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Features of Reflection of Persons With Schizophrenia, Schizotypal States and Delusional Disorders (F20-F29)

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This article presents the results of an empirical study of the features of reflection of persons with schizophrenia, schizotypal states, and delusional disorders (F20-F29). The cognitive-emotive test of Y. M. Orlov, S. N. Morozyuk was used as a method of studying the features of reflection of persons with the above disorders. The study involved 54 respondents—men (29 people) and women (25 people) aged 18-50 years with schizophrenia, schizotypal conditions, and delusional disorders. All patients were either in remission.

Keywords: reflection, protective reflection, sanogenic reflection, schizophrenia, schizotypal states, delusional disorders

Introduction

Schizophrenia is the most common disorder in developing countries. Schizotypal disorders have many characteristic features of schizophrenic disorders and are genetically related to them. However, since they do not detect hallucinatory and delusional symptoms, gross behavioral disorders characteristic of schizophrenia, they do not always attract the attention of doctors. Most delusional disorders are not associated with schizophrenia, although it can be quite difficult to distinguish them clinically, especially in the early stages. They constitute a heterogeneous and not fully understood group of disorders, which for convenience can be divided, depending on the typical duration, into a group of chronic delusional disorders and a group of acute and transient psychotic disorders.

In the International Classification of Diseases (ICD-10), schizophrenia, schizotypal states, and delusional disorders are listed under the code (F20-F29) and are included in the heading "Schizophrenia, schizotypal and delusional disorders" (F2) (Karvasarsky, 1985).

Schizophrenic disorders in general are characterized by fundamental and characteristic disorders of thinking and perception, as well as inadequate or reduced affect. As a rule, clear consciousness and intellectual abilities remain, although some cognitive impairments may appear over time. Disorders peculiar to schizophrenia affect the fundamental functions that give a normal person a sense of their individuality, uniqueness, and purposefulness.

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Often, the most intimate thoughts, feelings, and actions seem to become known to others or are shared by them. In such cases, explanatory delusions may develop, as if there are natural or supernatural forces that affect, often in a bizarre way, a person's thoughts and actions. Such people can see themselves as the center of everything that happens.

Theory

A characteristic disorder of thinking in schizophrenia is that insignificant features of a general concept (which are suppressed during normal purposeful mental activity) become predominant and replace those that are more adequate for this situation. Thus, thinking becomes fuzzy, intermittent, and unclear, and speech is sometimes incomprehensible. Interrupting thoughts and interfering thoughts are also a frequent occurrence, and patients have a feeling of thoughts being taken away. It is characterized by a superficial mood with capriciousness and inadequacy. Ambivalence and volitional disorders can be manifested as inertia, negativism, or stupor. Catatonic disorders are possible. The onset of the disease can be acute with pronounced behavioral disorders or gradual, with the increasing development of strange ideas and behavior. The course of the disease also reveals a significant variety and in no way means an inevitable chronic development or an increasing defect (the course is determined by the fifth sign), in some cases, the frequency of which varies in different cultures and populations, recovery may be complete or almost complete.

The leading causes of schizophrenia include heredity, an unfavorable environment and social living condition.

The risk of developing schizophrenia in children, one of whose parents suffers from this disease, is 7%-13%, and if both parents are sick, then 27%-46%. In each subsequent generation, the risk decreases. Men and women get schizophrenia equally often, but in men the disease usually manifests earlier—at the age of 18-25 years, whereas in women—at 25-30 years[1].

Environmental factors are important in the development of schizophrenia. Scientists have found that urban residents are diagnosed with the disease more often than rural residents. There is a risk of this mental disorder in migrants. Obstetric and gynecological complications (premature birth, fetal hypoxia), infectious diseases, and maternal malnutrition in the first and early second trimester of pregnancy, infectious diseases during pregnancy (influenza, rubella, toxoplasmosis, herpes), as well as early childhood psychological trauma can also cause schizophrenia.

The symptoms and signs of schizophrenia are diverse, since the disease has various forms and variants of course.

In psychiatry, all the symptoms of schizophrenia are divided into three large groups:

- positive (productive);
- negative;
- cognitive.

The concept of "positive" here does not mean that these symptoms are "good". On the contrary, they say that changes are taking place in the human psyche. The first signs of schizophrenia are such phenomena as hallucinations, delusions, depersonalization, and derealization. At the initial stage of the disease, positive symptoms are rarely

[1] https://daily.afisha.ru/relationship/12842-menya-sravnivayut-s-opasnym-beshenym-zverem-kak-v-rossii-zhivut-lyudi-s-shizofreniey/https://www.psychiatry.ru/stat/121.

present and most often appear at the acute stage. It is the productive symptoms of schizophrenia that most often causes hospitalization in a hospital.

