Schizophrenia Spectrum/Other Psychotic Disorders & Substance Use

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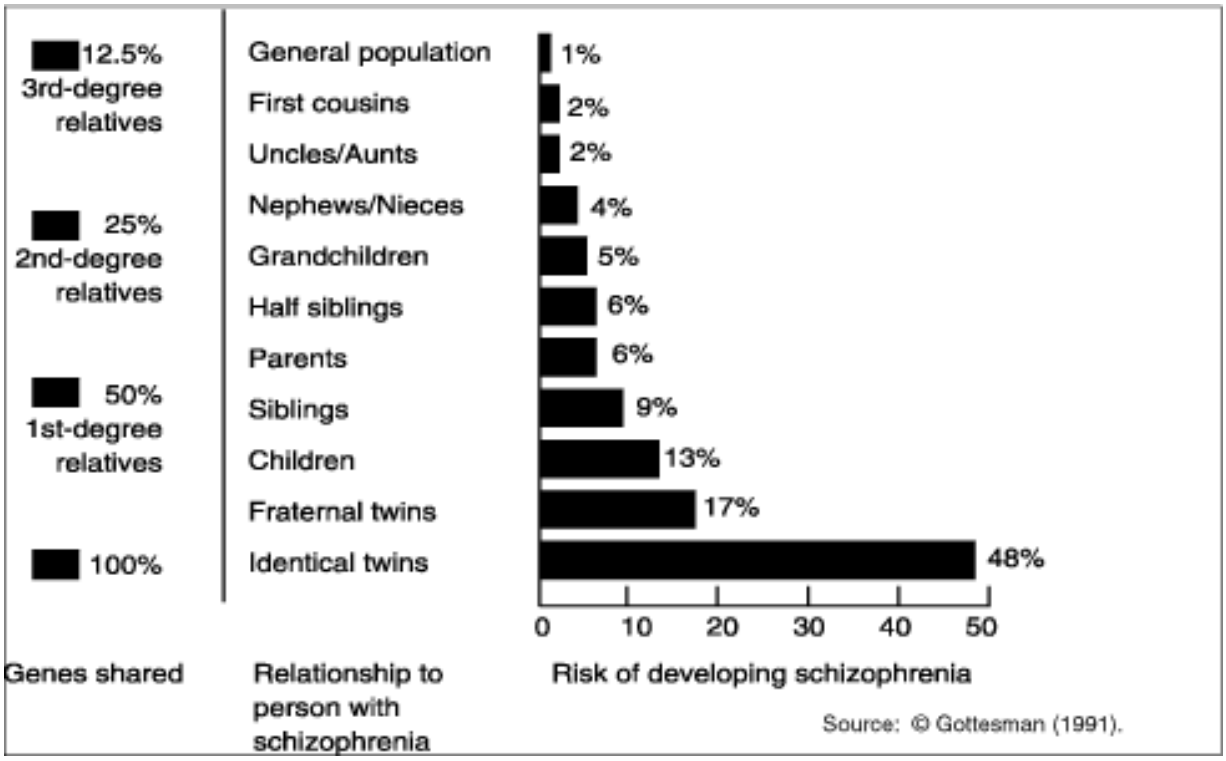
Schizophrenia is:

Many people are frightened by the bizarre thoughts and behavior associated with schizophrenia. Job one is to explain to them that schizophrenia is a brain disease caused by an imbalance of neurotransmitters.

While the symptoms can interfere with one' life, people with schizophrenia need to know:

- They are not a fault for having schizophrenia.
- Schizophrenia can be managed.
- Schizophrenia is being widely researched and improved treatment is on the horizon.

They most likely inherited a predisposition for schizophrenia. In most cases, some stimuli triggered their first psychotic episode. Typical triggers include substance abuse, going to college or the military, or even puberty. The chart below shows the probability of developing schizophrenia if a relative has the disease.



Schizophrenia is treatable, but not curable. Like addiction,

schizophrenia can go into long remissions if scrupulously managed. Treating schizophrenia takes effort, on the part of the client and the treatment system.

People coping with schizophrenia may have some or all of the following positive symptoms:

Hallucinations: Auditory hallucinations, called "voices," are the most common. Auditory hallucinations that tell people what to do are called "command hallucinations." Frequently, hallucinations are voices that torment the patient, sometimes directly, and sometimes by talking to other hallucinations.

How bad can these hallucinations be?

