SCHIZOPHRENIA

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WHAT IS SCHIZOPHRENIA

- Severe mental disorder resulting in personality deterioration and loss of touch with reality that manifests as **hallucinations** and **delusions**
- Deranged thought process, affect and behavior

- **Positive symptoms →**
  - Delusions
  - Hallucination
  - Catatonia
  - Agitation
- **Negative symptoms→**
  - Flat affect
  - Apathy
  - Social withdrawal
  - Anhedonia
  - Poverty of thought and speech content

OTHER PSYCHOTIC DISORDERS

- Schizophreniform disorder
- Schizoaffective disorder
- Delusional “
- Brief psychotic “
- Shared psychotic “
- Psychotic disorder due to a general medical condition
- Substance induced psychotic disorder
- Psychotic disorder NOS

EPIDEMIOLOGY

- 1% of the general population

- M:F → 1:1

ETIOLOGY

- **Genetics**
  - Familial transmission
    - Monozygotic twins: 47%
    - Children both parents schizophrenia: 40%
    - One parent: 12%
    - Dizygotic twin: 12%
    - Non-twin sibling: 8%
  - Developmental theories
    - Fetal exposure to risk factors
    - Obstetric complications
- **Biological mechanisms**
  - Neurotransmitters system abnormalities
    - Dopamine theory: D2 receptor; PET scans and dopamine activity
    - Serotonin → esp. for negative symptoms
    - Glutamate
    - GABA
  - Structural abnormalities
    - Enlarged ventricles
    - Decreased thalamus size; hippocampus

DSM IV DIAGNOSTIC CRITERIA OF SCHIZOPHRENIA

- **A.** 2 of the following for most of one month
  - Delusions
  - Hallucinations
  - Disorganized speech
  - Grossly disorganized or catatonic behavior
  - Negative symptoms
  - **(Only one if delusions are bizarre or hallucinations give a running commentary on the person's thoughts or behavior)**
- **B.** Marked social or occupational behavior impairment
- **C.** Duration: Persistent signs and disturbances persist for at least 6 months. IN this period, at least one month of criteria A symptoms (or less if successfully treated) and may include periods of prodromal or residual symptoms or negative symptoms
- **D. Schizoaffective** and **mood disorder** exclusion
- **E.** Substance use and general medical condition ruled out

SUBTYPES OF SCHIZOPHRENIA

- **Paranoid type**
  - Paranoid delusions among other psychiatric symptoms
- **Disorganized type**
  - Disorganized behavior e.g. picking rubbish
- **Catatonic type**
  - Catatonic symptoms e.g. decrease or sudden increase in purposeless motor activity
  - They may hold some unnatural positions for a very long time
- **Undifferentiated type**
  - One can’t classify
- **Residual type**
  - Symptoms have disappeared due to treatment on otherwise

FEATURES

- Symptoms: disruption in psychological and social functioning

- Some areas of functioning may be preserved

MSE FINDINGS

- **Form of thought**
  - Loosening of associations
    - Thoughts do not connect at all
  - Poverty of thought
    - Thought slowing and reduced content
  - Thought blocking
    - Train of though just suddenly stops
    - Patient may switch to another topic abruptly

- **Content of thought**
  - Delusions:
    - Persecutory – ‘people are out to get me’
    - Of reference vs. ideas of reference
    - Of influence → ‘someone is controlling me; making me do certain things’
    - Thought broadcasting → ‘someone else can read my thoughts’
    - Grandiose
    - Somatic

- **Perceptual disorders**
  - Hallucinations
    - Auditory
      - Third person
      - Command
    - Visual
    - Others
  - Illusions

- **Affect**
  - Blunted, inappropriate

- **Motor activity**
  - Catatonic stupor; catatonic excitement; Catatonic posturing (rigidity, waxy flexibility)

COURSE

- **Onset**
  - Peak is late adolescence, early childhood (Multiple stresses around this time)
  - Smaller peak in 4th decade

- **Precipitating events**
  - Psychosocial stressors
  - Traumatic events

- **Prognostic variables**
  - Negative symptoms → poor prognostic factor
  - Gender → male gender is a poor prognostic factor
  - Marital status → being married is a good prognostic factor since the partner will offer psychosocial support
  - Premorbid personality
  - Comorbid disorders

MANAGEMENT

- **In patient vs. out patient**
  - Severity
  - Concurrent medical symptoms
    - You may want to think of admitting this patient if they have comorbidities
  - Social support
    - Admit if there is no assurance of social support
  - Risk of harm (suicide)
    - Depending on their delusions and whether or not they are acting on them
    - Assess risk of harm to the patient and to others

- **Physical Exam**

- **Lab**
  - There is NO DIAGNOSTIC TEST FOR SCHIZOPHRENIA but R/O other disorders that can present in a similar manner e.g. delirium

- **Imaging**
  - There is NO IMAGING THAT IS DIAGNOSTIC but R/O other disorder that can present in a similar manner

TREATMENT

1. Biological

- Antipsychotics
  - **Atypical** -> lower likelihood of causing EPS. Include Risperidone, Olanzapine, Aripiprazole, Clozapine; Some will give the patient weight gain, metabolic syndrome, diabetes etc.
  - **Typical** → older generation e.g. Haloperidol
  - **MoA**: On dopamine receptors
  - **REMEMBER:** they cause EPS (Extrapyramidal symptoms); esp. the atypical antipsychotics
    - Tardive dyskinesia
    - Torticollis etc.
- ECT (Electroconvulsive therapy)
  - Induce a seizure to allay some of the severe symptoms of Schizophrenia and MDD (Major Depressive Disorder)

2. Psychosocial

- Social support
- Vocational training
- Psychotherapy to manage delusions
- Psychoeducation

TYPED BY EFFIE NAILA