortune teller to drive him insane.

The voices sometimes commented on his thoughts or behaviour ("he's going to sleep" [laughter]); sometimes they criticised him ("the way you act makes me sick"; "you're daft, I am") and sometimes they were bizarre or humorous ("he's not well liked but he's well liked", "monster crab claws for you old boy"). Colin refused to watch TV as he felt he heard thinly disguised references to him and his sanity. Colin's family had no previous acquaintance with such behaviour and at the time were resistant to identifying it as a mental illness, preferring to view it as a "phase" he was going through. Their perceptions changed suddenly when they realised that he had not eaten for three days and they called the family doctor who immediately admitted him to the local psychiatric hospital.

The following two months at the hospital Colin was much improved but he nonetheless continued to hear voices. He was unable to keep his job as the voices were too intrusive and distressing. At home, Colin withdrew further and his family were finding difficulty motivating him. Two years later Colin rarely laughs and seems to find it hard to understand what is said to him. He has given up the idea of working again and spends three days a week in a Day Centre. He spends much of the time alone in his room.

(Colin, a 24-year-old man diagnosed with schizophrenia)

Not everyone with schizophrenia, however, can be viewed as having an unfavourable outcome. Many (approximately 20%) will experience just one episode of psychotic symptoms in their entire life and return to a relatively normal existence. Even more (60%) will relapse more than once but will return to premorbid levels of functioning between episodes. Longitudinal prospective research studies throughout the world (e.g., Thara, Henrietta, Joseph & Eton, 1994), which overcome many of the bias sample effects in previous studies (i.e., tendency to follow up those in hospitals with the poorest outcomes), have concluded that a deterioration in schizophrenia is not inevitable. The advent of new drugs such as Clozapine, Olanzapine, and Risperidone as well as advances in psychosocial

approaches, such as assertive community outreach, cognitive therapy, and early intervention (see Chapters 7 and 8) have meant that we are standing at the cusp of a new optimism in the treatment and management of schizophrenia. This is important because schizophrenia not only impacts upon the individual sufferers, but also upon those closest to them such as their families and on society in general, in terms of socio-economic costs.

Schizophrenia and the family

> . . . She just sits there . . . she looks the same but she's not the same. She won't do anything unless I tell her. She often follows me around like a puppy which makes me lose my temper and then I feel guilty for shouting. I know they are doing all they can but they can't bring my daughter back. Sometimes my husband and I just want to cry.
>
> (Mother of 30-year-old woman [Sharon] with schizophrenia)

The vast majority (i.e. between 60% and 70%) of people with schizophrenia will return to live with their families, particularly in the early years following a first episode of psychosis (Stirling, Tantam, Thonks, Newby, & Montague, 1991). As we move away from hospital settings to more community-based approaches, families have an increasing role in the long-term care of their relatives with schizophrenia.

Such families are likely to encounter a range of problems which impact significantly upon family life. These will include withdrawal (staying in bed, emotional detachment, avoiding social contact); dealing with psychotic symptoms (i.e., persecutory delusions, hallucinatory behaviour); behavioural excesses (aggression, restlessness, and provocation of family discord), and impaired social performance (i.e., poor self care, domestic tasks, and independent skills).

Studies also describe the financial, physical, and psychological burden of caring for a relative with schizophrenia (Grad, & Sainsbury, 1968; Hatfield, 1978; see also Fadden, 1998).

Grief can be an understandable reaction to the changes sometimes brought about by schizophrenia (Birchwood, & Osborne, 2001). As illustrated in the previous example of the mother of Sharon, families

may witness changes in social functioning and behaviours consistent with the "loss of a living relative" (Miller, 1996). This, of course, is not exclusive to schizophrenia or other forms of severe or enduring mental illness.

The myths of schizophrenia

> [New York] . . . In January, Kendra Webdate, a young receptionist, was pushed to her death under a Manhattan subway train by a man who had stopped taking his medicine for schizophrenia. A month ago, both legs of Edgar Rivera, a father of 3, were severed by a rush hour subway train after he was shoved onto the tracks by a homeless man believed to be off his medication for schizophrenia.
>
> Earlier in April, New York police shot Charles Stevens eight times after he threatened them with the sword he was brandishing at commuters in Penn Station.
>
> Stevens, who survived the attack, had refused to take his medication for schizophrenia.
>
> (*Chicago Tribune*, Tuesday, 1 June 1999)

Unfortunately, much of our understanding and knowledge of schizophrenia is influenced by the media. Although many articles, reports, and TV programmes are undoubtedly informative, editing bias and selective abstraction on the part of the reader conspire to maintain many of the myths and stereotypes we hold about people with schizophrenia. As indicated in the quote from the *Chicago Tribune*, one of the major myths is that people with schizophrenia are disproportionately violent and aggressive unless sedated with powerful antipsychotic medication. Yet, if we examine the evidence for this in more detail, the truth is more complex. Modestin (1998), reviewing the literature on criminal and violent behaviour in people with schizophrenia, concludes that although there does appear to be a slightly elevated risk of aggression, much of this risk depends upon the nature of the symptoms (delusions, hallucinations, etc.) and whether or not illicit substances are involved. In reality, people with schizophrenia are much more likely to kill themselves than others (Allebeck, Varla, & Wistedt, 1986).

