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# Schizophrenia

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## DESCRIPTION OF SCHIZOPHRENIA

- Schizophrenia is characterized by delusions, hallucinations (most commonly auditory), disorganized thinking or speech, disorganized or abnormal motor behavior, and negative symptoms (e.g., flat affect; American Psychiatric Association [APA], 2013).
- Others conceptualize schizophrenia as involving disturbances in thinking, perception, affect, and social behavior (World Health Organization [WHO], 2010).
- Schizophrenia is typically a life-long illness with symptoms that present in a prodromal phase between the ages of 16 and 30 (National Institute of Mental Health [NIMH], 2009). The disorder is usually formally diagnosed in early adulthood and treatment is typically required, in varying degrees, throughout an individual's life.

Resources:
National Alliance for Mental Illness (NAMI) Schizophrenia: Public Attitudes, Personal Needs
http://www.nami.org/SchizophreniaSurvey/SchizeExecSummary.pdf

WHO: International Statistical Classification of Diseases and Related Health Problems
http://apps.who.int/classifications/icd10/browse/2010/en#/F20-F29

### Prevalence

- The estimated prevalence rate for schizophrenia is 1% of the population in Western, developed countries (Myers, 2011; National Institute of Mental Health [NIMH], 2009). However, the global prevalence is estimated at 24 million, of which 90% is untreated in developing countries (WHO, 2014).
- The average age of onset is mid-20s for men and late-20s for women (WHO, 1997). The ratio of prevalence for men to women is 1.4:1 (McGrath & Susser, 2009), indicating that men are slightly more likely to develop schizophrenia than women.
- Socio-economic status (SES) and race/ethnicity also affect the prevalence of schizophrenia. Kirkbride et al. (2008) suggested the increased rates of schizophrenia diagnoses in African American and non-dominant ethnic groups may be explained by lower SES. However, Bresnahan et al. (2007) reported that after adjusting for SES, African Americans were three times more likely to be diagnosed with schizophrenia than Caucasian counterparts. Although culture can serve as an important role in treatment as a protective factor, it is critical for counselors to understand how cultural misattributions may contribute to over-diagnosis of psychotic disorders among non-dominant social and cultural groups.

Resources:
National Institutes of Health. Epidemiology of Schizophrenia: Review of Findings and Myths
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2727721/pdf/nihms30677.pdf

Medical Journal of Australia: New Directions in the Epidemiology of Schizophrenia https://www.mja.com.au/journal/2009/190/4/new-directions-epidemiology-schizophrenia

## IDENTIFICATION/ASSESMENT STRATEGIES

Due to the nature and scope of schizophrenia, assessment of symptoms might rely disproportionately on third-party sources, such as a family member. However, counselors may prefer to include clients in the assessment process. Therefore, the first assessment included is a client-rated measure of the experience of psychosis. Also, outlined is a clinician-rated assessment. A combination of client-report, third-party report, and clinician report provides a holistic assessment of how individuals experience schizophrenia. Furthermore, the measures outlined allow counselors to track progress across the course of treatment.

### Subjective Experiences of Psychosis Scale

The Subjective Experiences of Psychosis Scale (SEPS; Haddock, Wood, Watts, Dunn, Morrison, & Price, 2011) measures self-perception of how psychosis impacts an individual. The 41-item measure is divided into three subscales: impact of experience, impact of support, and dimensions of psychotic experiences. The impact of experience subscale (29 items) includes items associated with how an individual functions in daily life, such as isolation, socialization, and mood. The impact of support subscale (5 items) assesses support from people, religion, and medication. The dimensions of psychotic experiences subscale (6 items) includes self-perceptions of how an individual experiences his or her psychosis. Individuals self-rate their responses on a 5-point Likert scale ranging from *not at all* to *very much.* Haddock et al. (2011) reported a unique feature of the measure is that each item is rated in regards to positive impact and negative impact. For example, an item such as, *ability to socialize*, is rated for both positive impact on ability to socialize and negative impact on ability to socialize. Furthermore, at the end of the survey, individuals report a qualitative response assessing if completing the measure elicited any distress. Haddock et al. (2011) reported good reliability because Cronbach's alphas of subscale scores ranged from .66-.95. Furthermore, researchers conducted factor analysis to establish discriminant and convergent validity (Haddock et al., 2011). Counselors may use the SEPS to measure outcomes throughout treatment because Haddock et al. (2011) reported sensitivity to change. The measure is free and does not require permission for use.

