# Symptoms of Psychosis- Definitions

**Psychosis**: Traditionally meant loss of reality testing and impairment of mental functioning-manifested by delusions, hallucinations, confusion and impaired memory- commonly has become synonymous with severe impairment of social and personal functioning characterized by social withdrawal and inability to perform the usual household and occupational roles.

**Positive symptoms**: “Reflect an excess or distortion of normal function”, “experiences that would be considered grossly abnormal”, marked distortion of reality, typically associated with the acute phase of the disorder. DSM 5 specifies that the positive symptoms include distortions in thought content (delusions), perception (hallucinations), language and thought process (disorganized speech) and self monitoring of behavior)grossly disorganized or catatonic behavior). It further divides positive symptoms into two “dimensions”- “psychotic dimension”- delusions and hallucinations and the “disorganization dimension”- disorganized speech and behavior.

**Hallucinations**: False sensory perceptions that are disconnected from an appropriate source.

Auditory hallucination (most common type- occurring in nearly 50% of all patients with Schizophrenia) : Usually experienced as voices, whether familiar or unfamiliar, that are perceived as distinct from the person’s own thoughts, (If occur while falling asleep “hypnagogic”, or waking up “hypnapompic”- they are considered to be within the range of normal experience).

**Certain types of auditory hallucinations have been considered to be particularly characteristic of Schizophrenia- two or more voices conversing with one another or voices maintaining a running commentary on the person’s thoughts or behaviors- if these types are present, then only this single symptom is needed to satisfy Criterion A for Schizophrenia.**

Visual hallucinations: False perception involving sight consisting of both formed images (persons) and unformed images (flashes of light) **:most common in medically determined disorders.**

Tactile hallucination: False perception of touch or surface sensation, as from an amputated limb, crawling sensation on or under the skin.

**Delusions**: Fixed, false beliefs that are not subject to reason or contradictory evidence (one source estimates that approximately 90% of patients describe delusional beliefs at some point in their illness. A delusional belief involves four features 1) objectively false 2) idiosyncratic 3) illogical 4) stubbornly maintained. Three distinct entities- Delusions of influence (delusions of being controlled, thought insertion or thought withdrawal), Self-significance delusions (grandeur, reference, guilt/sin) and delusions of persecution.

Bizarre delusions are beliefs that are totally out of the realm of physical possibility, if they are clearly implausible, not understandable, do not derive from ordinary life experiences. **If bizarre delusions are present, then only this single symptom is needed to satisfy Criterion A for Schizophrenia**.

**Disorganized Speech** (must be severe enough to substantially impair effective communication): “Derailment” or “loose associations” where the person “slips off track, “tangentiality” where the person responds obliquely or completely off subject to a query, or, rarely- “word salad” / incoherence where speech is so disorganized that nearly incomprehensible and may resemble receptive aphasia-

**Behavior –**

Disorganized:

Problems may be noted in any form of goal-directed behavior, leading to difficulties in performing activities of daily living, client may appear noticeably disheveled, may dress inappropriately, may display clearly inappropriate sexual behavior, or unprovoked and unpredictable agitation.

Catatonic:

Marked decrease in reactivity to the environment, sometimes reaching an extreme degree of complete unawareness, maintaining a rigid posture and resisting efforts to be moved, active resistance to instructions or attempts to be moved, the assumption of inappropriate or bizarre postures, or purposeless and unstimulated excessive motor activity **(nonspecific symptom- may occur with other mental disorders, in general medical conditions or be induced by medications).**

**Negative symptoms:** “Reflect a diminution or loss of normal function”- difficult to tease out whether these may be in relation to positive symptoms- must stand on their own to be used in diagnosis of Schizophrenia- excellent test is the test of time- do they persist?

Affective flattening: Person’s face appears immobile and unresponsive- the person’s range of emotional expressiveness is clearly diminished most of the time.

Alogia: Poverty of speech, decreased fluency and productivity of speech.

Avolition: Inability to initiate and persist in goal-directed activities.