Symptoms of schizophrenia

One of the most traditional methods of classifying mental illness is by dividing it into either neurosis or psychosis. The former usually refers to anxiety disorders (i.e., post traumatic stress disorder, obsessive compulsive disorder, generalised anxiety disorder, social anxiety, phobias, and panic disorder; see Rachman, 1998) and unipolar depression (see Hammen, 1997). It is argued that within the neuroses despite often suffering extreme levels of distress, a person's sense of reality remains intact. In psychosis it is believed that contact with reality is severely distorted (Cutting, & Charlish, 1995), even if this is only on a temporary basis. Schizophrenia is the most common and perhaps best known of the psychotic disorders. Related disorders such as schizophreniform disorder, schizoaffective disorder, delusional disorder, and brief psychotic disorder are differentiated diagnostically from schizophrenia on the basis of the nature and duration of the psychotic symptoms (see Hirsch, & Weinberger, 1995; McKenna, 1997 for a more detailed review). People with manic depression and chronic unipolar depression may also display psychotic features such as hallucinations and delusions (Goodwin, & Jamison, 1992; Sands, & Harrow, 1994).

Table 1.1 presents what most clinicians and researchers agree to be the main symptoms of schizophrenia. Although, as discussed previously, some of the symptoms may also be present in other disorders such as manic depression and other types of psychosis, it is argued that people with schizophrenia demonstrate a particular pattern and intensity of symptoms. This will be discussed in more detail in the next section, "Diagnosing schizophrenia".

Many of the symptoms described in Table 1.1 are illustrated by the case material at the beginning of the chapter. For instance, Joe felt compelled to do as his "voices" (auditory hallucinations) had told him; Errol's "voice" continued for 4 months before it announced "over and out" and was not heard again; Colin's hallucinations either commented on his thoughts and behaviour, criticised him, or made bizarre comments. Colin believed that a fortune teller had "cast a spell upon him" and therefore exerted control over his behaviour and thoughts (experiences of control).

Most of the case examples describe delusions. Joe, for example, felt everyone was against him including the doctors and nurses, whereas Mark believed the Mafia were after him (delusions of persecution). Delusions of reference are common: Errol, for instance, thought that

TABLE 1.1

Main symptoms of schizophrenia

Auditory hallucinations: false perceptions often in the form of noises or voices talking to each other about the person or commentating on his/her thoughts or actions in the third person.
Experiences of control: person feels under the control of an alien force or power. They may also experience the feeling that an external force has penetrated their mind or body. This is often interpreted as the presence of spirits, X-rays, or implanted radio transmitters.
Delusions: false personal beliefs about the world, which can take many different forms (i.e., persecutory, grandiose, reference, etc.). For instance, delusions of reference are beliefs held by the person that the behaviour and/or remarks of others (in the street, on TV, on the radio, etc.) are meant for them.
Disorders of thinking: the feeling that thoughts have been inserted or withdrawn from the mind. In some cases the person may feel that their thoughts are being broadcast so that others can hear them, often over long distances.
Emotional and volitional changes: emotions and feelings become blurred or less clear and are often described as being "flat". There may also be a loss of initiative or energy. Such changes are sometimes referred to as "negative symptoms".

messages relating to him were being transmitted by car registration numbers and written sentences (in coded form); Colin avoided watching TV as he believed that television programmes often made references about him and his sanity. Delusions may sometimes be interpretations of hallucinations: Errol thought God was speaking to him, and Colin believed his thoughts were an attempt by the fortune teller to drive him insane.

Disorders of thinking can also be witnessed in this previous case material. Joe describes the distress of thought broadcast ("people could read my thoughts") and how it may provoke avoidance and social withdrawal. After some time changes in emotion and volition may increase such social withdrawal as people struggle to energise themselves. This is clearly evident in Colin's case as his family struggle to motivate him and Colin struggles to recapture some of the emotions that were evident before the onset of the illness (i.e., being able to laugh).

In describing the changes that can occur with schizophrenia, Wing, a British social psychiatrist has argued that a distinction should be drawn between impairments which are intrinsic to the disorder (largely psychological) and those that are secondary, resulting from

TABLE 1.2

Some common problems associated with schizophrenia

Intrinsic impairments
Persisting symptoms (hallucinations), delusions, thought disorders
Tendency to withdrawal, apathy, emotional blunting ("negative" symptoms)
Cognitive impairments: attention and problem-solving
Vulnerability to further schizophrenic episodes
Secondary impairments
Social
Unemployment, downwards social drift
Social adversity: housing, finance, etc.
Institutionalisation
Diminished social network
Family discord or rejection
Social prejudice to mental illness
Psychological
Loss of confidence and achievement motivation
Social and community survival skills impaired or fall into disuse
Dependent or semi-independent on family or institutions
Distress due to poor coping with persisting symptoms (e.g., auditory hallucinations)

the interaction of primary impairments with the social environment. These are illustrated in Table 1.2.

Throughout this book reference will be made to these different levels of impairment, their causes and more importantly how one may intervene to reduce them.

Diagnosing schizophrenia

There is no doubt that in the past the diagnosis of schizophrenia has been too widely and too liberally applied to a number of psychological and psychiatric difficulties. For instance, prior to 1970 there was a great difference in the prevalence rates of schizophrenia in different countries. Before 1970, American psychiatry employed a broad concept of schizophrenia, which included disorders that in European countries often attracted a diagnosis of manic depressive illness. Scandinavian psychiatry in contrast tended to exclude brief schizophrenic illnesses and place more emphasis on poor outcome cases (Warner, 1994). It also became apparent from studies looking at the reliability of psychiatrists' diagnostic practices that there was