UNIT 2 SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS

Structure

2.0 INTRODUCTION

In the previous Unit, you have learnt about historical perspective of mental disorders and need for their classification. In this Unit, we shall learn about schizophrenia and other psychotic disorders. Worldwide, schizophrenia and other psychotic disorder represent a major health problem and result in huge burden on the individual, family and society.

Objectives

After studying this unit, you will be able to:

- define severe mental illness;
- describe the classification of schizophrenia and other psychotic disorders;
- describe clinical features of schizophrenia;
- explain the causes of schizophrenia;

2.9 Answers to Self Assessment Questions

2.10 Unit End Questions

2.11 Suggested Readings
2.1 SEVERE MENTAL ILLNESS

Schizophrenia and related psychotic disorders are a group of severe mental illnesses. In severe mental illness, a person has mental health problems that are persistent, result in moderate to severe disability and may require treatment for long time. One of the ways in which mental health problems, in severely mentally ill persons manifest is psychosis.

Psychosis is a psychiatric condition in which a person has hallucinations, delusions, disorganised behaviour and impaired reality testing. Hallucinations are false perceptions without any stimulus which means s/he may perceive something that does not exist in reality e.g., s/he may start hearing voices of people talking when there is no one around. These can occur in all five senses like sound, sight, smell, touch and taste and are called auditory, visual, olfactory, tactile and gustatory hallucinations. Delusions are firmly held false beliefs that cannot be corrected by any amount of reasoning or evidence to the contrary. These beliefs cannot be explained by the person’s educational, social and cultural background. Delusions may be of many types e.g. delusion of persecution, grandiosity etc. Persons with psychosis are unaware that their experiences could be imaginary and they cannot differentiate real from unreal. There is severe disturbance in social and personal functioning.

Self Assessment Questions 1

Note:  i) Read the following questions carefully and answer in the space provided below.

ii) Check your answer with that provided at the end of this unit.

1) What is severe mental illness?

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2) What is psychosis?

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2.2 CLASSIFICATION OF SCHIZOPHRENIAS AND OTHER PSYCHOTIC DISORDERS

You have already learnt in the previous chapter that in India, Chapter V (F) of tenth revision of International Classification of Diseases (ICD -10) is used for making diagnosis of psychiatric disorders. A psychiatric disorder is a syndrome where a group of signs and symptoms occur together to make up a recognisable psychiatric condition.
In ICD-10, schizophrenia and other psychotic disorders are classified under F20-F29 and contain all types of psychoses which are not due to organic causes, abuse of psychoactive substances or mood disorders. These are as follows:

F20 Schizophrenia
F21 Schizotypal disorder
F22 Persistent delusional disorders
F23 Acute and transient psychotic disorders
F24 Induced delusional disorder
F25 Schizoaffective disorder
F28 Other non organic psychotic disorder
F29 Unspecified non organic psychosis

Schizophrenia is the commonest and most important disorder of this group and will be discussed in detail.

Self Assessment Questions 2

Note:  
1) Read the following question carefully and answer in the space provided below.
2) Check your answer with that provided at the end of this unit.

1) Which classificatory system is used for making diagnosis of psychiatric disorders in India?

2.3 SCHIZOPHRENIA

The term schizophrenia was introduced by the Swiss psychiatrist Eugene Bleuler at the beginning of last century.

2.3.1 Epidemiology

People have conducted studies worldwide and reported that persons with schizophrenia are present across all geographical locations and societies in the world. In adults, incidence rates per year (proportion of new cases in one year) is 0.1-0.4 per 1000 population. Life time prevalence (proportion of existing cases, both old and new) of schizophrenia is about 1%. To understand it better, let us consider a locality where 10,000 adults reside. In that locality, every year about 1-4 new persons will have schizophrenia. However, in their life time, about 100 persons may have schizophrenia. Therefore, although incidence of schizophrenia is low, due to persistence of symptoms, the prevalence is relatively high. Schizophrenia most commonly occurs in young people. The age of onset is 15-35 years and it occurs often earlier in men than in women although men and women are affected equally.