Negative symptoms of schizophrenia are manifested by a decrease in normal mental functions. These include changes in emotions, autism, or asociality ("immersion in oneself", the appearance of unusual thoughts and fantasies), social passivity, a drop in energy potential, violations of the will. Such symptoms and behavior in schizophrenia, as a rule, occur at the prodromal stage.

Cognitive symptoms are characterized by impaired attention, memory, and a decrease in the speed of information processing. They prevent a person from planning and carrying out purposeful actions. Like negative symptoms, cognitive impairments manifest themselves in the prodromal period.

Thus, several main signs of schizophrenia can be distinguished (Figure1):

- loss of reality;
- delusional ideas (delusions of persecution, jealousy, greatness, or the feeling that someone is controlling you);
- hallucinations—perception of non-existent phenomena (auditory, tactile, or tactile hallucinations);
- thinking disorders (incorrect use of words, inability to express your thoughts);
- emotional disorders;
- changes in facial expressions (becomes expressionless);
- speech disorders (emotional color is lost);
- detachment from the outside world;
- lack of energy (lethargy, inactivity);
- disorders of affects, impulses, impaired motor skills.

Many scientists are of the opinion that schizophrenia develops as a result of a violation of the exchange of neurotransmitters, in particular, dopamine, in the brain. Neurotransmitters are biologically active substances that are produced by nerve cells (neurons) and transmit information from neuron to neuron and to other cells.

However, the following possible causes of schizophrenia are distinguished[2] (Karvasarsky, 1985):

1. Hereditary predisposition. Scientists have identified several genes that presumably can contribute to the development of the disease. The genetic basis of schizophrenia is also confirmed by genealogical studies. It is known that the risk of developing schizophrenia in a child increases significantly if one of the parents suffers from this ailment.

2. Biological factors. These include head injuries, infectious diseases (including intrauterine).

3. Psychosocial factors. Unfavorable family situation, acute emotional stress, prolonged traumatic situation, social isolation—all this can become a "push" to the development of the disease with an existing predisposition.

4. Somatic diseases. Recently, there have been data on the connection of some autoimmune diseases with the occurrence of schizophrenia.

5. Drug addiction and alcoholism. Some types of narcotic substances can provoke the development of schizophrenia, and also contribute to a more severe course of the disease.

6. Structural changes in brain areas. When performing MRI studies of the brain in individuals with schizophrenia, gray matter degradation is detected, functional differences in the work of the lobes are observed, abnormal integration of functional brain systems is recorded.

[2] https://daily.afisha.ru/relationship/12842-menya-sravnivayut-s-opasnym-beshenym-zverem-kak-v-rossii-zhivut-lyudi-s-shizofreniey/https://www.psychiatry.ru/stat/121.

7. Metabolic disorders of biogenic amines (dopamine, norepinephrine, adrenaline, serotonin, melatonin, and others).

Summarizing the scientific data, we can say that often the main reason, the "impetus" for the development of schizophrenia, is the psychosocial distress of the individual, which is understood as psychological discomfort, experiencing internal conflict as a consequence of the mismatch of expectations with the real course of events, feeling unhappy, flawed, helpless, lonely, abandoned, an outcast who rejects himself, others, or the whole world.

In numerous studies carried out in line with the scientific school of Orlov Yu. M., Morozyuk S. N., it is proved that the psychological well-being of a person is determined by the style of her thinking, the quality of reflection, the everyday philosophy that has developed under their influence (Adamyan, 2012; Kananchuk, 2009; Krainova, 2010; Morozyuk, Morozyuk, & Kuznetsova, 2023; Orlov, 2006; Pavlyuchenkova, 2001).

Repetitive negative thinking destroys cognitive functions (memory deteriorates, attention is impaired, critical thinking decreases, information processing speed decreases, its prognostic function weakens). This prevents a person from planning and carrying out purposeful actions. All the symptoms characteristic of the third group of signs of schizophrenia described above are manifested. This is a favorable ground for the development of schizophrenia.

Despite the fact that schizophrenia is considered an incurable disease, it successfully lends itself to competent control and treatment, as a result of which the level of social adaptation and family life of patients increases.

Is there a means that allows the patient to realize his condition, mitigate the symptoms of the disease, socially adapt to and establish relations with family and society?