Imagine the most critical person you ever met being with you from the moment you wake up and having full access to your thoughts and memories, including the most embarrassing and shameful things you have ever done.

The problem with these voices is that they sound very real. Some clients can point to where in the space around them the voices originate. The voices develop personas, and many clients name these hallucinations.

Visual hallucinations are most often the result of substance abuse, but are also experienced with schizophrenia. Tactile hallucinations also most often result from substance abuse and withdrawal, but can be part of schizophrenia. Olfactory and gustatory (taste) are less common. In rare instances they can be caused by a brain tumor. If your client complains of foul smells or tastes, you would be wise to refer him or her for a neurological consult.

Delusions: There are many types of delusions. The most common are persecutory/paranoid delusions. Someone suffering from paranoid delusions may believe the neighbors are spying on her, the TV is watching her every move, and her phone is tapped.

Delusions of grandeur are false beliefs that one has special abilities. Grandiose delusions involve one's relative importance, wealth, or

connections. For example, a man who believed he was a descendent of a famous European banking family, insisted he could add huge numbers in his head. He was convinced once he confronted his rich 'relatives,' he would be given his rightful inheritance. He predicted his talent with numbers would enable him to streamline the banking industry here and abroad.

Delusions have four notable components.

- First they have to be false. If you believe you are the world's best golfer, and your name happens to be Tiger Woods, it's not a delusion.

- Delusions have to go against beliefs commonly held in your culture. Believing you have a special relationship with a deity is not a delusion in a Christian culture. Believing you are a deity would be considered delusional in most of North America, but not in other parts of the world.

- There is also a question of degree with delusions. If the tennis player ranked #2 in the world believes she really is the best that would not be considered a delusion. If the 524th ranked player believes a computer error has robbed her of her #1 ranking, she is probably delusional.

- Finally, delusions do not yield to logic and contradictory evidence. That is why you never argue delusions – agree to disagree instead.

People coping with schizophrenia often experience disordered thinking.

Thought Disorder: Schizophrenia can be very frustrating because of the way it disrupts one's thinking. People coping with schizophrenia put up with disorganized thinking, i.e. the inability to organize one's thoughts into coherent sentences. They suffer from thought blocking, where whatever thoughts they have seem to vanish. Others experience thought insertion, the feeling that the thoughts in their head were put there by someone else.

Knight's Logic is characterized by faulty conclusions drawn from illogical connections, e.g.: Socrates was a man, I am a man, therefore I am Socrates.

Echolalia is repeating words or sounds one hears. Early in life it aids in language development, but can later signal autism in children or neurological disorders in adults.

Loose associations are marked by ideas only marginally connected. "Let me fish this out of my pocket. I like to fish the river. The river is flooding."

Flight of ideas is marked by jumping from one topic to the another with no logical connection. "I like toast. Men walked on the moon. Leopards are really big cats."

Strange/Abnormal Motor Behavior: Inappropriate smiling/laughter, staring, grimacing, talking to oneself, responding to hallucinations, strange and often repetitive movements.

People with schizophrenia may experience negative symptoms.

Many people coping with schizophrenia learn to hide positive symptoms, e.g. not talking back to voices in public. They only symptoms noticeable to others are negative symptoms. Unfortunately, these symptoms look a lot like depression, which can lead to misdiagnosis and ineffective treatment. The term "negative symptoms" can include

- flat affect
- lack of focus
- anhedonia
- paucity of speech
- poor hygiene
- Lack of energy

Schizophrenia is not:

Most people experience the "blues," and therefore depression does not seem alien to them. Psychotic symptoms on the other hand, seem very strange to people who have not experienced them personally. (They seem

very strange and frightening to people who have experienced them.) Because they are so frightening and alien, people often attribute psychotic symptoms to phenomenon more familiar. They may do so in a conscious or unconscious attempt to manage their fear.

Your job as the clinician is to help the client and the family understand that mislabeling schizophrenia is not helpful. Common misconceptions you may encounter include:

- Demonic possession: There are many cultural and historical reasons people believe schizophrenia is due to supernatural forces. Point out:
    - Anti-psychotics often rid people of psychotic symptoms. Either the Devil fears Olanzapine, or these symptoms are due to an imbalance of brain chemicals.
    - Stimuli that seem to be external can be manufactured internally.

