Phenomenology of schizophrenia

OVERVIEW

- INTRODUCTION
- HISTORICAL LANDMARKS
- DIAGNOSTIC CRITERIA
- SYMPTOMS OF SCHIZOPHRENIA

INTRODUCTION

SCHIZOPHRENIA- Splitting of mind (psychic functions)

A group of disorders with heterogeneous etiologies with varying disturbances in thinking, perception, emotion, cognition and violation.

Schizophrenia defined and diagnosed based on clinical phenomenology

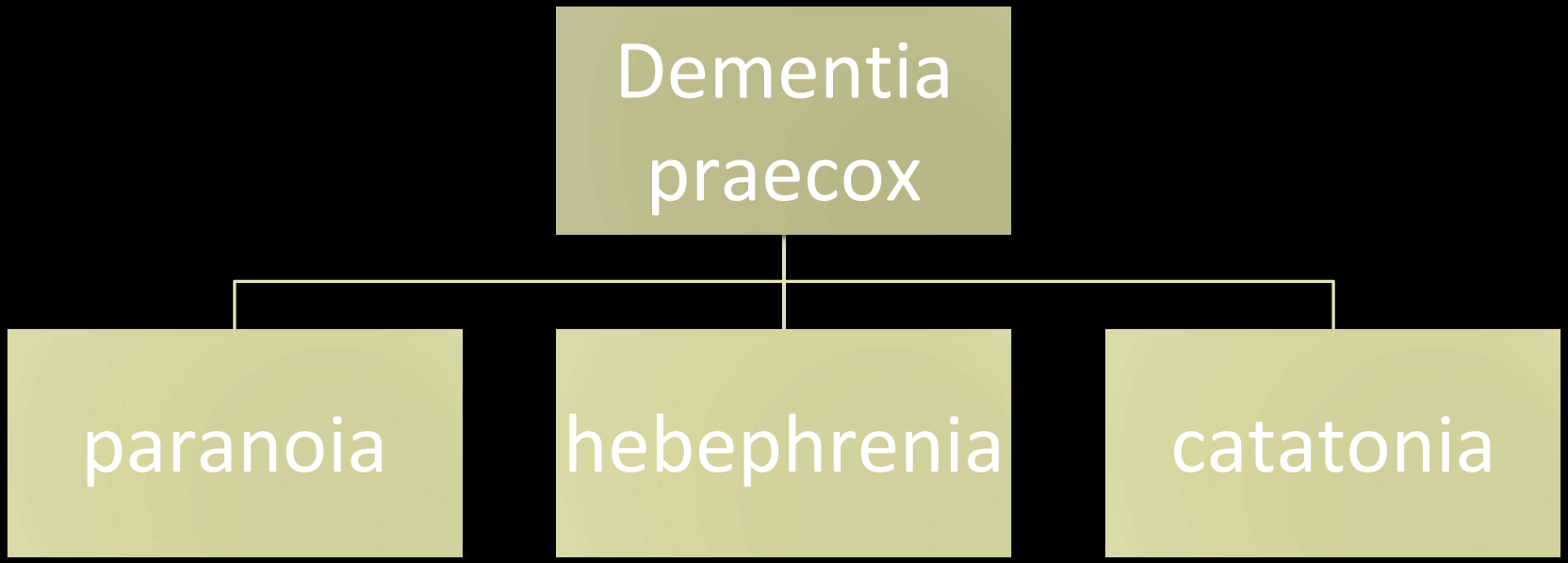
HISTORICAL LANDMARKS

EUGEN BLEULER

EMIL KRAEPLIN

HISTORICAL LANDMARKS

1896 Emil Kraepelin- ‘Dementia praecox’



HISTORICAL LANDMARKS

Characteristics- delusion, hallucinations, disturbances of affect and motor disturbances

Delineated it from the episodic manic depressive psychosis

HISTORICAL LANDMARKS

1911 Eugen Bleuler- ‘Schizophrenia’

Added simplex in subtypes

Fundamental symptoms-

1. Ambivalence- marked inability to decide
2. Autism- withdrawal into self
3. Abnormal Affect- inappropriate affect
4. Abnormal Association- loosening of association, thought disorder

HISTORICAL LANDMARKS

Loss of harmonic coordination among thought, emotion, and behavior -hallmark of the illness.