In international recommendations for schizophrenia, psychotherapy has been recognized as one of the evidence-based and productive methods of treatment, especially in the case of persistent psychotic symptoms. Thinking as one of the causes of psychological distress, as an actualizer of long-term traumatic situations, can also become a means of managing them if it is aimed at understanding the causes and factors that trigger the further course of the disease. As Y. M. Orlov said, "The power of thought is obvious. It creates reality."

The mechanism that develops a special healing thinking (sanogenic) can be personal reflection, which allows the subject to objectify his thinking as a process that leads either to suffering or to a constructive solution of the problem.

Reflection is a process that allows the subject to rise above the situation, not to be in the experience, but above it.

Since our respondents were people with schizophrenia, schizotypal states, and delusional disorders, their reflection, as we believed, has its own specific features.

In order to verify our assumption, we conducted a survey using the cognitive-emotive test of Y. M. Orlov, S. N. Morozyuk, followed by a comparative analysis of the data of persons with and without a diagnosis of schizophrenia in order to identify differences in the quality of their reflection. The survey data of persons without a diagnosis of schizophrenia are presented in the journal *Human Factor. Social Psychologist*, Issue No. 1(45), 2023, pp. 179-188 (Morozyuk et al., 2023).

Materials and Methods

The study was conducted in February-March 2023, in which 54 respondents took part—men (29 people) and women (25 people) aged 18-50 years with schizophrenia, schizotypal conditions, and delusional disorders.

All patients were in remission. The empirical base of the study is the State Budgetary Healthcare Institution of the Moscow region "Psychiatric Hospital No. 5" in Khotkovo, Moscow region.

The results of the empirical study were processed using the statistical program STATISTIKA 7.0 using the parametric statistical method of data processing for independent samples of the Student's T-criterion.

Figure 1 presents the results of a study of the protective reflection of schizophrenics, persons with schizotypal conditions and with delusional disorders.

