Understanding and Responding to Common Symptoms of Schizophrenia

Source: http://www.schizophrenia.com

Each case of schizophrenia will have a unique combination (in terms of severity, duration, prominence, etc) of positive, negative, and other symptoms. Related conditions such as depression, anxiety disorders, and mood-swings are not uncommon either.

One schizophrenia.com member diagnosed with the disease described his symptom experience with the following words:

The things that I have that I wish I didn't have are hallucinations, delusions, and loss of thought control.
The things that I don't have that I wish I did have are curiosity, motivation, and sex interest.
The above is pretty much the way schizophrenia goes.

Many family members struggle to understand what their loved one is dealing with, and want to relate and empathize with their illness experience. One of the best ways to understand what is behind some of the common symptoms of schizophrenia is to educate yourself as much as you can. Surviving Schizophrenia (Dr. E. Fuller Torrey) and I Am Not Sick! I Don't Need Help! (Xavier Amados) are two books repeatedly recommended by veteran families on schizophrenia.com for people searching to better understand the experience of mental illness. Other recommended books, videos, and websites can be found on the schizophrenia.com website.

The following section, written by a schizophrenia.com member, explains the various symptoms someone with schizophrenia may have and how best to respond.

Hallucinations

Hallucinations are false perceptions, inaccuracies that affect our senses and cause us to hear, see, taste, touch or smell what others do not. In the acute phases of schizophrenia, patients are likely to insist they are hearing voices that no one else can hear. Sometimes they hear noises, clicks or non-word sounds. On occasion they are disturbed by seeing, smelling or feeling things that others do not.

Descriptions of these perceptions differ. Sometimes they are experienced as very forceful and apparently important thoughts. Frequently they seem to come from outside the self and are heard as conversations between other people, or commands, or compliments (or insults) addressed to the person. Sometimes the voices are reassuring, at other times menacing. Often the remarks heard are not addressed to the person but seem to be concerned with them in an unclear (but perhaps derogatory) way. Individuals who experience this describe it "like a tape playing in my

head". The experience is so real that many schizophrenics are convinced someone has implanted a broadcasting device in their bodies. Or they come to believe in a supernatural explanation for the strange sensation. It is so real to the person that it cannot be dismissed as imagination. During periods of convalescence, patients are in control of their "voices"; they can often summon and dismiss them at will. Or they may learn to ignore them, or treat them as benign accompaniments of everyday living. But during acute periods, the hallucinations, usually the same ones over and over, take control and the patient feels victimized, powerless, at the mercy of a "foreign presence".

Patients themselves, and those close to them, must recognize hallucinations as symptoms of illness. Discussions about their objective truth or plausibility are not valuable. The experience is true and very vivid and has to be accepted as such. Attempts to "set the person straight" result in resistance, tension, and bad feelings.

It is, however, helpful to clarify that others do not hear, see, smell, or feel what the patient is experiencing. This helps to identify it as a special experience of the patient whether he can or can not accept it as a symptom of the illness. At least everyone can agree that something is happening.

Hallucinations tend to diminish as a result of a lessening of stress and an increase of antipsychotic medication. Keeping busy is important as it provides helpful distraction. Competing stimuli can sometimes "drown out" the voices. Encourage the patient to discuss when the hallucinations occur and what they say with his therapist. This can clarify the nature of the stress that tends to bring them on.

Another useful strategy is to point out to the patient that he has some control over the hallucinations. Often, unconsciously, the patient has developed the habit of listening for his voices, as if he were a passive recipient. Directing his mind to other interests, and helping him recognize he need not wait for incoming voices, can be surprisingly effective.

These are techniques that the patient develops for himself over time and that require a fair amount of trial and error. Encouragement to persevere, not to give up, to discuss things with the therapist and reassurance that the family and close friends understand, are important. Constant talking about hallucinations can be exasperating but it is understandable that the patient is preoccupied with such extraordinary events. Chronic hallucinations must be accepted as part of everyday life and are not usually sufficient reason to excuse participation in activities or household chores.

Delusions

Delusions are false beliefs or misinterpretations of events and their significance. For instance, a person may get accidentally bumped in the subway and may conclude that this is a Government plot to harass him. He may be awakened by noise from his neighbor’s apartment and may decide

this is a deliberate attempt to interrupt his sleep. Everyone tends to personalize and misinterpret events, especially during times of stress or fatigue. What is characteristic of the schizophrenic, however, especially during an acute period, is that the conviction is fixed and alternate explanations for the events experienced are not even considered. Usually attempts at reasoning or discussion about possible other meanings of the bumping or the noise in the night can only lead to the further conviction that the reasoner must be in on the plot, too. Arguing with a delusion only leads to further mistrust or anger. The beliefs are tenaciously held, against all reason, and they are characteristically not shared beliefs. They are held only by the person himself and by no one else.