2.3.2 Clinical Features

Before proceeding with this section let us see how a hypothetical case of schizophrenia presents.
Mr. S., a 30-year-old married, 10th passed salesman with no past or family history of psychiatric disease with good work record and stable interpersonal relationships, was brought by his parents with a 2-month history of abnormal behavior. He was fine till about 2 months back when a gradual change in his behavior was noticed. After coming back from work, he would remain in his room instead of talking to family members, watching TV, eating dinner with them which was his usual routine. He also looked preoccupied and interacted less with family members. At times he would not eat his meals. He was noticed to have less sleep and would pace up and down in his room. When asked by family members why he remained lost, he told them that there were cameras fitted in their house to spy on him. He also told them that this was done by their neighbors. Their neighbors were being paid by his colleagues in the office who were planning to implicate him in a false case. He would also insist on keeping the lights switched off so that cameras were not able to catch what they were doing. His family members tried to argue with him that he always had good relationship with neighbors and his colleagues but he would not be convinced. He also told that in the streets, people were talking about him. He started remaining self-absorbed and was seen muttering and smiling to self and would give no reason for the same. Family members would coax him to take bath and change clothes. He stopped going for work and stopped meeting his friends. He would become angry on trivial matters. Later, he started accusing family members that they were helping his colleagues and stopped talking to them and would abuse them without reason.

There was no history of alcohol/drug abuse and any physical disease. On physical examination no abnormality was detected.

Psychiatric evaluation revealed ill-kempt, ill-groomed individual. He was muttering to self. He told the doctor that his colleagues were planning to kill him and had recruited many people to help them. His food was poisoned, his neighbors discussed about him all the time and called him names and threatened him. Though he heard their voices clearly, he could not see them in the vicinity. He also told that they had fitted a camera and a sensor in his house through which they were constantly emitting electric waves which hit him like current against his will. He denied that he had any problem and did not see any point in taking treatment.

What is the problem with Mr. S.? Mr. S. has schizophrenia. This case highlights the main clinical features of schizophrenia. We will discuss about findings of this case once you have understood the signs and symptoms of schizophrenia.

In schizophrenia, there are characteristic disturbances of thinking, perceptions and emotions that affect the most basic functions in persons with schizophrenia. Consciousness remains clear and intellectual capacity is usually maintained, although certain cognitive deficits may also be noticed.

The knowledge of these typical changes helps in making diagnosis of schizophrenia by eliciting symptoms in history from the informants/patients and the signs on psychiatric examination. This is in contrast to a physical illness like tuberculosis where simple laboratory tests confirm the diagnosis; there are no laboratory tests available for detecting schizophrenia.

**Symptoms in history from the informants/patients**

The changes in behavior are generally noticed by people who are in close contact with the patients like family members, friends or teachers. These behavioral changes may develop rapidly over a period of days to weeks (acute onset) or gradually over months.
(insidious onset). The recognition of symptoms is easier if the behavioural changes are marked and develop suddenly.

Initially, very few changes may be noticed like sleep disturbances, irritability, remaining preoccupied or appearing different from his/her usual self. Some of the patients may not answer relevantly to the questions asked. Their speech may be difficult to understand because of lack of proper connections between sentences or phrases or words. They may speak very less or may not speak at all. However, some patients may continue to speak relevantly and coherently.

The patients may express thoughts which are false and do not correspond to the reality. They may remain convinced about these beliefs even on the face of opposite evidence, e.g. they may believe that there is a conspiracy against them, strangers are talking about them, their actions/emotions being controlled by others/some external force etc.

They may laugh or cry without any apparent reason, mutter or talk or shout loudly to self and may make apparently meaningless gestures in the air. It may appear as if they are talking/communicating with someone. This is generally in response to hearing voices of people talking whereas in reality, no one is talking. These voices may talk to the patient in second or third person, give command to the patient or may comment on his/her actions. The content of the voices may be abusive, threatening or neutral.