Accessory symptoms-

1. Delusions
2. Hallucinations
3. Social withdrawal
4. Diminished drive

HISTORICAL LANDMARKS

1959 Kurt Schneider- characteristic symptoms to make diagnosis reliable

First Rank Symptoms:

1. Audible thoughts
2. Voices arguing or discussing
3. Voices commenting on patient's action
4. Somatic passivity

HISTORICAL LANDMARKS

5. Thought withdrawal
6. Thought insertion
7. Thought broadcasting
8. Made feelings
9. Made impulses or drives
10. Made volitional acts
11. Delusional perception

HISTORICAL LANDMARKS

DSM- II – Bleulerian influence, broad and arbitrary

1968-77- IPSS by WHO using Wing's PSE

1980- DSM-III – conceptual departure, Schneider influence

DIAGNOSTIC CRITERIA
DSM- 5

Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be (1), (2), or (3):

1. Delusions
2. Hallucinations
3. Disorganized speech (e.g. frequent derailment or incoherence)
4. Grossly disorganized or catatonic behavior
5. Negative symptoms (i.e. diminished emotional expression or avolition)

DIAGNOSTIC CRITERIA

- Continuous disturbance of 6 months(attenuated or residual symptoms)
- Significant social and/or occupational dysfunction for most of period
- Catatonia as a specifier
- No sub-types

DIAGNOSTIC CRITERIA
ICD-10

1 month continuous duration

One of the following:

a. Thought echo, thought insertion/broadcast/withdrawal
b. Passivity, delusional perception of control
c. Third person auditory hallucinations
d. Bizzare persistent delusions

Or two of :

e. Persistent hallucinations or delusions
f. Thought disorder
g. Catatonic behavior
h. Negative symptoms
i. Significant behavior change

DIAGNOSTIC SUBTYPES

Diagnostic subtypes of schizophrenia ICD-10.

1. Paranoid - paranoid delusions, auditory hallucinations, perceptual disturbances

2. Hebephrenic- Affective disturbances, thought disorders, fleeting and fragmented hallucinations and delusions, unpredictable behaviour, mannerisms, incoherence, social isolation

DIAGNOSTIC SUBTYPES

3. Catatonic- Psychomotor disturbances, Posturing and other features

4. Undifferentiated- When symptoms do not fit any single category

5. Post-schizophrenic depression- Depressive episode following acute illness

DIAGNOSTIC SUBTYPES

6. Residual Schizophrenia- long standing negative symptoms with H/O psychotic symptoms

7. Simple Schizophrenia- no overt psychotic symptoms with deterioration of daily/social functioning, strange behaviors, negative symptoms

8. Other schizophrenia

9. Schizophrenia unspecified

DIAGNOSTIC CRITERIA

DSM-V	ICD-10
6 months	1 month
No subtypes	subtypes
Functional deterioration	No functional deterioration
Exclude mood disorder	Doesn’t exclude mood disorder

ICD-11

Renamed block: schizophrenia spectrum and other primary psychotic disorders

Similar to DSM-5, subtypes omitted

Replaced by coded qualifiers (symptom, course, functional)

SYMPTOMS OF SCHIZOPHRENIA

FIVE FACTOR MODEL

Clustering into sub-syndromes

(dimensions):

1. Psychotic
2. Negative
3. Disorganisation
4. Depression and anxiety
5. Agitation

HALLUCINATIONS

False sensory perception occurring in the absence of any relevant external stimulation of the sensory modality involved (CTP)

Perceptions that can cause people to “feel all the torture and perhaps all the pleasant things”

Hallucinations- the general population, substance use, anxiety disorder and other disorders

Hallucinations in schizophrenia have greater chronicity

HALLUCINATIONS

Hallucinations can be:

1. Auditory (most common)
2. Visual
3. Olfactory
4. Gustatory
5. Tactile

HALLUCINATIONS

AUDITORY HALLUCINATIONS-

most common

The IPSS studies -more than 70 percent of people with schizophrenia have auditory hallucinations.

Believe them to be real, from external source and test reality of voices.

HALLUCINATIONS

Verbal auditory hallucinations- generally derogatory, threatening and profane

Response- guilt, depression, belligerence

Emotional experiences, stressors, illness- increase frequency and intrusiveness of hallucinations

Unremitting or irregular and infrequent

HALLUCINATIONS

Types:

1. Voices- clear and understood, at times whisper or from distance. Single words. Gender generally identified. Mean 3 voices

2. Elementary hallucinations- footsteps, telephone ring, buzzing, music, etc

3. Extracampine hallucinations- perception was received by the patient outside the sensory apparatus

HALLUCINATIONS

Initially upsetting.

