

Screening Questions for Psychosis

The prevalence of some lifetime history of hallucinations and delusions in the general population is 9.1 percent, although most of those reports were fleeting visions or briefly hearing the voice of a departed loved one (National Comorbidity Survey; R. C. Kessler, Berglund, Demler, Jin, & Walters, 2005). The prevalence of psychotic disorders (schizophrenia, schizophreniform disorder, schizoaffective disorder, delusional disorder, and psychosis not otherwise specified) was found in a recent U.S. national survey to be 0.5 percent (National Comorbidity Survey; R. C. Kessler et al., 2005), but that is almost certainly an underestimate since many individuals with psychosis are not in a household setting (e.g., hospitalized, in a long-term institution, or in prison). Research that examined institutions as well as households finds twice the rate of psychotic disorders in the population (Goldner, Hsu, Waraich, & Somers, 2002). Thus, a reasonable guideline would be to expect about or at least a 1 percent prevalence of psychotic disorders in the U.S. population.

Screening for psychosis is not easy because psychotic disorders are extremely heterogeneous. To make a diagnosis of schizophrenia according to the Diagnostic and Statistical Manual of Mental Disorders (4th ed., text revision; American Psychiatric Association, 2000), the client must have two of these: hallucinations, delusions, disorganized speech, disorganized or catatonic behavior, and negative symptoms for 6 months. Hallucinations can occur in any sensory modality, and if you are being thorough, you will ask about each possible sense. Delusions are very heterogeneous as well, although there are six or so common categories of them. Disorganized speech is generally diagnosed by observation, although if you haven't seen it before, it can be difficult to diagnose. Negative symptoms are diagnosed by observation and asking about the client's daily functioning. In addition, clinically, I have found that some clients with psychotic symptoms to have mild thought disorder symptoms that may interfere with their cognition but are not obvious in their speech.

Screening for psychosis is recommended for every client but can be overly intrusive and time intensive when the client is high functioning and has a very low probability of psychosis. Thus, in practice, how does one balance these considerations? As a practical matter, research has shown that auditory hallucinations are by far the most common type of hallucination experienced by inpatients with schizophrenia or bipolar disorder (Baethge et al., 2005), with visual hallucinations coming in a distant second, and that persecutory delusions are the most common

delusions. This might suggest that observing the client for thought disorder, coupled with screening for auditory and visual hallucinations and paranoia, might be sufficient in a high-functioning population. Alternatively, if you have screened for psychosis in the written intake forms and the client's behavior shows no sign of psychosis, it may be ok to skip asking about it in a high functioning population. In a lower-functioning population, a more thorough screening should be considered.

Here is how the client typically experiences auditory hallucinations. Auditory hallucinations are often voices commenting on the client's behavior or thoughts. The voices might tell them what to do, although the client may not act on it. The voices may talk almost all the time, or they may talk just occasionally. In milder cases, the client might hear what sounds like mumbling but cannot make out the words. Or the client might hear a voice calling her name when no one is present. Visual hallucinations are almost always visions of humans or humanlike beings. Usually visual hallucinations happen less frequently than auditory ones. Tactile hallucinations are often described as feelings of electricity or crawling on the skin. Occasionally, a client may have a sensation within the body or under the skin that often accompanies a delusion of parasitic infestation. Olfactory hallucinations are extremely common. Usually, the client cannot articulate what the smell is but does state that it is unpleasant and realizes that others do not smell it. Gustatory or taste hallucinations are generally experienced as a bad taste. Sometimes these are accompanied by a delusion that the client is being poisoned. Here are screening questions for hallucinations in each sensory modality:

- *Have you been hearing any voices?*
- *Does it seem that other people are commenting on your behavior?*
- *Have you been seeing any visions?*
- *Have you been having any unusual feelings on your body or skin?*
- *Have you been experiencing any unpleasant smells that others don't notice?*
- *Have you been experiencing any unusual bad tastes lately that others don't notice?*

In addition, you may notice that the client is looking around the room for something that is not there or seems distracted. In these cases, the client may be experiencing hallucinations during the interview and is responding or attending to them.

Here are some screening questions for paranoid delusions and delusions of reference:

- *Does it seem like people are talking about you?*
- *Are people paying special attention to you?*
- *Do you feel that people are out to get you?*
- *Does it ever seem that the television or radio is talking specifically to you? Tell me about that.*

Here are some questions for some other, less common delusions:

- *Do you feel that you have any special abilities? What are those?*
- *Do you feel that you have some special importance? What is that?*
- *Have you ever felt that you could read people's minds or that they could read your mind?*

Clients might also have erotic delusions and somatic delusions, but these seem to be much less frequent. Somatic delusions (delusions of illness) often seem to be accompanied by tactile hallucinations. Delusions of being poisoned often seem to be accompanied by gustatory hallucinations.

Thought disorder can also be a prominent symptom. If hallucinations and delusions are present, but there are not observable symptoms of thought disorder in the client's speech (tangentiality, disorganized; see Chapter 8), you might ask the following:

- *Are you having difficulties getting organized? Planning? Getting things done?*
- *What does your home (bedroom) look like? Is it messy?*
- *Are you having any difficulties with feeling confused or having your thoughts feel scattered?*

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