They may appear depressed, anxious, irritable or fearful or alternatively may show lack of emotions and emotional reactivity. They may remain emotionally indifferent and may not participate in the family events like festivals, death, marriage etc. Sometimes, they may show inappropriate emotional reactions.

They may become restless or alternatively, their body movements may become slow and awkward, and they may remain in same position for long periods e.g. standing at one place for hours.

They may appear shabby as they neglect their personal care. They need to be reminded for doing activities of daily living like brushing teeth, taking bath, changing clothes, taking food etc. Their functioning at home, school or job may deteriorate. They may lose interest in the activities which they earlier used to be fond of like watching TV, reading newspaper, dressing, etc. They may avoid company and stop interacting with family members, friends and others. They may withdraw from world around them and start believing in the reality of their imaginary experiences. They are reluctant to seek medical help as they believe that there is nothing wrong with them. They are also at increased risk of having alcohol and drug problems and suicide.

**Signs on psychiatric examination**

*Psychosis:* In the section 2.1, you have already learnt that psychosis is characterised by hallucinations, delusions, disorganised behaviour and impaired reality testing. These may be present for long time before others notice them. Auditory hallucinations are the most common type of hallucinations in schizophrenia. Some of the typical auditory hallucinations are running commentary (voices comment on behaviour of the patient), commanding (voices command to do certain actions), third person (voices talk to each other about the patient), thought echo (patients hear aloud what they think). In some patients, visual, tactile, olfactory and gustatory hallucinations may also be present. Somatic passivity is special type of hallucination in which the patient believes that he/she is passive recipient of the bodily sensations caused by an external agency e.g. may report that electric sensations in his/her body are being sent by neighbours. Typical delusions seen in patients with schizophrenia are:
Classification of Mental Disorders

- Delusion of control: The patients believe that their emotions, behaviour or sensations are under the control of some external agency.

- Bizarre delusions: absurd and implausible beliefs.

- Delusions of thought withdrawal and insertion: believe that their thoughts are withdrawn or new thoughts are being inserted into their mind.

- Delusion of thought broadcast: believe that their thoughts are known to others without their speaking them aloud.

- Delusional perception: patient attributes a new meaning, usually in the sense of self-reference, to a normally perceived object.

- Delusion of reference: believe that people are talking about them or are laughing at them. They may believe that people are talking about them on television, radio and newspaper and

- Delusions of persecution: believe that they are being cheated, harassed or poisoned. They may also report that people/agency is spying and plotting against them or their close associates.

**Formal thought disorder:** In some patients with schizophrenia, speech may appear vague and woolly. It may be incomprehensible, irrelevant and incoherent. There may be break in thoughts which manifest as loss of apparent connection between sentences, phrases or words and is because of difficulty in organising their thoughts. Neologism is use of new words with special meaning for the patient.

**Catatonic signs:** Some patients with schizophrenia may show problems in motor movements called catatonic signs. Their body movements may become odd and clumsy like maintaining same and awkward postures for long time, grimace or show unusual mannerisms and mimic movements (echopraxia) or speech (echolalia) of others, run without purpose or become completely immobile. Some patients may become mute (not speaking at all) and have stupor (complete absence of movements).

**Negative signs:** In some patients, especially in those with long duration of illness, there may be loss/decrease in mental functions, these are called negative signs. Some of the negative signs seen in patients with schizophrenia are anhedonia (loss of interest in previously pleasurable activities), apathy (lack of emotions, poor reactivity to any event), alogia (minimal/no speech), avolition (decreased/absent motivation to initiate or maintain activities) and asociality (minimal/no interaction with others).

The negative signs are more difficult to identify than positive signs. The family members may incorrectly assume that patients with negative symptoms are lazy and do not want to do any work.

**Cognitive impairment:** It is now believed that patients with schizophrenia have problems in cognitive functions like attention, memory, decision-making, motor skills, executive functions and intelligence. Cognitive deficits are most difficult to recognise but have the most disabling impact on day to day normal functioning.