Coping strategies-

1. Yelling/ humming
2. Some degree of insight
3. Limited control over prosody/ content
4. Companionship with voices

HALLUCINATIONS

COMMAND AUDITORY HALLUCINATIONS

- Lifetime prevalence = auditory hallucination prevalence
- Likely to follow if -
  1. Real
  2. Benevolent
  3. Omnipotence
  4. Adverse consequences
  5. Non-violent command
  6. Trait anger and impulsivity
  7. Congruence to delusional beliefs

HALLUCINATIONS

VISUAL HALLUCINATIONS

Do not exceed 55% prevalence - Total 1/3 of all pts in lifetime

Relatively uncommon in absence of auditory hallucinations

Suggested to predict more severity

HALLUCINATIONS

The most common visual hallucinations are formed images of animate objects, people, or parts of people, religious images, fantastic creatures

Inanimate objects, grids, lines

Dramatic distortions of world itself

HALLUCINATIONS

Lilliputian hallucinations are rarely present in schizophrenia- mostly encephalopathic process

More discrete and limited in duration

Continuum with illusions elicited

Content influenced by culture

HALLUCINATIONS

TACTILE HALLUCINATIONS

Tactile hallucination -15 to 25 percent persons with schizophrenia.

Eg: touch, burn, cut, electric shock, sexual assault, someone entering and exiting body

Types:

1. Superficial (thermic, haptic, hygric, paraestethic)
2. Kinaesthetic
3. Visceral (deep)

HALLUCINATIONS

OLFACTORY AND GUSTATORY HALLUCINATIONS:

Small minority of patients, olfactory hallucinations the more common

Smells of rotting meat, garbage , and faeces common, and the taste of blood or metal frequently described

DELUSIONS

False belief that is firmly held, despite objective and obvious contradictory proof or evidence and despite the fact that other members of the culture do not share the belief (CTP)

DELUSIONS

Can occur in general population, other disorders

Recent research- no ‘direct experience of meaning’ but reasoning errors

Continuum with over-valued ideas. Flexible and changing at times

clinically significant delusions in schizophrenia may exceed 70 percent.

DELUSIONS

Delusions in schizophrenia are-

1. More strongly held
2. Preoccupy more time
3. More pervasive in influence on patient cognition

To explain hallucinations. More systematized when complex and persistent hallucinations

“Rush to judgement” trait

DELUSIONS

1. Delusions of persecution(most common)
2. Delusions of reference
3. Delusions of bodily control
4. Thought broadcasting/ Thought insertion
5. Grandiose delusions
6. Bizzare delusions

DELUSIONS

Delusions of persecution-False belief of being harassed or persecuted

Most common- up to 80% of inpatients

From doubts about strangers intentions to conspiracies by govt, corporates, family

DELUSIONS

Delusions of reference- It refers to delusions in which neutral stimuli or events or people take on a particular significance in reference to the person who experiences delusion

Persecutory or self-aggrandising slant

DELUSIONS

Bizarre delusions- delusions that are considered implausible and physically impossible by people who are in the patient's culture

Not pathognomonic although more common in schizophrenia

Rater reliability low

Special status dropped in DSM-V

DELUSIONS

Delusion of control- False belief that a person's will, thoughts, or feelings are being controlled by external forces

Thought insertion-Delusion that thoughts are being implanted in one's mind by other people or forces

Thought broadcasting- Feeling that one's thoughts are being broadcast or projected into the environment, are audible to others

DELUSIONS

Delusions of grandiosity - Exaggerated conception of one's importance, power, or identity.

Others-

Delusion of guilt, sin, jealousy, infidelity, poverty, love

NEGATIVE SYMPTOMS

Negative symptoms represent “a loss or diminution of normal functions”.

John Strauss and *William Carpenter, T.J. Crow, Nancy Andreasen through 1970-80 – acknowledgement of negative symptoms*

NEGATIVE SYMPTOMS

T.J. Crow- two syndrome concept (+/-)

Nancy Andreasen- reliable rating scales (PANSS, SANS, SAPS)

40% Patients had significant negative symptoms and half of those didn’t have significant positive symptoms in CAITIE

NEGATIVE SYMPTOMS

The National Institutes of Mental Health (NIMH) MATRICS consensus 2005 - 5 categories

1. Avolition
2. Anhedonia
3. Affective blunting
4. Asociality (social withdrawal)
5. Alogia

NEGATIVE SYMPTOMS

1. Avolition- loss of will or drive

According to DSM-V it is an inability to initiate and persist in goal-directed activities" and specifies subsequent deficits in work, intellectual pursuits, and self-care as resulting from avolition.