- An overactive imagination: People with vivid imaginations still know the difference between the real world and fantasy. J.R.R. Tolkien for example, wrote in fantastic detail about middle earth, but he lived an otherwise ordinary life in England.
- Laziness: Lazy people still do the things they find pleasurable, e.g. watching TV. People coping with schizophrenia often lack the energy to pursue any activity. They may appear depressed, but when asked will report no depressed mood.
- Substance abuse: Substance abuse and schizophrenia are closely linked. About 55% of people coping with schizophrenia will become addicted. Substance abuse is often the catalyst to someone's first psychotic episode. But:
    - People who never touch alcohol and other drugs experience psychotic symptoms.
    - People who abuse alcohol and other drugs don't typically experience psychotic symptoms.

- Multiple personalities: Schizophrenia and multiple personality disorder are two very different illnesses.
    - People coping with schizophrenia have one personality that may not completely grasp reality. Schizophrenia is a brain disease that is inherited, and triggered by stress.
    - Multiple personality disorder is the shattering of a personality into two or more components. It is caused by extreme stress, usually childhood abuse.
- The result of poor parenting. There is no such thing as a "schizophrenogenic mother." The old theory that mixed messages from such a mother has been discarded.

Maybe your loved ones really are driving you crazy

Shared psychotic disorder, *folie a deux*, happens when a healthy person adopts the delusions of the mentally ill people around him or her, especially when the formally healthy person is isolated with the delusional person. The cure for this disorder is contact with people who don't share the delusion.

DSM-V Criteria

A. Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be 1, 2, or 3:

1. Delusions
2. Hallucinations
3. Disorganized speech (e.g., frequent derailment or incoherence)
4. Grossly disorganized or catatonic behavior
5. Negative symptoms, (i.e., diminished emotional expression or avolition)

B. Once the symptoms manifest, most of the time the person functions at a much lower level in an important aspect, e.g. at work, interpersonally, and self-care. Or, a child or adolescent fails to develop in these areas because of the illness.

C. Symptoms persist for at least 6 months, including a month of positive symptoms. (Less with successful treatment.)

D. You've ruled out schizoaffective disorder and depressive or bipolar with psychotic features.

E. Symptoms are not due to substance use/abuse.

F. You can only add schizophrenia to an existing diagnosis of autism spectrum disorder/communication if prominent delusions or hallucinations, in addition to the other required symptoms of schizophrenia, also are present for at least 1 month (or less if successfully treated).

Specify if:

- First episode, currently in acute episode
- First episode, currently in partial remission
- First episode, currently in full remission
- Multiple episodes, currently in acute episode
- Multiple episodes, currently in partial remission
- Multiple episodes, currently in full remission
- Continuous
- Unspecified
- With catatonia
- Current severity

  "Severity is rated by a quantitative assessment of the primary symptoms of psychosis, including delusions, hallucinations, disorganized speech, abnormal psychomotor behavior, and negative symptoms. Each of these symptoms may be rated for its current severity (most severe in the last 7 days) on a 5-point scale ranging from 0 (not present) to 4 (present/severe)." APA (2013, pp. 99–100).

Types of Schizophrenia

Paranoid Type

This is the most common type of schizophrenia. People suffering from this disorder experience pronounced delusions and hallucinations. Usually, there is a theme to their delusions. Auditory hallucinations, including command hallucinations are common.

Disorganized Type

People coping with this disorder have flat or inappropriate affect, disorganized speech The characteristics of this type of schizophrenia are disorganized speech, and flat or inappropriate affect. People with this type of schizophrenia have difficulty organizing responses, have trouble formulating, let alone reaching goals. They are often inappropriately silly.

Catatonic Type

Results when schizophrenia goes untreated. This type is rare today, but not unheard of. A brief description follows:

> "They may assume a rigid, uncomfortable looking posture and then not move for hours or days, resisting efforts to move them. Catatonic patients may also display 'waxy flexibility', meaning that they allow themselves to be moved into new positions, but do not move on their own. Most of the time, this is not an act or a show but rather a genuine and unpremeditated symptom of the illness that patients cannot help."
>
> *http://mentalhelp.net/poc/view_doc.php?type=doc&id=8810&cn=7*

Undifferentiated Type

They have the symptoms of schizophrenia, but none so much that they meet the criteria for paranoid, disorganized, or catatonic types.

Residual Type

Patients who have had prior one or more psychotic episodes but only mild symptoms now, can be diagnosed with schizophrenia, residual type.