### Self Assessment Questions 3

**Note:**

1) Read the following questions carefully and answer in the space provided below.

2) Check your answer with that provided at the end of this unit.
2.3.3 Diagnosis

As has been discussed earlier, for making diagnosis of schizophrenia, diagnostic guidelines are given by International Classification of Diseases – tenth revision (ICD-10). These guidelines require the symptoms to be present for duration of at least one month. Diagnostic Guidelines for Schizophrenia as per ICD-10 are:

- At least one of the following must be present most of the time for a month:
  a) Thought echo, thought withdrawal, thought insertion, or thought broadcast.
  b) Delusions of control for the movements of the body or extremities, specific thoughts, acting or feelings, delusional perception.
  c) Hallucinatory voices; running commentary, discussing the patient in third person, or voices coming from some parts of the patient’s body.
  d) Bizarre or culturally inappropriate delusion.

  OR

- At least two of the following first three must be present most of the time for a month; or last one symptom for 2 years:
  e) Persistent daily hallucinations accompanied by delusions
  f) Formal thought disorder (incoherent speech)
  g) Catatonic symptoms
  h) Negative symptoms

  AND

- A significant and consistent change in the overall quality of some aspects of personal behaviour, manifest as loss of interest, aimlessness, idleness, a self-absorbed attitude, and social withdrawal.
Classification of Mental Disorders

- Such symptoms should not be due to organic causes or due to psychoactive substance use.

If there is indication in history towards the presence of organic (physical/medical diseases) causes and psychoactive substance use responsible for symptoms of schizophrenia, further physical examination and investigations should be done to rule these out. The pointers towards presence of organic causes are:

- Sudden appearance of symptoms in previously healthy person
- Elderly
- Presence of fever
- Presence of altered consciousness and inattiveness
- Presence of confusion, memory problems
- Presence of urinary and/or bowel incontinence
- Reversal of sleep wake cycle i.e. sleeping in the time and remaining awake in the night
- Presence of visual hallucinations
- History of any other medical condition.

Schizophrenias have been further classified into paranoid, hebephrenic, catatonic and undifferentiated types.

**Paranoid schizophrenia:** The patients may have persecutory, referential or grandiose delusions with relatively less effect on speech, behaviour and affect.

**Hebephrenic schizophrenia:** The patients may show shallow and inappropriate emotions and ill organised, fleeting delusions or hallucinations.

**Catatonic schizophrenia:** The patients show predominantly catatonic signs.

**Undifferentiated schizophrenia:** The patients may have all above mentioned symptoms and signs with no specific features.

Now, Let us go back to Mr S. On psychiatric examination, he had delusions of persecution, delusional perception (criteria b) and third person auditory hallucinations (criteria c) with derogatory content and he lacked insight into these problems. He had these symptoms for more than 1 month and had significant dysfunction. His physical examination was normal and there was no history of drug/alcohol abuse or medical disease. Therefore, his illness had no organic basis. Mr S. has Schizophrenia. As he had persecutory delusions, he has paranoid schizophrenia.

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| **Note:**  
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   ii) Check your answer with that provided at the end of this unit.  

1) How many types of schizophrenias are there?  

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2.3.4 Etiology

There is no known single cause for schizophrenia like malaria is caused by malarial parasite. It is considered a biological disease which results from interplay of multiple factors like genetic and environmental factors.

2.3.4.1 Genetic Factors

Genetic vulnerability to schizophrenia has been found to be multifactorial which is caused by interaction of several genes. Role of genetic factors has been demonstrated by family, adoption and twin studies. People who have a close relative with schizophrenia are more likely to develop the disorder than the people who have no relatives with the illness. The genetic closeness and genetic loading to the person with schizophrenia increases the risk for schizophrenia. If both parents are affected, the risk in children of having schizophrenia is 50%. The risk is about 10% in siblings of patients with schizophrenia. Twin studies show that rate of having schizophrenia in non-identical and identical twin of patients with schizophrenia is 8-12% and 50% respectively.