Families and friends must first realize that delusions are a result of illness and not stubbornness or stupidity. Although fixed delusions can be irritating, emotional reactions should be avoided, as should taunts or threats. There is almost always something about the delusional belief that can be empathized with. For instance: "Getting bumped in subways is very annoying. It must make you feel as if no on cares, no one pays attention, that you're not important enough to get an apology or an 'excuse me'." (Presumably the belief that one is at the center of a government plot must derive, at least in part, from the fear that one is really very unimportant or worthless.) Or: "Getting awakened at night is terrible. It's so hard to get back to sleep later. It saps you of all your strength. If you feel your neighbor is not your friend, it is important to be strong and healthy." (This kind of reasoning may persuade a person to seek medical attention and/or an increase in his medicine in order to be strong and fend off annoyances by others. It works better than saying, "You're deluded, you had better see the psychiatrist."

Another approach is to help cut down the stimuli that lead to delusion formation. If crowded subways bring on experiences that lead to persecutory ideas, avoid them. An emergence of delusional ideas, whether persecutory or grandiose (thinking one is special) usually means there is too much activity or emotion, perhaps too many people around. Example: "I think I am Jesus." Unhelpful response: "That's totally irrational. You're crazy." Helpful Response: "I guess you feel really special and different today. Maybe it's all the excitement around here. Let's try a very low key routine for the next few days." When well on medication, if the person persists in talking about left over delusions, a helpful response would be, "That's how you see things. I have explained that I don't agree--we will have to agree to disagree." (This acknowledges his view yet stops pointless discussion.)

Talking Nonsense

This generally occurs when a person is in the active phase of his illness. It can re-emerge sometimes when medications are too low or stress is too high. What the patient says becomes incomprehensible to those around him either because sentences are unconnected to each other, or else because there seems to be no point to the stories told, or else because topics seem to switch with great frequency. Words may take on special meanings in schizophrenia either because they trigger private associations or because attention is paid to individual sounds rather than hole words. For instance "psychiatry" may sound like "sigh Kaya tree" and the topic may switch

suddenly from a discussion of psychiatry to a discussion about mystical trees. Certain words may be avoided because they sound harsh or evil. Sometimes intonations are changed for similar reasons. Sometimes language is used as an incantation to ward off threats. Difficulty making sense to others is a symptom of the acute phase of the illness. It is almost impossible to communicate with patients when they are in this phase and it is very frustrating to family.

Try to communicate non-verbally. Sometimes communication through writing works, as thoughts tend to be more organized in writing. Do not force yourself to listen and understand; it will usually lead to headache and irritation. When talking to others, however, do not speak as if the patient were absent. Do not tease or mimic him. Most people use one side of their brain for language and the other side for art or music or movement. If the language side is disturbed, it might be a good idea to concentrate on the other side and encourage patients to draw, sing, or play an instrument, to exercise or dance. These are other ways of communicating which might prove to be effective.

Like other positive symptoms, thought disturbances respond to a reduction of stress and an increase in antipsychotic medication.

Preoccupations

These are fixed ideas, not necessarily false (like delusions) but overvalued. They take on extraordinary importance and take up an inordinate amount of thought time. One idea often returns and returns. Frequently it is a worry about doing the right thing or doing it well or in time. Characteristically, the worry grows and becomes unrealistic. A common sequence of events is for the worry to take up so much of a person's time that the "right thing" does not get done and its not being done is then attributed to the bad motives of others. Or it may be rationalized as God's wish. OR, frequently, the person may decide he's physically unable to carry out the task.

Example of unrealistic explanation: "I can't get up because I'm paralyzed." "I'm supposed to stay in bed today because it's the Lord's day." "If I get up, I'll get hurt." These kinds of explanations sound odd to others but to the schizophrenic they seem warranted. They do not understand why others see them merely as "excuses". To them they explain the facts better than any other explanation. Sometimes these preoccupations have a mystifying character to them. They seem to require puzzling over and decoding.

The schizophrenic spends much time in this kind of puzzling activity and that is why he thinks he has solved mysteries that others haven't, since they spent no time at it. When lost in thought, schizophrenics do not want to be distracted. They feel they have important work to do to try and come to the bottom of the puzzle and they do not appreciate offers of conversation or shared activities at those times. Preoccupations are usually seen in the active phase of the illness but may continue into the convalescent stage. They may take the form of daydreaming.

They must not be allowed to control the life of the patient or the life of those around him. Distraction is helpful as is a structure or daily routine that does not permit too much time for sitting and thinking. The necessities of life: sleep, good food, exercise, fresh air, cleanliness, health and social interactions must be maintained. Preoccupations must not be allowed to interfere. Increased meds may be required.