Other Related Disorders

- Schizoid Personality Disorder
- Schizotypal Personality Disorders
- Brief Psychotic Disorder
- Shared Psychotic Disorder
- Psychosis Due to a Medical Condition
- Substance-Induced Psychotic Disorder
- Delusional Disorder
- Schizoaffective Disorder

Substance Use Disorders

According to SAMHA TIP 42 "Compared with the general population, people with severe psychotic disorders have

- 4 times greater risk of heavy alcohol use,
- 3.5 times the risk of heavy cannabis use,
- 4.6 times the risk of recreational drug use (Hartz et al., 2014)."

TIP 42 points out that people coping with schizophrenia and other psychotic disorders who misuse substances die sooner than cohorts. They cite self-destructive and violent behaviors, victimization, suicide, homelessness, unemployment, legal difficulties, non-adherence to medication regimens, and unstable social relationships as contributing factors. (Bennett, Bradshaw, & Catalano, 2017; Trudeau et al., 2018; and Werner & Covenas, 2017).

Quick Review: DSM-V Criteria

1. Using more and/or over a longer period than intended.

2. Failing in efforts to cut down.

3. A great deal of time spent getting, using, and recovering from using.

4. Strong cravings, urge/desire to use.

5. Not meeting responsibilities because of substance use.

6. Using despite persistent or recurrent social/interpersonal problem caused or exacerbated by substance use

7. Giving up/reducing important social, occupational or recreational activities because of substance use.

8. Recurrent substance use in physically hazardous situations.

9. Continued use despite having a persistent or recurrent physical or psychological problem caused/made worse by the substance.

10. Tolerance, as defined by either using more, or getting less effect from the usual amount.

11. Withdrawal, or using just to avoid withdrawal.

Interventions

Remember you are farmer – you plant seeds during lucid moments hoping they convince your client to do whatever is necessary to remain stable. Many clients will go through one psychotic episode after another before they 'seeds' take root, and your client tries to manage his or her thought disorder. Don't give up!

Don't argue delusions, reflect reality and agree to disagree. No matter how illogical and easily disproved a delusion may seem, it makes perfect sense to your client. Reflect reality, never agreeing with a delusion, not debating the merits of an unrealistic belief

Do not focus on feelings. One of the hardships imposed by schizophrenia is a disconnect from one's feelings. Many people coping with schizophrenia feel nothing emotionally, or observe their own reactions to events rather than feel one way or another about their own experiences.

Educate about your client and his or her loved one about the illness, but expect resistance. Try to see "resistance" through the eyes of the person coping with schizophrenia. Would you rather believe you were divinely chosen, or that you had a highly stigmatized brain disease?

Focus on day-to-day life skills. Try to reduce stress and stimulation as much as possible. Simplifying life can reduce the frequency and severity of psychotic symptoms. (Numerous studies have shown that schizophrenia rates are lower in stable, agrarian societies.)

Keep goals concrete and achievable. Avoid the philosophical, e.g. "Goal 1: Be a better person, and not interfere with predestined unfolding of my life." A better goal would be: "drink less than five cups of coffee each day."

What are some concrete goals you'd like to see your clients adopt?
1.
2.
3.

Help build social networks. This is for your sake as well as the client's. If you are the only person helping someone deal with schizophrenia, you are likely to be overwhelmed. Seek help wherever you can find it, using as many programs as possible. Use a representative payee whenever possible.

List symptoms that signal a possible relapse. Try to get your client to sign an agreement spelling out the path of relapse, and what steps are to be taken. For example, you could agree that if your client starts listening for special messages over the radio, he will meet with the treatment team ASAP.

Make medication compliance as easy as possible. Someone who has a thought disorder will struggle remembering what pills to take when. Help your client organize her medications, and encourage the psychiatrist to keep the medication regime as simple as possible.

Ask your higher functioning clients to keep a journal. They may be able to find a patter to the waxing and waning of their symptoms.

Drug screen, drug screen, drug screen. Drug screens are great tools for confronting denial.

Prepare dually diagnosed clients for AA/NA. Debrief them after meetings. Work the steps with them.

Adapt substance abuse recovery programs. Start with the slogans. Teach the client a few slogans. Simplify the meanings for each slogan, trying to be as concrete as possible.

Easy Does It

Do just what I need to do.

1._____

2._____

3._____

One day at a time.