2.3.4.2 Environmental Factors

The environmental factors like poverty, lower socioeconomic class, residence in rural area have been linked to higher rates of schizophrenia. In the mothers of patients with schizophrenia, smoking, poor nutrition and infections during pregnancy have been reported. Further, complications during delivery and such as hypoxia (low oxygen levels) before, at, or immediately after birth may also be a risk factor for causing schizophrenia. The family members of patients with schizophrenia show high expressed emotions in the form of critical comments, emotional over involvement and hostility.

The changes in neurotransmitters like dopamine, serotonin and nor-epinephrine, have also been associated with schizophrenia. Brain-imaging studies (CT scan, MRI scan etc.) have shown certain structural changes in the brain like enlarged ventricles, reduction of cerebral blood flow, volume and cortical grey matter. Prenatal risk factors such as pre-natal stress, pre-natal malnutrition and pre-natal infection have also been implicated as causal factors of schizophrenia. Various infections during childhood such as influenza, polio, measles etc. have been correlated with later development of schizophrenia.

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<td>ii) Check your answer with that provided at the end of this unit.</td>
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<tr>
<td>1) What is the risk for schizophrenia in immediate family members of patient with schizophrenia?</td>
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2.3.5 Treatment

Management of patients with schizophrenia involves use of antipsychotic drugs and psychosocial interventions. The goal of the treatment is to help patients with schizophrenia
Classification of Mental Disorders

to function well and lead productive lives. The treatment is planned according to the specific needs of the patients and their families. Use of the antipsychotic drugs is the mainstay of treatment as these help in relieving the symptoms and prevent further relapse. Psycho-education helps patients and families cope with the illness. Rehabilitation is important for restoring educational and occupational functioning of the patient.

2.3.5.1 Pharmacological Treatment

The drug treatment can be prescribed only by a qualified physician. Most of the patients with schizophrenia can be treated with antipsychotic drugs at their homes. The antipsychotic drugs have to be started as soon as possible as improvement in symptoms takes place gradually. First sleep, appetite and agitated behaviour improve followed by improvement in psychotic symptoms and negative symptoms take long time to improve. These drugs are started at low dosage and gradually increased depending on the improvement. A drug should be tried for minimum of 4-6 weeks in adequate dosage. An important thing to remember is that the drug should not be stopped soon after improvement and should be continued for a long period, beyond the point of recovery, to prevent relapses or deterioration. The drug treatment should only be stopped on the advice of treating physician. Majority of patients show improvement on antipsychotic drugs.

The family members should be educated about the chances of recurrence and characteristic symptoms with which illness presents in the patient. The drugs need to be restarted in case of a recurrence. In about 20% of cases, relapses occur even if they are on continuous medicines. Even if a recurrence occurs while on medicines, the intensity of the symptoms and the frequency of the relapses is less.

In some situations, hospitalisation usually for 4-6 weeks, is indicated like when patient shows grossly disorganised or inappropriate behaviour, has suicidal ideations, is violent and unmanageable.

Drug compliance, the extent to which patients follow the recommended treatment, is an important issue in the treatment of schizophrenia. Poor drug compliance may lead to no improvement in symptoms or relapse in improved patients. There are many reasons for poor drug compliance. Family members and patients may have negative view about medications e.g. may consider these to be addicting. Patients may believe that they are not ill and therefore may not take medications. Prescribing physician may not have explained the treatment plan and side effects adequately. Family members and patients may not understand the instructions correctly so may unintentionally take drugs in wrong dose/timing or may incorrectly stop treatment when the patient is feeling better.

For improving the drug compliance, family members and patients should be adequately educated about the prescribed medications. Most of these drugs can be given in a single night time dosage and can be scheduled according to the patient’s daily routine and work. Oral intake of these medicines by patients needs to be carefully observed as some of them may not swallow the tablets and later on throw away the tablets. Some drugs are available as long-acting depot injections which may be repeated at an interval of 2-4 weeks.