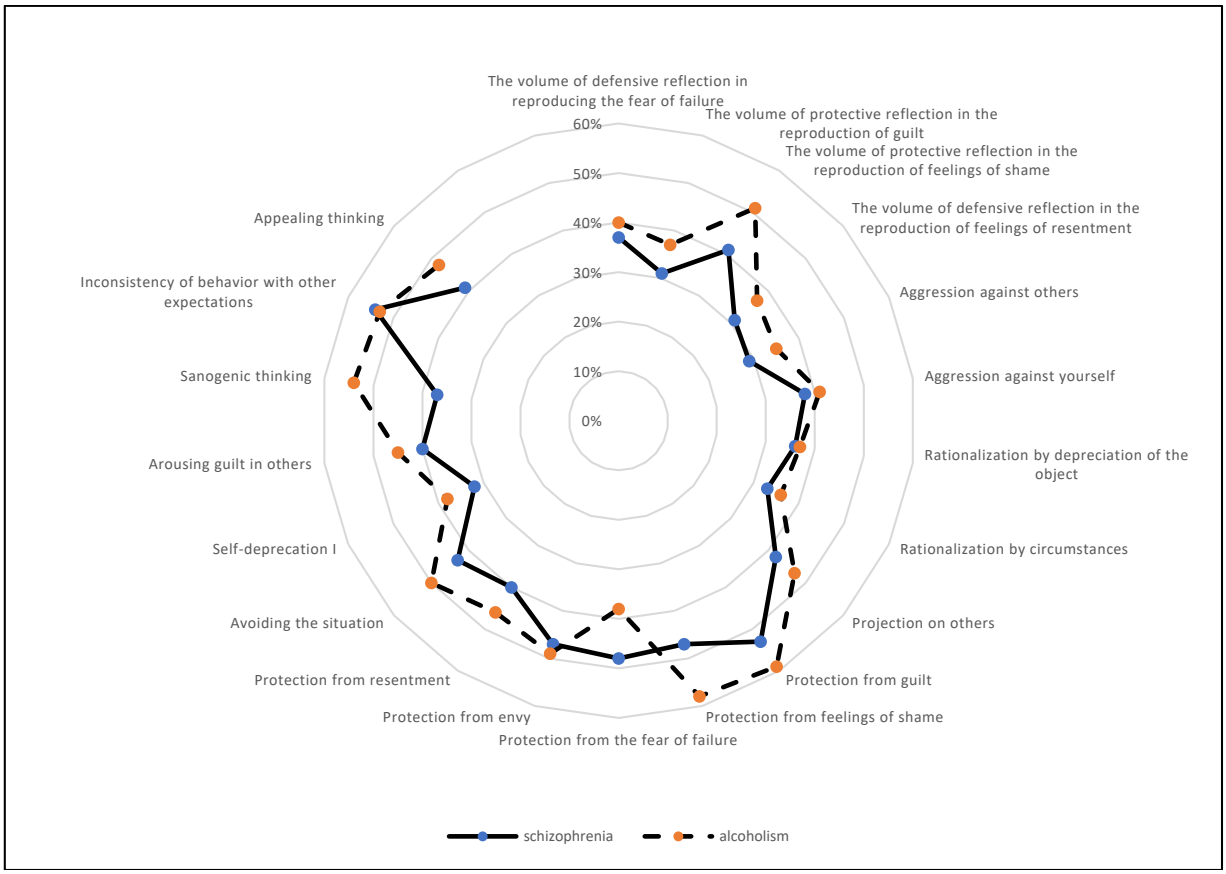

Figure 1. Profile of protective reflection of persons with schizophrenia, schizotypal states, and delusional disorders (F20-F29).

Discussion

The data presented in the diagram reveal a peculiar profile of protective reflection in individuals with schizophrenia, schizotypal states, and delusional disorders. If alcoholics have the most pronounced protection from feelings of shame (59%), then schizophrenics have protection from feelings of guilt (54%). In our opinion, this suggests that the triggers triggering psychological distress and mental disorders are situations of interaction in the family and outside the family, in which the most sensitive, easily vulnerable people did not have enough psychophysiological resources to survive them. This may be a single, traumatic case (violence, loss of a loved one, etc.) or situations with a cumulative effect that leads to a breakdown of adaptation. Alcoholics have situations associated with the experience of shame, and schizophrenics have a sense of guilt. "It's like I don't have skin. Any glance, remark thrown in my direction, hurts. It hurts me to live," the patient says during a clinical conversation. This means that the therapy of persons with socially acquired schizophrenia, schizotypal states, and

delusional disorders should be carried out through the development of sanogenic reflection aimed at ensuring psychological resistance to guilt factors.

How does the personality itself protect itself from such unbearable experiences? She goes into the world of fantasies, dreams. He builds his own world, which has nothing to do with reality. In a state of remission, coming out of her imaginary world, she sees the discrepancy between her ideas and reality. And then the inconsistency of the behavior of others with their expectations is experienced (50%), the individual defends himself from the fear of failure (48%), shame (46%), and guilt (54%), again seeks to leave the environment that traumatizes his personality into "his own world" ("Leaving the situation"—42%).

Results

At the same time, the comparative data presented in the diagram indicate less pronounced reflection on socially directed feelings: shame, fear of failure, guilt in schizophrenics than in people with alcohol dependence. In our opinion, this indicates that reflection weakly performs its protective and healing function in schizophrenics and persons with schizotypal conditions and delusional disorders. This is also indicated by statistically significant differences in the indicator "sanogenic thinking". Alcoholics have this indicator more pronounced (54%) than schizophrenics (28%).

Despite the satisfactory physical condition and the absence of an innate predisposition to schizophrenia, the patient shows signs of obvious psychological distress: he shows aggression against others ("obscenely expressed", blames his mother for his insolvency), and is psychologically closed ("he presents information about himself in a confusing way", "prefers not to disclose experiences", "periodically freezes, withdraws into himself"), experiences are ambivalent, the mood is unstable. Since thinking is not critical and inconsistent in behavior and actions, it is unpredictable, "gets out of the social skin", and this is a sign of not just psychological distress, but also illness.

However, a mental status with obvious signs of not only psychological distress, but also an obvious disease requires treatment. Aggression against oneself is manifested in suicidal thoughts and masochism (inflicts cuts on oneself and gets pleasure at the same time). It is also inaccessible in terms of experiences (the mood background is reduced) and social communications (contacts are extremely formal due to forced necessity); facial expressions do not correspond to experiences. The patient experiences only at the level of emotions: fear, anxiety, pleasure, etc. at the same time, the higher feelings are weakly expressed or completely absent: resentment, guilt, shame as psychological mechanisms for the appropriation of morality and moral beliefs. Due to the lack of critical thinking, they cannot develop and be regulators of their behavior, which is often based on delusional ideas. And then the disintegration of the personality is inevitable.

