CHAPTER 11

Psychotic disorders

Psychotic disorders are unusual in childhood and adolescence but are serious when they occur. They consist of:

- bipolar disorder (severe mood swings); this used to be called manic–depressive psychosis
- delusions (false ideas without any basis in reality), hallucinations (sensory perceptions such as hearing voices when there is no one there) and disorders of thinking. These are most likely to be signs of schizophrenia, which may take different forms. All are serious, but there are now effective treatments for schizophrenia.

11.1 Bipolar disorder

Case 11.1

Indira was a 14-year-old girl brought to see a health professional by her mother. Her mother said that she had had to drag Indira to the clinic because she had not wanted to come and thought there was nothing wrong with her. Indira thought that she had never felt better. But for the past 3 months she had become more and more difficult and impulsive. She talked much more than normal and it was hard to interrupt her once she started. She got very angry when she was interrupted. She had been stealing money from her mother's purse and spending it on clothes she could not possibly afford. She was sleeping much less, only about 5 hours a night. Indira had never behaved like this before. She had always been a rather shy girl. About 2 years ago she had gone through a period of 6 months when she was sad and miserable and did not want to go out. It had never been clear why she was so depressed at this point. Indira's father had left home some years ago, after having relationships with a number of other women. He did not keep in touch. Indira has no brothers or sisters. What should the health professional do?

11.1.1 Information about bipolar disorder

People with bipolar disorder do not understand that they have a mental illness – they lack insight. It is called bipolar disorder because many people experience unusually elevated and depressed states for periods of time. Some people only have episodes of unusual happiness or irritability. The illness does not usually start before mid-adolescence.

Before the illness begins, the child or teenager may have shown mood swings more so than other children. There is usually a trigger, a stress, especially a loss, that triggers the illness. Symptoms in the 'manic' phase include:

- mood: feeling extraordinarily happy for no good reason, irritability

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- thinking: believing that one is a very special, powerful person – handsome, good-looking, rich or having special abilities
- behaviour: rapid speech, overactivity, impulsive, lacking self-control (e.g. sexually), spending extravagantly, needing less sleep, drinking alcohol excessively or using drugs
- imagining things: hearing voices or seeing visions when there is nothing there.

In a manic phase it may be difficult to know whether bipolar disorder is present or whether the problem is mainly one of overactivity and lack of concentration. If the problem has been present from the early years and the child does not have mood swings, it is probably best to think of the illness as an attention disorder. If there are mood swings and the illness develops in adolescence, it is better to think of it as bipolar disorder. Children who have attention problems in earlier childhood may, however, develop bipolar disorder in later life.

In the depressed state the patient may show:

- great sadness
- false ideas of being guilty for something trivial or something he has not done
- poor sleep or excessive sleep
- poor appetite or eating too much
- lack of energy
- hopelessness about the future
- thinking about death and possibly suicide.

The illness is episodic. Each episode may last for weeks or months, but only rarely more than 2 years. There are also periods lasting months or years when the patient is well and without symptoms. In some episodes the patient may show signs of both unusual happiness and depression – this is a mixed form of the illness. Often someone else in the family has had a similar disorder. There may be a strong genetic influence.

Without treatment (see Appendix 2) to prevent further episodes, the illness can often be life-long.

11.1.2 How to assess bipolar disorder

- Check when the problem began. Did the child have mood swings even before the illness began? Did the child have any problems in attention and concentration before the illness began?
- What are the main features of the child's mental state? Is the child displaying an unusually cheerful mood, overactivity, irritability, false ideas about being wealthy or very bright, sleep disturbance, rapid speech, lack of self-control, or extravagant spending? Has the child ever been very sad, had ideas of being guilty of something quite trivial, or been constantly tired and lacking in energy?
- Was there a stressful event, a loss, when the episode of unusual cheerfulness and overactivity began?
- How has the child's life been affected by the illness at home or at school? Is the child in trouble at school or with the police for antisocial behaviour? Is the child able to concentrate on schoolwork?
- Has anyone else in the family had a similar problem?
- If the child or adolescent is in a depressed state or has been in such a state recently, are there any suicidal ideas or is the child at risk of taking his own life?