2.3.5.2 Psychosocial Treatment

Schizophrenia afflicts people when they are young, the time for getting education, training for vocation and making new relationships. Therefore, many of them may not complete their education, may lack vocational skills required to work on any job and may not have skills to build friendships/intimate relationships. The psychosocial interventions
are non medical interventions which help in dealing with difficulties in personal and socio-occupational functioning. We shall be considering only two types of psychosocial interventions: Psychoeducation and rehabilitation.

**Psychoeducation**

Psychoeducation aims at improving the treatment compliance, reducing risk of relapse and admission rates. In India, families are the primary care givers for 95% of the persons with schizophrenia and experience significant burden and stigma. They should be engaged early in the treatment. The psychoeducation also helps in decreasing the burden and stigma experienced by their families.

The families and patients are educated over multiple sessions about the schizophrenia. Common misconception about schizophrenia, especially in the rural areas, is that it is due to curse/black magic/sins of previous births and should be treated by faith healers. They have to be educated that it is a biological disease like heart disease/diabetes mellitus with multi factorial causation and should be treated with drugs prescribed by a qualified physician. They are also explained about various drug treatments available, their side effects, and schedule of how to take these drugs. They may have apprehensions about use of antipsychotic drugs in the treatment. Some may worry that the antipsychotic drugs are addicting and turn the patient into a zombie. It has to be explained that these drugs are not addicting as these do not produce joy or drug seeking behaviour. Also, they may believe that these drugs act as a kind of mind control by sedating the patient. Though sedating effect of these drugs can be useful but it is their ability to diminish the hallucinations, agitation, confusion, and delusions which is curative. They have to be explained that although medications do have some side-effects, their beneficial effects far outweigh the side effects. They should keep a record of name of medications, side effects and effectiveness of the medications. They need to be psycho-educated about issue of drug compliance in these patients as about 50% of outpatients and 20% of inpatients fail to take prescribed medications. So ensuring drug compliance is very important. They are also sensitized to the variations in chances of recovery.

Sometimes there are misconceptions that these patients are violent, lazy, unproductive and that their illness is incurable. Most of these patients prefer to remain alone and are not violent; some especially those with drug/alcohol abuse may become violent in response to auditory hallucinations with derogatory/threatening content or persecutory delusions. Such incidents should be handled in a calm reassuring manner without fear. Due to the negative and cognitive symptoms, they may appear lazy and unproductive.

Certain myths and facts related to schizophrenia are given below:

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<thead>
<tr>
<th>Myths</th>
<th>Facts</th>
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<tr>
<td>Schizophrenia is caused by sins of previous life or black magic</td>
<td>Schizophrenia is a biological disease with multi factorial causation</td>
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<tr>
<td>Anti-psychotic drugs will make the person into a zombie</td>
<td>Anti-psychotic drugs help in reducing the symptoms of schizophrenias such as delusions, confusion etc.</td>
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<tr>
<td>Drugs will develop addiction</td>
<td>Rather, drugs are curative</td>
</tr>
<tr>
<td>Schizophrenia is not treatable</td>
<td>Can be treated with proper diagnoses &amp; early start of treatment</td>
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The patients should be encouraged to follow structured daily activity schedule and to
perform simple tasks around the house. Appreciation of the smallest task and achievements of the patients helps to boost their self confidence and productivity. The family members have to be tolerant and supportive. Emotional reactions to patients should be kept at low level and feelings must be expressed in a matter-of-fact way. Efforts should be made to engage patients in conversation, express interest in what they are talking and prolong normal conversation. The family members should not make derogatory statements. Talk to the patients and show an interest in what they are doing, even if they sound dull and repetitive. Ignore deluded or abnormal talk, appear interested and prolong normal talk and conversation.

A checklist of symptoms of the patient’s illness can be provided to the family to help them identify signs of relapse at the earliest like sleeplessness, increased restlessness, irritability, return of hallucinations, etc. The patient should be taken to a psychiatrist immediately so that medications may be restarted/adjusted.