In the realities of the modern world, the problem of psychological well-being and protection of mental health of the individual is acute. Unfortunately, modern technologies that make it possible to control the masses are aimed at dehumanizing a person: imposing false values from early childhood, focusing only on bodily pleasures, egocentrism, denial of spiritual bonds that make an individual Human, through atrophy of higher feelings and, above all, shame and guilt. A crowd of schizophrenics, deprived of will, quite suits those who strive for total domination over humanity.

Conclusions

Thus, our hypothesis was confirmed that the protective reflection of persons with schizophrenia, schizotypal states, and delusional disorders has its own specific features:

1. The most pronounced features of protective reflection of persons with schizophrenia, schizotypal states, and delusional disorders are protective reflection from feelings of guilt, fear of failure, shame, and resentment in the form of withdrawal from traumatic situations into the virtual reality of their fantasies.

2. The reflection of persons with schizophrenia, schizotypal states, and delusional disorders almost does not perform its protective function, as evidenced by the profile of protective reflection, in which not only indicators of protection from socially directed experiences are poorly represented: guilt, shame, resentment, and fear of failure, but also the indicator of "Sanogenic thinking" is significantly lower than that of individuals with alcohol addiction.

3. The triggers that trigger psychological distress and mental disorders are situations of interaction in the family and outside the family, in which the most sensitive, easily vulnerable people did not have enough psychophysiological resources to persistently survive them. This may be a single, traumatic case (violence, loss of a loved one, etc.) or situations with a cumulative effect that leads to a breakdown of adaptation. Alcoholics have situations associated with the experience of shame, and schizophrenics have a sense of guilt. This means that the therapy of persons with socially acquired schizophrenia, schizotypal conditions, and delusional disorders should be carried out through the development of sanogenic reflection aimed at ensuring psychological resistance primarily to guilt factors.

4. It is necessary to use sanogenic thinking to help a person with these disorders to become stronger than their feelings at the stage of the first signs and symptoms of the development of this disorder. For "The power of thought is obvious. It creates reality." And what this reality will be depends on the person himself, motivated to make a positive change in himself and his life.

In this we see a promising way of psychological assistance aimed at preventing and solving the problem of mental disorders.

5. Despite the fact that consultative practice based on the principles of sanogenic thinking and sanogenic reflection shows the effectiveness of this approach to solving problems of overcoming psychological distress, we are aware that the application of sanogenic therapy methods to persons with schizophrenia, schizotypal states, and delusional disorders requires fundamental theoretical justification and experimental verification with representative samples.

References

Adamyan, L. I. (2012). Sanogenic reflection as a factor of psychological stability of the individual. In *Diss. on competition of a scientific degree*, Cand. PS. B. 21. Adamyan Luisa Igorevna: Psychological Sciences.

https://daily.afisha.ru/relationship/12842-menya-sravnivayut-s-opasnym-beshenym-zverem-kak-v-rossii-zhivut-lyudi-s-shizofreniey/https://www.psychiatry.ru/stat/121

Kananchuk, L. A. (2009). Sanogenic reflection as a factor of adaptation of students in the polyethnic environment of the university (PhD thesis, Cand. Psychological Sciences, 2009).

Karvasarsky, B. D. (1985). *Psychotherapy*. M: Nolidzh.

Krainova, Y. N. (2010). *Sanogenic reflection in the structure of emotional competence of future teachers: dis. ... cand.* M.: Psychological Sciences.

Marchukova, S. F. (2005). Sanogenic reflection as a factor of optimization of socio-psychological adaptation of cadets of educational institutions of the Ministry of Internal Affairs of Russia (PhD thesis, cand. Psychol. N. M., 2005).

Morozyuk, S. N., Morozyuk, Y. V., & Kuznetsova, E. S. (2023). Features of reflection of persons with mental and behavioral disorders caused by alcohol consumption. *BSF: The Human Factor. Social Psychologist, 45*(1), 179-188.

Orlov, Y. M. (1999). *Cognitive-emotive test.* S. N. Morozyuk & Y. M. Orlov (Eds.).

Orlov, Y. M. (2006). *Sanogenic (healing) thinking*. Y. M. Orlov (Eds.). M.: Sliding.

Pavlyuchenkova, N. V. (2001). *Sanogenic reflection as a factor in the development of emotional competence: dis. ... cand.* Pavlyuchenkova Natalia Valeryevna: Psychological Sciences.

Rudakov, A. L. (2009). *Sanogenic reflection as a factor of stress resistance of personality: on the example of athletes in freestyle wrestling: dis. ... cand*. Rudakov Andrey Leonidovich. M.: Psychological Sciences.