## Assessment and Interview of Psychotic Patients

1. Evaluation should be more focused and structured than that of other patients. You must provide an organization for thinking that the client cannot provide themselves.
   1. Short, direct questions as opposed to open-ended and abstract.
      1. Introduce yourself to the patient, mention the purpose of the interview, see how this accords with the patient’s perceptions, and give the patient an opportunity for comment.
      2. Research has shown that patients with schizophrenia often have a fear of the unknown- so, for a first meeting, approach the person from the front, let them “look you over”- Offer them a chair, tell them where you will be sitting, ask them if they are comfortable with that.
   2. People reporting auditory hallucinations should be asked about: content, context, volume, clarity, what they make of it, and their response to it.
      1. "Have you had any unusual or strange experiences, such as hearing voices that no one else seems to hear?” “Have you seen things that other people haven’t seen. Or felt things when there was nothing there?” –
         1. “When was the first time, the last time that you remember hearing voices?” “Are you hearing the voices now?“ “How does it make you feel to hear the voices?”
      2. For delusions- “Sometimes people worry more than they should that other people are spying on them, or planning to get them into trouble. Has anything of that sort ever happened to you?- for thought insertion “Do you ever get the feeling that other people or the radio or TV are putting thoughts into your head?”
      3. Thought broadcasting- “Do you ever get the feeling that your thoughts are being transmitted to other people or come out on the radio or TV?
         1. Need to distinguish between true hallucinations on the one hand, and illusions, hypnagogic, hypnapompic and vivid imaging on the other hand.
      4. With patients with schizophrenia, impulses for suicide, homicide and assault often enter consciousness as hallucinations and/or delusions. Ask about whether the voices or delusions they have described every give them commands to obey or suggestions to follow- if so, when did they last have them, how close did they come to acting on them, are they having the thoughts now, do they want help controlling them?
   3. “No collusion with delusion”- Dr. Norman Reider of the Mt. Zion hospital in SF, CA (“No, that is not what I believe, but I am interested in is how things look to you”).
      1. Without agreeing with their delusions, you should find an area of agreement- finding something that is bothersome or tormenting to them, that can help build a therapeutic alliance.
      2. Countering paranoia with sweetness/affability may add to a client’s paranoia/ they may think you are trying to trick them- instead remain reserved, businesslike- research has shown that patients with schizophrenia often have a fear of the unknown- so, for a first meeting, approach the person from the front, let them “look you over”.
      3. Avoid pronouncements about what you are seeing from the client, make an observation and then ask the client instead.
2. No clinical sign or symptom is pathognomonic for schizophrenia: every sign or symptom seen in schizophrenia occurs in other psychiatric and neurological disorders- thus, a patient’s history is essential for the diagnosis of schizophrenia.
   1. Epidemiology: Lifetime prevalence of schizophrenia is about 1%, is found in all societies and geographic areas, and prevalence rates are roughly equal worldwide.
      1. Gender and age: equally prevalent in men and women.
         1. Onset is earlier in men: peak ages of onset are 10 to 25 for men.
         2. Onset in women is 25 to 35- unlike men, women have a bimodal age distribution, with a second peak occurring in middle age (related to menopause).
         3. Onset before age 10 or after 60 is extremely rare.
         4. When onset occurs after 45- disorder is characterized as late onset.
         5. Outcome is generally better for female patients then men.
         6. Some studies have indicated that men are more likely to be impaired by negative symptoms then women, and that women are more likely to have better social functioning prior to onset.
         7. Males are more vulnerable to schizophrenia than females- median male: female risk ratio of 1.4. Overall worse outcome for males who develop schizophrenia.
      2. Infection and Birth season
         1. Persons who develop schizophrenia are more likely to have been born in the winter and early spring.
      3. Reproductive factors
         1. Morbid risk in the monozygotic twin of a proband is estimated to be 48% compared to 1% for the general population. The risk for children with one parent with schizophrenia is 10-15x greater then in the general population.
      4. Suicide risk