### 2.3.5.3 Rehabilitation

In rehabilitation, the core intervention is training patients with schizophrenia to perform the skills required for improved personal and socio-occupational functioning. Principles of behavioural theories are used for training. Along with the training of patients, environment support should also be increased. Training must be tailored to the needs of individual patients as they present different combinations of social abilities and deficiencies and have varying degrees of support from their environment.

The methods used for rehabilitation are social skills training, vocational counseling, job training, problem-solving and money management skills, use of public transportation, etc.

Training is provided in doing daily activities such as bathing, cleaning, cooking, buying groceries and making financial transactions in bank. Social skills such as making friends, engaging in conversation and communicating with family and friends can also be taught.

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| **Note:** i) Read the following questions carefully and answer in the space provided below.  
  ii) Check your answer with that provided at the end of this unit. |
| 1) What steps can be taken to improve the drug compliance in patients with schizophrenia?  
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| 2) Highlight the points used in psychoeducation.  
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2.3.6 Course and Prognosis

The typical course of schizophrenia is one of exacerbations and remission and outcome is reported to be better in developing rather than developed world. After the first episode patients generally recover, many function normally for a relatively long period. Usually pattern of illness during first 5 years after diagnosis generally indicates the future course. With each relapse, there is further worsening in patient’s baseline functioning.

It is difficult to predict course of schizophrenia in an individual patient. However, presence of certain factors confers good prognosis, these are: female gender, late age of onset, good premorbid social functioning and work histories, acute presentation with positive symptoms, married, history of maintaining stable job, good support system and family history of mood disorders. Some of the factors related to poor prognosis are: young onset, no precipitating factors, insidious onset, poor premorbid social functioning and work histories, single divorced or widowed, family history of schizophrenia, poor support system, negative symptoms, presence of neurological signs and symptoms, history of perinatal trauma, no improvement in 3 years, many relapses and history of assaultive behaviour.

Self Assessment Questions 7

Note: i) Read the following questions carefully and answer in the space provided below.

ii) Check your answer with that provided at the end of this unit.

1) What are the factors which predict good prognosis in patients with schizophrenia?

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2.4 PERSISTENT DELUSIONAL DISORDER

Persistent delusional disorder is characterised by the development of a single delusion or a set of related delusions which are usually persistent and sometimes lifelong. These delusions can be persecutory, grandiose, jealous, or hypochondriacal. A person having hypochondriacal delusion firmly and falsely believes that he/she is suffering from serious disease. On psychiatric examination, apart from well systematized delusions, their mood, speech, and behaviour are normal. They may seem odd and eccentric because of actions related to their delusions.

It is an uncommon disorder, and prevalence is about 0.025-0.03%. The mean age of onset is about 40 years. It is slightly more common in females.

For making diagnosis on ICD 10, following criteria should be fulfilled.

- The presence of a delusion or a set of related delusions other than those listed as typically schizophrenic delusions
- The delusions must be present for at least three months.
- The general criteria for schizophrenia are not fulfilled.
- Persistent hallucinations in any modality must not be present.
Exclude evidence of brain disease or a psychotic disorder due to psychoactive substance use or secondary to mood disorder.

The disease runs waxing and waning course. The treatment is with antipsychotic drugs and psychosocial therapies including psycho education.

### 2.5 ACUTE AND TRANSIENT PSYCHOTIC DISORDERS

In this, psychosis occurs in association with an acute stress. The patient may present with hallucination, delusions, rapid emotional changes, and schizophrenic symptoms. Acute stress means that the first psychotic symptoms occur within 2 weeks of one or more events that would be regarded as stressful to most people. Common events are bereavement, unexpected loss of partner or job, marriage, or the psychological trauma of combat, terrorism, and torture. Long-standing problems like chronic financial problems, marital difficulties should not be included as a source of stress in this context.

For making diagnosis on ICD 10, following criteria should be fulfilled:

- An acute onset of delusions, hallucinations, incoherent or incoherent speech, or any combination of these.
- The time interval between the first appearance of any psychotic symptoms and the presentation of the fully developed disorder should not exceed two weeks.
- Transient states of bewilderment, misidentification, or impairment of attention and concentration are present.
- The disorder does not meet the criteria for manic episode, depressive episode.
- No evidence of brain disease or a psychotic disorder due to psychoactive substance use or serious metabolic disorder.