NEGATIVE SYMPTOMS

2. Anhedonia- In DSM-5, anhedonia is “Lack of enjoyment from, engagement in, or energy for life’s experiences; deficits in the capacity to feel pleasure and take interest in things.”

most persistent of the negative symptoms experienced by at least half the pts of schizophrenia

Not depression when part of negative symptoms

NEGATIVE SYMPTOMS

3. Affective blunting- consists of both an inability to understand or recognize displays of emotion from others and an inability to express emotions (Flat affect)

It is more common in men, people with an early onset illness, people with poor premorbid function

predicts lower scores on quality-of life measures

NEGATIVE SYMPTOMS

4. Social withdrawal- indifference to social relationships and decrease in the drive to socialize.

Patients with social withdrawal have deficits in *theory of mind*- ability to understand how another person might be thinking when there is common knowledge of their current circumstance

NEGATIVE SYMPTOMS

5. Alogia- It is the decrease in verbal communication or ‘poverty of speech’ due to decreased verbal cognition

And it is found in up to 25 percent people of schizophrenia.

This loss of production includes an increased latency to response, short verbal responses, and a paucity or complete lack of spontaneous production

NEGATIVE SYMPTOMS

Causes-

1. Primary
2. Iatrogenic (long IPD stays)
3. Secondary to positive symptoms
4. Neuroleptics
5. Depression

Those which don’t remit in a year should be considered primary negative symptoms

PRIMARY NEGATIVE SYMPTOMS

Negative symptoms that appear intrinsic to the disease process for the affected person.

The Schedule for the Deficit Syndrome

The Schedule for the deficit syndrome requires the presence of two or more negative symptoms in a patient with schizophrenia. At least two symptoms should have been present in the preceding year, and the symptoms are not better attributed to other symptoms of schizophrenia, to another psychiatric illness, or to a medication effect.

PRIMARY NEGATIVE SYMPTOMS

The six negative symptoms listed it the schedule for the deficit syndrome are as follows:

1. Restricted affect
2. Diminished emotional range
3. Poverty of speech
4. Curbing of interests
5. Diminished sense of purpose
6. Diminished social drive

DISORGANIZATION

Disorganization symptoms certainly include the formal thought disorders, bizarre and catatonic behaviours and inappropriate affect.

It also includes the erratic episodes of agitation and aggression, including assuming postures suggesting the person is preparing for violence.

DISORGANIZATION

Disorganization syndrome- the most heritable of the sub-syndromes of schizophrenia.

INCLUDES:

1. Thought disorders
2. Inappropriate affect
3. Bizarre and catatonic behaviors

Impairment of attention and poverty of content of speech fit best in the disorganization symptoms.

Poor hygiene and Indifference to activities of daily living

DISORGANIZATION

THOUGHT DISORDER-

It is the most studied form of disorganization symptoms.

Thought disorder here refers to the disorganization of the form of thought and not content.

And speech is examined as a means to determine a patient's verbal cognition.