Now, using the information you have obtained from the young person with bipolar disorder and the family member(s) you have seen, try to understand what has happened and decide what is the best course of action.

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11.1.3 Helping young people with bipolar disorder

If the diagnosis is definite, then the mainstay of treatment is antipsychotic medication (see Appendix 2). Because of side-effects to which the young are especially sensitive, begin with a small dose and build up gradually.

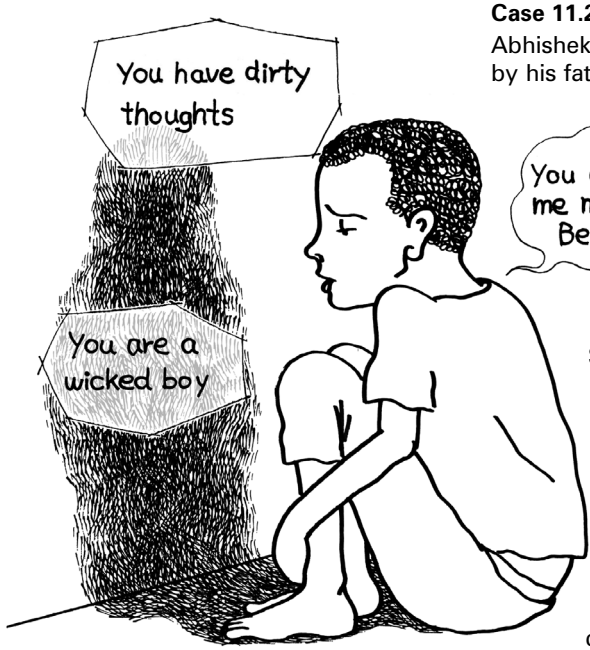
It is really important that the medication is taken regularly, so parents should be involved in making sure this happens. Patients with this condition are often not cooperative as they lack insight and think that there is nothing wrong with them. At the same time, patients should be protected from getting involved in risky and perhaps dangerous behaviour. Any money at home should be securely put away so that the child cannot steal and spend it. Someone should escort the child everywhere to prevent him from getting into trouble for sexually inappropriate or other risky behaviours.

If the child goes into a depressive state, the possibility of suicidal behaviour should be borne in mind. Again, a close eye needs to be kept on the child to prevent self-harm (see Section 9.4). If the child's problem becomes chronic and he develops repeated episodes of unusual happiness and depression, a mood stabiliser should be prescribed (see Appendix 2).

When in a stable state, the child needs to be helped to avoid stresses that might trigger another episode. Other family members need to be involved in the management of the disorder, as they can play a very helpful part in keeping the patient well.

Now make a list of the ways in which the health professional might be able to help Indira.

11.2 Schizophrenia



Case 11.2

Abhishek is a 15-year-old boy who was brought by his father to the clinic because he seemed a changed boy. Over the past few months he had become moody and suspicious of everybody, even members of his family. All he wanted to do was to sit alone and not talk to anybody but himself. Sometimes he seemed to be in a conversation with someone who was not there. Abhishek had never been any trouble before. He was not a very bright boy, had been slow to speak and was a bit clumsy. Otherwise he had developed normally. He used to have one or two friends, but now that he had changed, no one wanted to talk to him. The only thing his father could think of that might have started this off was that when his personality began to change he was smoking a good deal of *bhang* (cannabis). His father did not like him doing this but as he had smoked *bhang* himself when he was younger he could not really say very much about it. Abhishek's father wondered whether he was turning out to be like his wife's brother. This man had become very odd at the age of 19 and was in a mental hospital. What should the health professional do?

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11.2.1 Information about schizophrenia

As with bipolar disorder, people with schizophrenia lack insight and do not understand that they have a mental illness. In schizophrenia, there may be several problems.

1 Thinking problems
   - i The patient may have difficulty in thinking clearly and logically.
   - ii He may think that his thoughts are being interfered with.
   - iii He may have delusions – beliefs that are not true, such as that people are all against him.
   - iv The delusion that everything that is happening in the world is somehow aimed at him. So, for example, he may believe that programmes on the television refer to him, or that others are talking about him.
   - v The patient may have a strange belief that there is something odd going on in his body, for example that there is an animal inside his belly.