### Clinician-Rated Dimensions of Psychosis Symptom Severity

The Clinician-Rated Dimensions of Psychosis Symptom Severity (APA, 2013) assesses eight symptoms related to psychosis. Counselors may use this assessment to determine the presence and severity of hallucinations, delusions, disorganized speech, abnormal psychomotor behavior, negative symptoms, impaired cognition, depression, and mania. Each of the 8-items corresponds to the eight domains or symptoms of psychosis. Counselors rate the client's symptoms from the past 7 days on a 5-point scale in which *0 = not present, 1 = equivocal, 2 = mildly present, 3 = moderately present,* and *4 = severely present.* Scores can be tracked over time, and higher scores indicate problem areas for further consideration as it relates to treatment implications. APA created this measure in association with the *Diagnostic and Statistical Manual of Mental Disorders Fifth Edition* (DSM-5; APA, 2013). The measure is free and does not require permission to use. The publishers accept counselor and researcher feedback on the use of the measure. Currently, the publishers do not report psychometric properties of the measure.

Resource:
Online Assessment Measures
http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

## INTERVENTION STRATEGIES

Counselors working with individuals diagnosed with schizophrenia are typically part of a multidisciplinary treatment team, which may include a psychiatrist and case manager (Barrio Minton & Prosek, 2014). Treatment for schizophrenia includes a combination of psychopharmacological and psychosocial interventions (Rössler, 2011). Counselors may provide services to clients with schizophrenia during short-term acute care or long-term community-based care, therefore intervention strategies may need to be adopted for congruency with setting (Barrio Minton & Prosek, 2014). Although psychopharmacological treatment provided by psychiatrists is important for stabilization of psychosis, counselors can promote long-term treatment success using evidence-

based psychosocial interventions that promote coping-mechanisms and community engagement. Moreover, counselors can attune to other mental health risk factors associated with schizophrenia. For example, Schwarz and Cohen (2001) identified risk factors of suicide among those diagnosed with schizophrenia to include severe depressive symptoms, younger age, and trauma symptoms. Therefore, counselors might continually assess for crisis risk among clients diagnosed with schizophrenia.

Resource:
NAMI
http://www.nami.org/Template.cfm?Section=schizophrenia9

## Psychopharmacological Interventions

According to the *DSM-5* (APA, 2013), there is no cure for schizophrenia, therefore treatment options focus on symptom management. Antipsychotic medications have a demonstrated ability to decrease symptoms of psychosis (NIMH, 2009). Two types of antipsychotic medications are generally used to treat schizophrenia: typical and atypical. Typical antipsychotics demonstrate a decrease in positive symptoms associated with schizophrenia, such as hallucination and delusions (Schizophrenia Medications, 2013). NIMH (2012) identified chlorpromazine, haloperidol, perphenazine, and fluphenazine as common typical antipsychotics. However, typical antipsychotics do not demonstrate effectiveness in treating the negative symptoms associated with schizophrenia and tend to result in challenging side effects, such as nausea, sexual dysfunction, and dulling of the mind (Schizophrenia Medications, 2013). Atypical, or second generation, antipsychotics released in the 1990s and served as an alternative with less invasive side effects (e.g., congestion, insomnia, confusion; NIMH, 2012; Schizophrenia Medications, 2013). NIMH (2009) identified clozaril, risperidone, olanzapine, quetiapine, ziprasidone, aripiprazole, and paliperidone as common atypical antipsychotics. Although atypical side effects tend to resolve shortly after an individual begins taking the medication, significant long-term side effects exist, such as diabetes (NIMH, 2009). Individuals diagnosed with schizophrenia typically require continuous psychiatric monitoring.

Resource:
NIMH
http://www.nimh.nih.gov/health/publications/schizophrenia/schizophrenia-booket-2009.pdf

## Psychosocial Interventions

The combination of psychosocial interventions, such as counseling and family programming, combined with psychopharmacotherapy is a best practice when working with individuals experiencing psychosis (Lewis, Tarrer, & Drake, 2005). Among the psychosocial interventions discussed, some represent long-term treatments (e.g., Assertive Community Treatment), whereas others (e.g., Acceptance and Commitment Therapy) demonstrated results after a brief intervention. Counselors must remember that research studies of psychosocial interventions for individuals with schizophrenia generally included the psychosocial interventions as an adjunct service to antipsychotic medication regimens.

**Assertive community treatment.** Assertive Community Treatment, or Program Assertive Community Treatment, is a community-based, multidisciplinary approach to serving those diagnosed with severe mental illness, such as schizophrenia (NAMI, 2007). The principles of the treatment approach include intensive in-home services offered 24 hours a day, seven days a week. The multidisciplinary team may include a psychiatrist, nurse, case manger, and other helping professionals, such as a counselor. The Substance Abuse and Mental Health Services Administration (SAMHSA) identified Assertive Community Treatment as an evidence-based practice for individuals experiencing psychosis. In the United States, implementation of Assertive Community Treatment programs demonstrated a 73-89% decrease in hospital stays for individuals receiving the intervention (NAMI, 2007). Although considered an evidence-based practice in the United States, European cultures reported less consistency in research findings that demonstrated long-term success of this intensive community-based intervention (Bodén, Sundström, Lindström, Wieselgren, & Lindström, 2010; Tempier, Balbuena, Garety, & Craig, 2012). The popularity of Assertive Community Treatment in the United States may be a result of its cost-effectiveness, estimated at $10,000-$15,000 per year per client (Allness & Knoedler, 2003), significantly less expensive than inpatient hospital care.

Resources:
Assertive Community Treatment information: NAMI, Treatment Options
http://www.nami.org/Template.cfm?Section=ACT-TA_Center

SAMHSA Assertive Community Treatment Evidence-Based Practice Kit
http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345

**Cognitive behavioral therapy.** Cognitive Behavioral Therapy (CBT) as an evidence-based practice used in managing the symptoms of individuals diagnosed with schizophrenia (Mueser, Deavers, Penn, & Cassisi, 2013). In their review of randomized studies, Turkington, Kingdon, and Wedien (2006) concluded CBT coupled with antipsychotic medication resulted in a reduction of psychotic symptoms among individuals diagnosed with schizophrenia. Furthermore, Turkington et al. (2006) reported CBT as the accepted evidence-based treatment for those diagnosed with schizophrenia in the United Kingdom. In comparison studies, CBT demonstrated similar symptom reductions than individuals assigned to a group therapy intervention (Sensky et al., 2000). Therefore, counseling as an adjunct service, regardless of specific theory, demonstrated better outcomes (Hewitt & Coffey, 2005), although CBT is widely accepted for treatment of schizophrenia. Moreover, researchers found CBT as more beneficial for individuals experiencing a psychotic episode compared to those with chronic psychosis (Zimmermann, Favrod, Trieu, & Pomini, 2005).

Resources:
SAMHSA's National Registry of Evidence-based Programs and Practices
http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=256

SAMHSA's National Registry of Evidence-based Programs and Practices
http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=273

**Acceptance and commitment therapy.** Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999) is an adaptation of CBT with greater attention to increasing perspective taking and decreasing undesirable thoughts and feelings. Bach and Hayes (2002) reported individuals experiencing psychosis who received ACT demonstrated a reduction in rehospitalization four months post-intervention. At the 1-year follow up, clients who received ACT at the time of hospitalization again demonstrated a reduction of rehospitalization (Bach, Hayes, & Gallop, 2012). Furthermore, Gaudiano and Herbert (2006) found positive results of ACT among non-dominant populations diagnosed with schizophrenia. Therefore, Bach et al. (2012) strongly suggested the consideration of ACT as an accepted evidence-based practice adjunct service for individuals with schizophrenia.

Resource:
SAMHSA's National Registry of Evidence-based Programs and Practices
http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=191

**Family psychoeducation.** Due to an accompanying decrease in functioning, individuals diagnosed with schizophrenia tend to rely on family members for support (Mueser, Deavers, Penn, & Cassisi, 2013). Therefore, Mueser et al. (2013) advocated for family psychoeducation as part of the treatment process. In a meta-analysis of randomized control studies, researchers indicated a family psychoeducation intervention yielded lower rates of relapse and rehospitalization for the family member experiencing psychosis (Pharoah, Mari, Rathbone, & Wong, 2010). Hooley (2007) indicated individuals with schizophrenia with higher rates of relapse also demonstrated higher levels of family stress; therefore, it seems family involvement remains an important aspect of comprehensive treatment.

Resource:
SAMHSA Family Psychoeducation Evidence-Based Practice Kit
http://store.samhsa.gov/product/Family-Psychoeducation-Evidence-Based-Practices-EBP-KIT/SMA09-4423

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