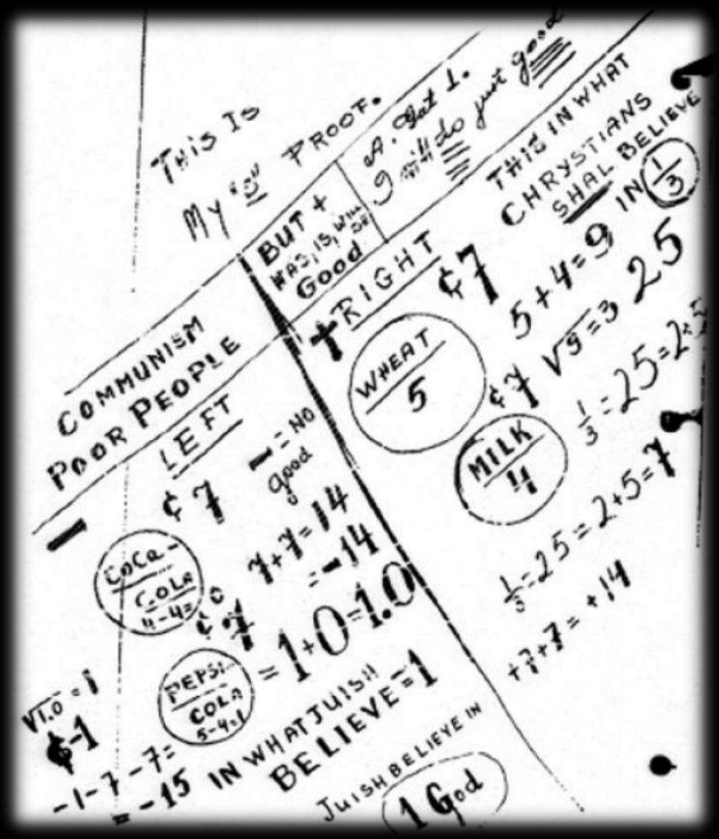
DISORGANIZATION

Speech may be Tangential.

Loosening of associations or derailment is frequent

Loosening of associations refers to changes in topic without identifiable links between the subjects and indicates a lack of internal structure for thought expressed as speech

derailment is a shift in topics

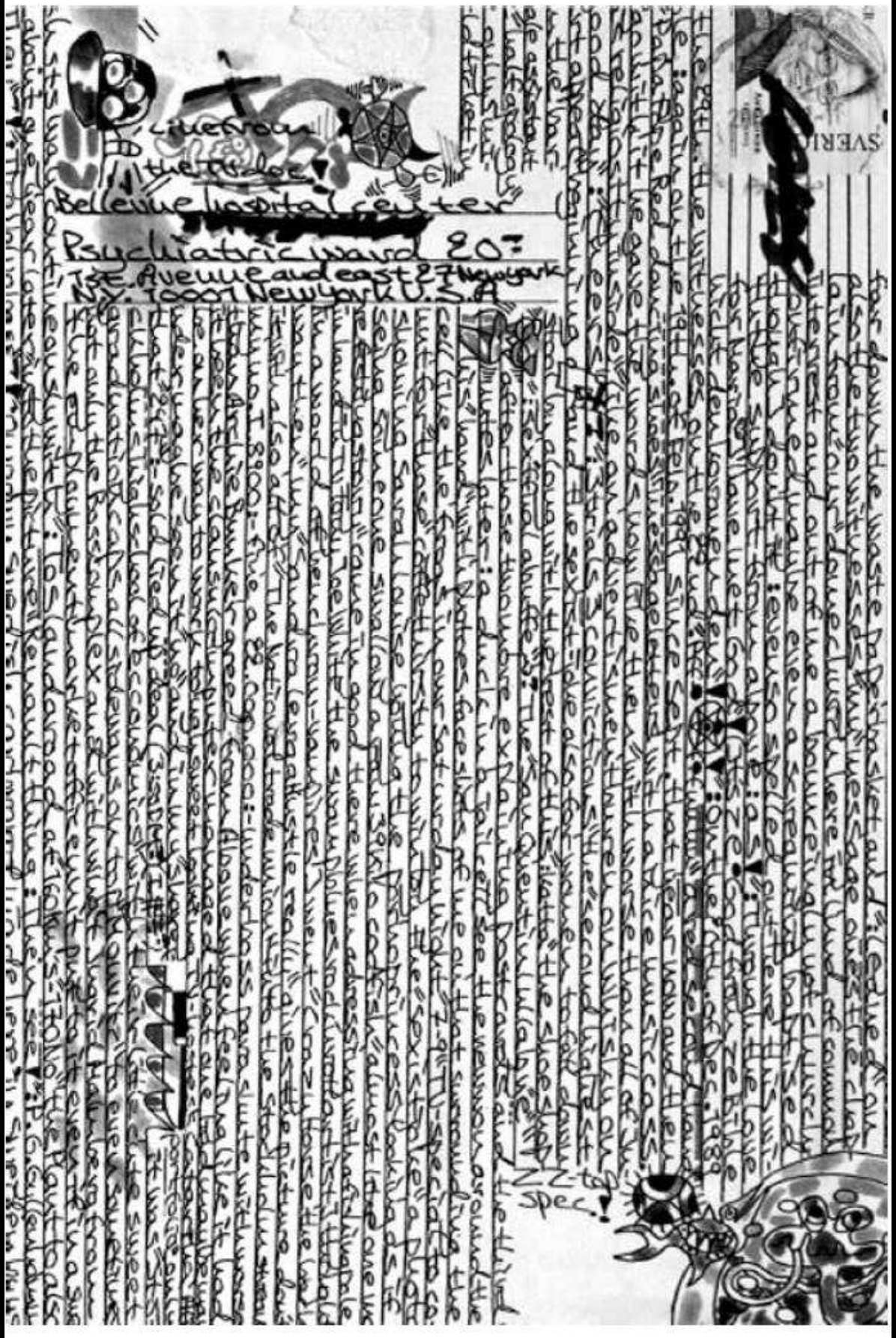


DISORGANIZATION

incoherence is a shift within clauses.