Today I will_____

I will not _____

❑ I will take my medications as prescribed today.

Don't Pick Up the First Drink or Drug!

Hungry, Angry, Lonely, Tired

I won't let myself get too hungry, angry, lonely, or tired today. Here's my schedule:

Sometimes circumstances will seem so overwhelming you may not be able to think your way through a dangerous situation. Suppose you have cravings so bad that you think you have no choice except to get high. Your brain may be flooded with images of your favorite chemical and what you imagine it would be like to get high again. A contingency card is used for three reasons:

1) to remind you what usually happens when you get high,

2) to remind you that you have options,

3) to list people you need to reach out to when you are craving.

On the front of a 3X5 card list three reasons you quit using in the first place. List all the options you have when you crave alcohol and other drugs. Finally, in bold letters, write "I will call at least three people listed on the back."

On the back of the card list all the people you can call who understand your need to stay away from alcohol and other drugs. Include hotline numbers such as local crisis lines. If you include family and friends, make sure they understand you need treatment for your mental illness.

Contingency Cards

Use contingency cards to help clients stay focused in the face of relapse triggers. Contingency cards are a way of planning what to do in critical situations. They are a contract and a reminder. They help clients overcome that 'deer in the headlights' state that engulfs many of them when faced with the people, places, and things of their addiction.

Some clients will keep these 3X5 cards as if they were a talisman. They will hold onto them and use them repeatedly. Others will use them once and then discard them, saying "I told you this wouldn't work." Still others will never use them at all. Using the cards will help the first group, give you insight into the lack of commitment of the second and third groups.

Two other 3X5 Cards

Day Planner

On another file card list every hour you will be awake and what you will be doing to stay sober. Be careful about any time where have nothing to do.

Ten Rewards/Catastrophes

On the front of a third card, list ten rewards you have gotten, or you hope to get from recovery. On the back of the card list the ten worst things that have happened to you, or could happen to you because of substance abuse.

Commonly Prescribe Medications

Medications fall into two groups. The first is the older, 'typical' antipsychotics:

- Haldol (haloperidol)
- Loxitane (loxapine)
- Navane (thiothixene)
- Prolixin (fluphenazine)
- Thorazine (chlorpromazine)
- Trilafon (perphenazine)
- Stelazine (trifluoperazine)

Unfortunately, these medications often have side effects that lead people to discontinue taking them against medical advice. Among these side effects are tardive dyskinesia, sexual dysfunction, sedation, weight gain, and constipation.

Newer 'atypical' antipsychotics include:

- Risperdal (risperidone)
- Rexulti (brexpiprazole)
- Saphris (asenapine)
- Seroquel (quetiapine)
- Vraylar (cariprazine)
- Zyprexa (olanzapine)

Clorazil is used when other antipsychotics fail, or to help treat overlying suicidal ideation. Initially, Clozaril causes hypersomnia and extreme drooling. It can also cause a drop in white blood cell count known as agranulocytosis.

Despite its harsh side effects, Clozaril is often prescribed when other medications have failed.

Other side effects from atypical antipsychotics include Decreased sex drive, weight gain, diabetes, high cholesterol, drowsiness, sun sensitivity, and seizures.

DOUBLE TROUBLE MEETING FORMAT

1. Ask if there any newcomers to the group. If there are, ask group members to introduce themselves.

2. Ask for any announcements from group members pertaining to Double Trouble or the group.

3. Ask to have the *Preamble* read.

4. Ask to have *How it Works* read.

5. Ask to have the *Promises* read.

6. Have the group pick one or more topics for discussion.

7. Have group members take turns discussing the topics.

8. Use any time left over for open discussion.

9. Close with a moment of silence and/or a brief prayer.

Preamble

Double Trouble is a fellowship of men and women who share their experience, strength, and hope with each other so that they may solve their common problems and help others to recover from their particular addictions and mental problems.

Double Trouble is designed to meet the needs of those having addictive problems as well as psychiatric illnesses. We also address the problems and benefits associated with psychiatric medication. Thus we recognize that, for many, having addiction and mental illness represents double trouble.

There are no dues for Double Trouble membership. We are self-supporting through our own contributions. Double Trouble is not allied with any sect, denomination, political group, organization, or institution. Our primary goal is to maintain freedom from addictions and to maintain our well-being.