The treatment is with antipsychotics. Complete recovery usually occurs within 2 to 3 months, often within a few weeks or even days, and only a small proportion of patients with these disorders develop persistent illness.

### 2.6 SCHIZOAFFECTIVE DISORDER

It is an episodic disorder in which both affective and schizophrenic symptoms are present within the same episode. It may be of schizo-depressive type or schizo-manic type depending on the type of affective symptoms present in the episode. The treatment is with antipsychotic medications and mood stabilizers and needs to be planned on long term basis.

#### Self Assessment Questions 8

**Note:**

i) Read the following questions carefully and answer in the space provided below.

ii) Check your answer with that provided at the end of this unit.

1) What are other important disorders included under the section schizophrenia and related disorders?

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2.7 OTHER PSYCHOTIC DISORDERS

These are very uncommon.

F 21 Schizotypal disorder: It is characterised by odd beliefs, eccentric behaviour, tendency to social withdrawal, appear cold, suspicious ideas, vague, overelaborate, stereotyped thinking and odd speech. The individual has no definite and characteristic abnormalities like schizophrenia. There is no definite onset and it runs a chronic course with fluctuations of intensity and its evolution and course are usually those of a personality disorder. It is more common in individuals genetically related to patients with schizophrenia.

F24 Induced delusional disorder: In this condition, a delusional disorder is shared by two or more people with close emotional links. Only one of them has a genuine psychotic disorder and the delusions are induced in the other/others. The delusions in the other person disappear when the persons are separated.

F28 Other nonorganic psychotic disorders: Psychotic disorders that do not meet the criteria for schizophrenia, persistent delusional disorder or for psychotic types of mood disorders and persistent delusional disorder are included under this category.

F29 Unspecified nonorganic psychosis: This category should be used for psychosis of unknown etiology

2.8 LET US SUM UP

- In severe mental illness, a person has mental health problems that are persistent, result in moderate to severe disability and may require treatment for long time. Mental health problems in severely mentally ill persons manifest as psychosis. In psychosis, a person has hallucinations, delusions, disorganised behaviour and impaired reality testing.

- In ICD-10, schizophrenia and other psychotic disorders are classified under F20-F29. Schizophrenia is the most studied of these conditions.

- Lifetime prevalence of schizophrenia is about 1% and incidence rates per year is 0.1-0.4 per 1000 population.

- Schizophrenia is characterised by typical delusions and hallucinations. Formal thought disorder, negative and catatonic signs and cognitive impairment. These should be present for one month for making diagnosis of schizophrenia.

- Schizophrenias have been further classified into paranoid, hebephrenic, catatonic and undifferentiated types.

- There is no known single cause for schizophrenia; considered a biological disease which results from interplay of multiple factors like genetic and environmental factors as in many physical diseases, such as heart diseases.

- Management of patients with schizophrenia involves use of antipsychotic drugs and psychosocial interventions. Use of the antipsychotic drugs is the mainstay of treatment as these help in relieving the symptoms and prevent further relapse. Psycho-education helps patients and families cope with the illness. Rehabilitation is important for restoring educational and occupational functioning of the patient.

- Drug compliance, the extent to which patients follow the recommended treatment,
is an important issue in the treatment of schizophrenia. For improving the drug compliance, family members and patients should be adequately educated about the prescribed medications.

- Psychoeducation of the persons with schizophrenia and their families should be part of the treatment. It involves educating them about symptoms of schizophrenia, treatment options available, clearing misconceptions, ensuring drug compliance, encouragement and motivation by family members, following daily structured routine, course of schizophrenia, identifying signs of relapse.

- The typical course of schizophrenia is one of exacerbations and remission and outcome is reported to be better in developing rather than developed world. After the first episode patients generally recover, many function normally for a relatively long period. