36.2: The Phenomenology Of Schizophrenia And Related Psychotic Disorders

Most of you have probably had the experience of walking down the street in a city and seeing a person you thought was acting oddly. They may have been dressed in an unusual way, perhaps disheveled or wearing an unusual collection of clothes, makeup, or jewelry that did not seem to fit any particular group or subculture. They may have been talking to themselves or yelling at someone you could not see. If you tried to speak to them, they may have been difficult to follow or understand, or they may have acted paranoid or started telling a bizarre story about the people who were plotting against them. If so, chances are that you have encountered an individual with schizophrenia or another type of psychotic disorder. If you have watched the movie *A Beautiful Mind* or *The Fisher King*, you have also seen a portrayal of someone thought to have schizophrenia. Sadly, a few of the individuals who have committed some of the recently highly publicized mass murders may have had schizophrenia, though most people who commit such crimes do not have schizophrenia. It is also likely that you have met people with schizophrenia without ever knowing it, as they may suffer in silence or stay isolated to protect themselves from the horrors they see, hear, or believe are operating in the outside world. As these examples begin to illustrate, psychotic disorders involve many different types of symptoms, including delusions, hallucinations, disorganized speech and behavior, abnormal motor behavior (including catatonia), and negative symptoms such anhedonia or amotivation and blunted affect/reduced speech.

**Delusions** are false beliefs that are often fixed, hard to change even when the person is presented with conflicting information, and often culturally influenced in their content (e.g., delusions involving Jesus in Judeo-Christian cultures, delusions involving Allah in Muslim cultures). They can be terrifying for the person, who may remain convinced that they are true even when loved ones and friends present them with clear information that they cannot be true. There are many different types or themes to delusions.

The most common delusions are persecutory and involve the belief that individuals or groups are trying to harm or plot against the person in some way. These can be people that the person knows (people at work, the neighbors, family...
members), or more abstract groups (the FBI, the CIA, aliens, etc.). Other types of delusions include grandiose delusions, where the person believes they have some special power or ability (e.g., I am the new Buddha, I am a rock star); referential delusions, where the person believes that events or objects in the environment have special meaning for them (e.g., that song on the radio is being played specifically for me); or other types of delusions where the person may believe that others are controlling their thoughts and actions, that their thoughts are being broadcast aloud, or that others can read their mind (or they can read other people’s minds).

Figure \(\PageIndex{1}\): Under surveillance: Abstract groups like the police or the government are commonly the focus of persecutory delusions in a person with schizophrenia. ["W beauty" by Thomas Hawk/Flickr is licensed under CC BY-NC 2.0.]

When you see a person on the street talking to themselves or shouting at other people, they are experiencing hallucinations. These are perceptual experiences that occur even when there is no stimulus in the outside world generating the experiences. They can be auditory, visual, olfactory (smell), gustatory (taste), or somatic (touch). The most common hallucinations in psychosis (at least in adults) are auditory and can involve one or more voices talking about the person, commenting on the person’s behavior, or giving them orders. The content of the hallucinations is frequently negative (“you are a loser,” “that drawing is stupid,” “you should go kill yourself”) and can be the voice of someone the person knows or a complete stranger. Sometimes the voices sound as if they are coming from outside the person’s head. Other times the voices seem to be coming from inside the person’s head, but are not experienced the same as the person’s inner thoughts or inner speech.
Figure \(\PageIndex{2}\): People who suffer from schizophrenia may see the world differently. This can include hallucinations, delusions, and disorganized thinking. [Untitled image by Noba Project is licensed under CC BY-NC-SA 4.0.]

Talking to someone with schizophrenia is sometimes difficult, as their speech may be difficult to follow, either because their answers do not clearly flow from your questions, or because one sentence does not logically follow from another. This is referred to as **disorganized speech**, and it can be present even when the person is writing. **Disorganized behavior** can include odd dress, odd makeup (e.g., lipstick outlining a mouth for 1 inch), or unusual rituals (e.g., repetitive hand gestures). Abnormal motor behavior can include **catatonia**, which refers to a variety of behaviors that seem to reflect a reduction in responsiveness to the external environment. This can include holding unusual postures for long periods of time, failing to respond to verbal or motor prompts from another person, or excessive and seemingly purposeless motor activity.

Some of the most debilitating symptoms of schizophrenia are difficult for others to see. These include what people refer to as "negative symptoms" or the absence of certain things we typically expect most people to have. For example, **anhedonia** and **amotivation** reflect a lack of apparent interest in or drive to engage in social or recreational activities. These symptoms can manifest as a great amount of time spent in physical immobility. Importantly, anhedonia and amotivation do not seem to reflect a lack of enjoyment in pleasurable activities or events (Cohen & Minor, 2010; Kring & Moran, 2008; Llerena et al., 2012) but rather a reduced drive or ability to take the steps necessary to obtain the potentially positive outcomes (Barch & Dowd, 2010). **Flat affect** and reduced speech (**alologia**) reflect a lack of showing emotions through facial expressions, gestures, and speech intonation, as well as a reduced amount of speech and increased pause frequency and duration.

In many ways, the types of symptoms associated with psychosis are the most difficult for us to understand, as they may seem far outside the range of our normal experiences. Unlike depression or anxiety, many of us may not have had experiences that we think of as on the same continuum as psychosis. However, just like many of the other forms of **psychopathology** described in this book, the types of psychotic symptoms that characterize disorders like schizophrenia are on a continuum with "normal" mental experiences. For example, work by Jim van Os in the Netherlands has shown that a surprisingly large percentage of the general population (10%+) experience psychotic-like symptoms, though many fewer have multiple experiences and most will not continue to experience these symptoms in the long run (Verdoux & van Os, 2002). Similarly, work in a general population of adolescents and young adults in
Kenya has also shown that a relatively high percentage of individuals experience one or more psychotic-like experiences (~19%) at some point in their lives (Mamah et al., 2012; Ndetei et al., 2012), although again most will not go on to develop a full-blown psychotic disorder.

Schizophrenia is the primary disorder that comes to mind when we discuss “psychotic” disorders (see Table \(\PageIndex{1}\) for diagnostic criteria), though there are a number of other disorders that share one or more features with schizophrenia. In the remainder of this module, we will use the terms “psycho- sis” and “schizophrenia” somewhat interchangeably, given that most of the research has focused on schizophrenia. In addition to schizophrenia (see Table \(\PageIndex{1}\)), other psychotic disorders include schizophreniform disorder (a briefer version of schizophrenia), schizoaffective disorder (a mixture of psycho- sis and depression/mania symptoms), delusional disorder (the experience of only delusions), and brief psychotic disorder (psychotic symptoms that last only a few days or weeks).

Table \(\PageIndex{1}\): Types of Psychotic Disorders Simplified from the Diagnostic and Statistical Manual, 5th edition (DSM-5) (American Psychiatric Association [APA], 2013)

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Lifetime Prevalence</th>
<th>Diagnostic Criteria</th>
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<tbody>
<tr>
<td>Schizophrenia (lifetime prevalence about 0.3% to 0.7%)</td>
<td>Two or more of the following for at least 1 month: hallucinations, delusions, disorganized speech, grossly disorganized or catatonic behavior, negative symptoms.</td>
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<tr>
<td>Schizophreniform Disorder (lifetime prevalence similar to Schizophrenia)</td>
<td>The same symptoms of schizophrenia described above that are present for at least 1 month but less than 6 months.</td>
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<tr>
<td>Schizoaffective Disorder (lifetime prevalence above 0.3%)</td>
<td>A period of illness where the person has both the psychotic symptoms necessary to meet criteria for schizophrenia and either a major depression or manic episode.</td>
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<tr>
<td>Delusional Disorder (lifetime prevalence about 0.2%)</td>
<td>The presence of at least one delusion for at least a month. The person has never met criteria for schizophrenia. The person’s function is not impaired outside the specific impact of the delusion.</td>
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The duration of any depressive or manic episodes have been brief relative to the duration of the delusion(s).

Brief Psychotic Disorder (lifetime prevalence unclear)

- One or more of the following symptoms present for at least 1 day but less than 1 month: delusions, hallucinations, disorganized speech, grossly disordered or catatonic behavior.

Attenuated Psychotic Disorder (in Section III of the DSM-5, lifetime prevalence unclear)

- One or more of the following symptoms in an “attenuated” form: delusions, hallucinations, or disorganized speech.
- The symptoms must have occurred at least once a week for the past month and must have started or gotten worse in the past year.
- The symptoms must be severe enough to distress or disable the individual or to suggest to others that the person needs clinical help.
- The person has never met the diagnostic criteria for a psychotic disorder, and the symptoms are not better attributed to another disorder, to substance use, or to a medical condition.