Violent or Aggressive Behavior

This is not really a symptom of schizophrenia, but when it does occur, it tends to occur in conjunction with hallucinations, delusions, preoccupations and jumbled thoughts. It, too, is triggered by stress and abates when antipsychotic medication is taken in appropriate amounts. Violent behavior is much more frequent in mental disorders that have nothing in common with schizophrenia. It is described here mainly because patients and families are so frightened of it and it leads to so much dread and worry. It is most common in young men. It can be precipitated by psychological or chemical stimulants.

Violence against others is often a result of misinterpretation of their intent and a resultant feeling of being cornered. A person in the acute stage of schizophrenia may exaggerate other's irritation and misread it as fury. He may see ridicule in what is meant as jest. He senses himself in danger when he is not and may strike out under those circumstances. Violence against the self is more common and is discussed under depression. In an attempt to prevent violence, try to avoid blame, ridicule, confrontation, teasing, or insult.

Allow your schizophrenic relative privacy and psychological distance. Should violence erupt, however, do not allow yourself to be intimidated by it. Take whatever measures are necessary for the safety of everyone concerned. This may require firmness or help from friends and neighbors. It may require summoning the police. Let the patient's therapist know if violence erupts at home. Ask the therapist for pointers on how to help the patient develop self-control. In addition, always maintain an up-to-date list of helpful community resources

You may find through experience that the patient responds best to certain friends or family members when he is frightened, distressed and potentially violent. Call upon these people in times of crisis. The best way to prevent dangerous moments is to anticipate them and be prepared with an effective plan of action, should they occur.

Although violence is not common is schizophrenia, it may become a pattern with some schizophrenics. If so, discuss appropriate living arrangements and appropriate anticipatory and preventive measures with the therapist.

Restlessness

Restlessness, anxiety, tension and agitation are words describing similar states. None of these are positive symptoms of schizophrenia but, like aggressive behavior, they tend to occur in

conjunction with the positive symptoms. They may result from fear and apprehension, as a response to the frightening aspects of hallucinations and delusions. If this is so, they require quiet, calm reassurance. Patients who are so anxious about what is happening to them need to have someone near to provide explanation and stability. The reduction of stress and the introduction of medicines will reduce anxiety as well.

Restlessness that begins after the patient is started on medication may be a secondary effect of the drugs. This kind of restlessness usually appears as a shaking of the legs and a need to pace the floor. Patients may be seen to move from one foot to the other or, when sitting, shake their legs up and down on the ball of the foot. At the dinner table, this constant motion may cause the whole table to shake.

Another commonly observed movement is tremor. This is a rhythmic contraction of muscles, usually seen in the extremities. The tremor is usually not particularly bothersome to the patient unless he plays the piano or uses the typewriter. The restlessness, however, is very uncomfortable. The patient has some control over it, can stop it for a few moments at a time but it comes back the instant he lets his attention waiver. It can be quite agonizing for some patients and needs to be reported to the doctor who can change the dose of antipsychotic drugs or add side-effect medicine which will make this restlessness disappear. The same procedures will reduce the tremor that is secondary to the medicine.

After many years of antipsychotic drug use, some patients develop other kinds of movement disorders, usually jerky movements around the mouth and extremities. These are not usually uncomfortable but can be unsightly. The prescribing doctor must be made aware of them and will adjust the dose of the drugs accordingly. These movements are more difficult to control. They may, in fact, become worse for a time after the drug dose is lowered. In most cases the movements gradually wane if the drugs can be discontinued for a prolonged period but that is sometimes risky because the patient may become acutely ill again.

Restlessness and tension, whether psychological or secondary to drugs, is made worse by stimulants (coffee, tea, cola drinks, chocolate, cold tablets). Sedative medication helps but should only be used with the advice of the prescribing doctor. Understanding helps. Do not criticize the patient for pacing. Instead, try accompanying him for a walk, encourage exercise, jogging and bicycle riding. If the pacing becomes unbearable in the house, suggest other areas, outside the home, where the patient might walk about without disturbing others.

More thoughts on coping with common symptoms of schizophrenia – compiled from schizophrenia.com members:

Delusions:

The common categories of schizophrenia delusions include persecution delusions (feelings that

you are being spied on, conspired against, cheated, drugged, or poisoned), jealousy delusions (a feeling without just cause that your loved on is unfaithful), and self-importance delusions (also known as delusions of grandeur - the feeling that one has a great but unrecognized ability or talent, or the belief that you are an exalted being. Sometimes these have a religious flavor to them). It's upsetting and frustrating (to put it mildly) to be the victim of such delusions, especially when your only goal is to love and support your ill relative; however, the closest family members and relatives are often the first targets of this and other hurtful behavior.

Due to the disease, a person with schizophrenia often can't think or reason rationally. Explaining logically why the accusation can't be true won't work, and will ultimately be draining and frustrating, due to this fact. Try talking directly with the psychiatrist about the delusional symptoms - the current medication may not be adequate to control them. Also, be aware that delusions can take weeks or months to fade, even if the person is medication compliant.