(Double Trouble Intergroup, 1991)

How it Works

Rarely have we seen a person fail who thoroughly follows our path. Those who do not recover are people who cannot or will not completely give themselves to this simple program, usually men and women who are constitutionally incapable of being honest with themselves. There are such unfortunates. They are not at fault; they seem to have been born that way. They are naturally incapable of grasping and developing a manner of living which demands rigorous honesty. Their chances are less than average. There are those too who suffer from grave emotional and mental disorders, but many of them do recover if they have the capacity to be honest.

Our stories disclose in a general way what we used to be like, what happened, and what we are like now. If you have decided you want what we have and are willing to go to any length to get it -- then you are ready to take certain steps.

At some of these balked. We thought we could find an easier softer way. But we could not. With all the earnestness at our command, we beg of you to be fearless and thorough from the very start. Some of us tried to hold onto our old ideas and the result was nil until we let go absolutely.

Remember that we deal with alcohol -- cunning, baffling, powerful! Without help it is too much for us. But there is One who has all power -- that one is God. May you find Him now!

Half measures availed us nothing. We stood at the turning point. We asked His protection and care with complete abandon.

Here are the steps we took, which are suggested as a program of recovery:

(ASK TO HAVE THE TWELVE STEPS READ.)

Many of us exclaimed, "What an order! I can't go through with it." Do not be discouraged. No one among us has been able to maintain anything like perfect adherence to these principles. We are not saints. The point is, that we are willing to grow along spiritual lines. The principles we have set down are guides to progress. We claim spiritual progress rather than spiritual perfection.

Our description to the alcoholic, the chapter to the agnostic, and our own personal adventures before and after make clear three pertinent ideas:

(a) That we were alcoholic and could not manage our own lives.

(b) That probably no human power could have relieved our alcoholism.

(c) That God could and would if He were sought.

(*Alcoholics Anonymous*, pp. 58-60)

Twelve Steps of Double Trouble

1. Admitted to ourselves that our lives were out of control because of our mental illnesses and addiction.

2. Came to trust that the group, mental health/addiction professionals, the Higher Power, and/or God would help us regain control.

3. Made a decision to accept and agree to follow the Double Trouble program, which may include seeing a therapist, taking appropriate medication, if needed, attending self-help groups, and finding a sponsor.

4. Made a searching and fearless moral inventory of ourselves.

5. Came to admit to ourselves, another individual, God and/or the Higher Power the exact nature of our problems.

6. Once we came to understand our problems we worked the Double Trouble program to improve the quality of our lives.

7. We continue to seek help from appropriate self-help groups, professionals, and/or the Higher Power.

8. Made a list of all persons we had harmed and became willing to make amends to them all.

9. Made direct amends to such people wherever possible, except when to do so would injure them or others.

10. Continued to take personal inventory and when we were wrong promptly admitted it.

11. Sought control of our lives by continued visits to therapists, counselors, doctors, etc. and by adherence to medication guidelines, which assist us in surrendering to a spiritual way of life.

12. Being now on the road to recovery, we try to apply these principles in our lives and attempt to spread the program to others with addictions and mental illnesses. (Double Trouble Intergroup, 1991)

Promises

If we are painstaking about this phase of our development, we will be amazed before we are half through. We are going to know a new freedom and a new happiness. We will not regret the past nor wish to shut the door on it. We will comprehend the word serenity and we will know peace. No matter how far down the scale we have gone, we will see how our experience can benefit others. That feeling of uselessness and self-pity will disappear. We will lose interest in selfish things and gain interest in our fellows. Self-seeking will slip away. Our whole attitude and outlook upon life will change. Fear of people and of economic insecurity will leave us. We will intuitively know how to handle situations which used to baffle us. We will suddenly realize that God is doing for us what we could not do for ourselves.

(*Alcoholics Anonymous,* pp. 83-84.)

Support Together for Emotional and Mental Serenity and Sobriety (STEMMS)

(1) I admit and accept my mental illness is separate from my chemical dependency and that I have a dual illness.

(2) As a result of this acceptance I am willing to accept help for my illness

(3) As a result of this willingness, I came to believe that with help and understanding, recovery is possible.

(4) As a result of this belief, I accept the fact that medical management must play a large part in my recovery program.

(5) As a part of this recovery program, I accept the fact that I must maintain an alcohol and drug-free* lifestyle.

(6) In following these steps throughout my life, I will reach my goals and help others to begin the recovery process.

*"Drug" refers to recreational chemicals, not prescribed medications.