         1. Leading cause of mortality in persons suffering from schizophrenia.- Suicide rates are elevated above not only population rates, but also rates for other psychiatric disorders. The risk of suicide is significantly increased in the first year after discharge following impatient admission, but especially in the first few weeks after discharge. As many as 15% may die because of a suicide attempt (risk factors to be noted are being white, socially isolated, depressive illness, history of suicide attempts, unemployment and recent rejection- a post-discharge course involving high levels of psychopathology and functional impairment - in addition, persons who have a realistic awareness of the deteriorative effects of the illness and a nondelusional assessment of their future mental deterioration, hopelessness, excessive dependence on treatment or loss of faith in treatment have an increased risk of suicide- risk of mortality is especially high in the young, early in the course of the illness) \* Recent studies the portion of suicides in total deaths (proportional mortality) of people with schizophrenia is estimated at about 30%. Risk for suicide in people with schizophrenia markedly decreases with age as opposed to that for most general populations (which increase with age)- severe negative symptoms tend to be a protective factor- reducing risk.
      5. Immigrants and Ethnic Minorities
         1. Migrants have a higher risk of developing schizophrenia in their own or their adoptive countries.
      6. Childhood Stressors
         1. Separation from a parent, death of a parent thru suicide, and sexual abuse in childhood have been reported as independent risk factors for schizophrenia.
   2. Course
      1. Factors associated with a poorer longitudinal illness course include being male, early onset of illness, poor pre-morbid social and occupational adjustment, low pre-morbid IQ, a predominance of negative symptoms, and a lack of affective symptoms.
      2. Poor outcome is also perpetuated by delayed, suboptimal or intermittent treatment with anti psychotic medication and ongoing illicit substance use. Also a strong association between poor outcome and a family environment characterized by a so-called high expressed emotion (EE). This encompasses critical comments, hostility, and/or over involvement of family members with nominally more than 72 hours per week of face to face contact with the individual.
      3. The disease construct of schizophrenia comprises several relatively independent symptom dimensions, with negative symptoms and cognitive impairments remaining relatively stable over the illness course, and positive symptoms occurring in most patients on an episodic basis.
      4. Full remissions without subsequent relapses persist in about 20% of cases in the long-term.
      5. Recovery or major sustained improvement occurs mostly in the first years following illness onset. Patients who do not improve in the first years, or who deteriorate slightly or markedly, tend to continue this trend in the long term, too.
   3. Onset
      1. In about 75% of cases, schizophrenia onset occurs with slowly mounting depressive and negative symptoms that involve increasing functional impairment and cognitive dysfunction. Less then 10% of cases start with positive symptoms only.
3. Differential Diagnosis- **Always always always rule out biological/drug induced First-** flags for these- when the age of onset and the timeline of the symptoms is not consistent with what we know about Schizophrenia.
   1. Psychotic Disorders 1 ½ % of the population, Anxiety disorders 25% of the population, Depressive disorders 15% of the population, Bipolar Disorders 1 ½% of the population.
   2. Psychotic symptoms vs. intrusive thoughts in panic and obsessive-compulsive disorders.
      1. In both cases, intrusive thoughts are unwanted or unacceptable to the person experiencing them and are perceived as uncontrollable- essential difference that psychotic symptoms are seen as coming from **outside the mind** ( do not mean “outside their head) , while the anxiety symptoms are perceived by the person **as coming from their own mind**.
   3. Hallucinations versus Flashbacks
      1. PTSD flashbacks will involve more then one type of hallucination at one time- as the person will experience themselves in a different place and time then they actually are- but, in both cases, the person will lose touch with reality.
   4. Bipolar Disorder vs. Schizophrenia
      1. Patients with mania may have a wide variety of psychotic symptoms- including hallucinations, paranoid delusions, and formal thought disorder- with mania, these psychotic symptoms will be abrupt and the affective symptoms will predominate.
   5. Depressive disorder vs. Schizophrenia
      1. People with depressive episodes may also experience hallucinations and/or delusions (the only DSM depressive disorder with psychotic features is coded severe)- the psychotic symptoms are usually mood-congruent when stemming from a depressive episode…so should be consistent with depressive themes- also, when patients with depressive disorder have hallucinations they are of shorter duration and fragmented and within the context of the depressive disorder.