Voices/Hallucinations:

The experience of hearing voices or seeing visions are as real as anything else to the person with schizophrenia. Like delusions, it usually does no good to try and refute them. On the other hand, it's also not a good idea to just "go along with them," which ultimately doesn't help anyone. Family members who have tried to support their loved ones in the search for "them", or tried to keep "them" out with elaborate security devices, have only ended up frustrated. There are no lock to keep out invaders in your mind; no matter how hard you search, "they" will always be there.

One thing you can do is to simply acknowledge that your loved one is experiencing something unique to them - you can say "I'm sorry it's bothering you" or "why don't you tell the doctor about it," which doesn't ignore their experience but also doesn't give false evidence that others can see or hear these things. Sometimes the best thing that family members can do is encourage the ill person to write down/remember their experiences, and discuss them with their doctor.

Anger/Irritability/Mood Swings:

Try to steel yourself internally; recognize that this is the illness talking, not the person. Some people have tried a detached, non-reaction to their relatives' anger; others have waited for the episode to pass (or calmed themselves down by going for a short walk) and then communicated how much they were hurt by that behavior. If mood swings are severe, a mood stabilizer might be beneficial. Talk to the doctor about possible options.

Violence or Abuse:

Call 911 or the emergency room and get help. Your first obligation is to yourself, your own safety, and the safety of other family members. If you truly feel that you are in danger, if you have ever been hurt or seriously threatened, convince the authorities any way you can of the seriousness of your situation. Do not accept a diagnosis of schizophrenia (or anything else) as an

excuse for this kind of harmful behavior. The disease may affect a person's thoughts and perceptions, but abuse is still abuse. What you need is not just action for domestic abuse, but an involuntary commitment to a treatment center and a psych evaluation.

Suicidal Thoughts and Tendencies:

Suicide is a real and tragic consequence for many schizophrenia patients - about 40% will make at least on attempt, and between 10% and 15% actually succeed in killing themselves. A major factor is depression, which is a common companion of schizophrenia disorders. If your loved one seems depressed, you can ask the psychiatrist about the possibility of taking an antidepressent medication in addition to antipsychotics.

Family and friends can help by being very aware of depressive and suicidal tendencies, especially in those individuals recently recovering from an episode or a relapse. Know the places you can call on quickly for help - find the crisis centers in your area and know the services they provide. Contact a local NAMI chapter (http://www.nami.org) or ask a hospital for references. You can always call 911 in an emergency.

Apathy/lack of motivation:

Although many people believe that these sorts of behaviors are due to medication side effects or a lack of will on the part of the patient, most often they are simply another symptom of the disorder. (Excessive apathy - i.e. sleeping all day - may be a medication side effect that is compounding the disease symptom. Talk to the psychiatrist about the possibility of adjusting meds). The current generation of antipsychotic medications are much better at treating the positive (psychotic) symptoms, but have not made major headway against the more cognitive/behavioral negative symptoms. When you consider that schizophrenia severely disorders the way an affected individual senses and perceives the world, it's easier to see why that person might stridently avoid any sort of stimulation, even just going out to a mall or riding on a bus. One schizophrenia.com member suggested a comparable situation: two guys are climbing a mountain, but one is carrying a backpack full of tennis balls and one is carrying a backpack full of rocks. It may seem that the one is lazier for not going at the same pace, but he's got a heavier burden to carry.

One of the best ways to help is to actively pay attention to your loved one's responses. If they respond positively to your overtures or your attempts at conversation, by all means continue. If you feel rejected or rebuffed, remember that it is most likely a protective mechanism against too much sensory overload; stop and try again later. Establishing small routines or rituals can be very helpful, and a good source of shared time.

Emotional flatness or social withdrawal:

Many family members are hurt by a feeling that their loved one is emotionally withdrawing into

themselves, and that they just don't relate or interact anymore to the people around them. Emotional withdrawal/flatness is one of the negative symptoms of schizophrenia. Some of the newer antipsychotic medications can help alleviate these negative symptoms; however, they are not 100% successful, and the response is different from every patient.

One member described his emotional responses in the following way: "As a schizophrenic I will tell you that my emotions are not just hard for the world to access, sometimes it is also hard for me to access my own emotions."

Schizophrenia patients often have trouble with common social cues that most people do and recognize without thinking - body language, eye-contact, gesturing, varying the tone of the voice, etc. They don't realize they are missing these basic cues, and their absence can make the person seem much more withdrawn and cold than they intend to be.

Experienced members suggest finding other emotional outlets for yourself - make time to go out with other friends or just you, and spend another time with your loved one. Another thing you can do is specifically bring to the person's attention the fact that you want to share something with them. Sometimes you may have to simply, lovingly, request their love and attention.