Patients can be present in severe form with:

- Neologisms
- Echolalia
- Word salad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Psychiatric Ward 20
First Avenue and East 27th
N.Y. 10001 New York U.S.A.
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DISORGANIZATION

more impaired in comprehension, attention, semantic organization, and fluency and complexity of speech in thought disorder of schizophrenia

Prominent thought disorder at illness onset and those not responding to treatment predict worse prognosis

DISORGANIZATION

Inappropriate affect - wildly inappropriate expressions of affect including odd or exaggerated gestures, singsong or childlike changes in prosody, silly or inappropriately bright affects, or alternatively, grimacing and wide-eyed expressions of surprise or anger.

Socially disabling and poor response to treatment

DISORGANIZATION

MOTOR SYMPTOMS-

Disturbance in motor activity seems to be more related to the disorganization symptoms.

It can include subtle repetitive hand movements or purposeless moments involving limbs and trunk.

Patients may sometimes mimic the motor behaviours of other referred to as Echopraxia.

DISORGANIZATION

Symptoms of catatonia are included in the disorganization symptoms.

Catatonia is suggested to be motor behaviour generated with “a marked decrease in reactivity to the environment”.

An early onset of prominent motor symptoms may predict greater disability and a deteriorating course.

CATATONIC SYMPTOMS

Ambitendence- Alternation between opposite movements

Echopraxia- Automatic imitation of another person's movements even when asked not to.

Stereotypies- Repeated regular fixed parts of movement (or speech) that are not goal directed, e.g. moving the arm backwards and outwards repeatedly while saying 'but not for me'.

CATATONIC SYMPTOMS

Negativism- Motiveless resistance to instructions and attempts to be moved, or doing the opposite of what is asked

Posturing- Adoption of inappropriate or bizarre bodily posture continuously for a substantial period of time

Waxy flexibility- The patient's limbs can be 'molded' into a position and remain fixed for long periods of time

DEPRESSION AND ANXIETY

Many, probably most, people with schizophrenia will experience significant depression and anxiety during the course of their illness.

Depression is the common symptom in the early course of illness, with about half of all patients experiencing significantly depressed mood especially during prodrome and first break

DEPRESSION AND ANXIETY

Disturbances of sleep, appetite, energy and concentration can be so common in schizophrenia that they become useless in screening for depression in these patients.

There is little known about anxiety in schizophrenia other than it is very prevalent.

Experience suggests that anxiety in schizophrenia can precipitate violence and suicidal ideation.

DEPRESSION AND ANXIETY

Social phobia, panic attacks and panic disorder, and generalized anxiety disorder are common in schizophrenia

Social phobia most common- 15%

Feed-forward cycles of persecutory delusions and related hallucinations precipitating panic, which then can worsen psychosis

PTSD- 12%

AGITATION

SUICIDE AND VIOLENCE-

Suicide accounts for a good part of the excess mortality that is usually found in schizophrenia.

20 to 40 percent people with schizophrenia will make a suicide attempt sometime during their illness. Suicide rate- 10%

A common finding suggests that people with schizophrenia are 4 times as likely as people without schizophrenia to be engaged in violent acts and 10 to 20 times higher risk of homicide

INSIGHT

Insight refers to the capacity of the patient to recognize that their metal symptoms are indicative of mental illness and that these symptoms require treatment.

Lack of insight was the most common symptom of schizophrenia in the IPSS.

INSIGHT

Poor insight is associated with decreased compliance, worse overall function, recurrent illness and poor outcomes.

Although good insight at the onset is a favourable prognostic factor, at present it cannot be concluded that improving poor insight will lead to better outcomes.

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THANK YOU


PSYCHIATRIST
ROY NIXON
CARTOONSTOCK
"I'VE GOT A FRIEND WHO THINKS I'M NAPOLEON."