2 Mood problems: the patient may find it difficult to express emotions or feel empty of emotions.

3 Behaviour problems
   - i Withdrawal from usual activities
   - ii Restlessness
   - iii Aggressive behaviour
   - iv Odd behaviour such as hoarding rubbish
   - v Not washing or cleaning himself properly

4 Problems of perception
   - i Seeing things that are not there (visual hallucinations)
   - ii Hearing voices when there is no one present (auditory hallucinations). The voices may accuse the patient of things he has not done. Sometimes the patient will talk to these voices. He cannot get them out of his head.

There may also be symptoms of depression or mania (see Section 11.1.1) – this is known as schizoaffective disorder.

Schizophrenia may begin at any time but most commonly it begins in the mid- to late teens or early 20s. Sometimes it starts for the first time much later in life. It may begin gradually or very suddenly. In some individuals, the illness may last for a short period of time and not recur, while in others the course can be chronic. There is sometimes a period lasting weeks or months in which the patient is very disturbed and agitated and has a number of upsetting, false beliefs. This may be followed by a period when the patient is much less disturbed but has little energy and finds thinking difficult. This may last for months or years before another episode of acute disturbance. This cycle may go on for the whole of the patient's life.

Language is slow to develop in early life in some patients who later develop schizophrenia. They may always have had difficulty in making friends and been rather isolated.

Schizophrenia is thought to be caused by physical changes in the brain, however it may begin after a stressful event. Smoking cannabis (*bhang*, weed, grass, hemp) may trigger an episode of schizophrenia in people who are likely to get it regardless. Quite often there is someone else in the family who has had schizophrenia. There is a strong genetic influence.

11.2.2 Finding out more about a child who may have schizophrenia

- Check when the problem began. Has the patient always had problems making friends and getting on with other people or is this something new?
- Were there any upsetting events occurring at the time the illness began? Was the patient smoking *bhang* (cannabis)?

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- What symptoms has the child shown? Check for disturbances of thinking, including the presence of false beliefs. Does he think that his thoughts are being interfered with? Has the patient been talking to himself as if there is someone there when there is not? Does the patient behave as if he is seeing things when there is nothing there? Has the patient's behaviour been odd in any way? Are there any signs of depression?
- Does anyone else in the family have any signs of mental illness?
- How is the patient's life affected by the illness? Has he been able to go to school or work?
- Have the lives of other members of the family been affected in any way? For example, does someone have to look after the patient in case he wanders off or hurts someone?

Now using the information you have obtained from the young person with schizophrenia and the family member(s) you have seen, try to understand what has happened and decide what is the best course of action.

11.2.3 How to help a child or adolescent who may have schizophrenia

If the diagnosis is definite, then the mainstay of treatment is antipsychotic medication (see Appendix 2 for details). Because young people are more sensitive to medication side-effects, begin with a small dose and only build up gradually. It is really important that the medication is taken regularly, so parents should be involved in making sure this happens. Patients with this condition are often not cooperative as they lack insight and think that there is nothing wrong with them. It is important to remember that medication is likely to shorten the acutely disturbing part of the illness but it is not likely to be a cure. The patient may well need medication for the rest of his life.

At the same time as being given the medication, the patient should be given the opportunity to talk about what is upsetting him. The health professional should not argue with the patient or try to persuade him that his false beliefs are wrong. It may be helpful to try to get the patient to check the evidence for his beliefs. For example, if he thinks that everything on television refers to him, you could ask whether anything might make him think this was not the case.

Family members also need to have the opportunity to learn about schizophrenia. It is helpful for them to know that it is thought to be a disease caused by physical changes in the brain. Although stress may bring the illness on, this is not the main reason the patient has developed the illness. Family members may need help to cope with the patient, especially if he wanders off or is aggressive.

Patients with schizophrenia may need looking after for the rest of their lives; but with medication, it may be possible for them to be independent and look after themselves and even return to study or work.

Now make a list of the ways in which the health professional might be able to help Abhishek.

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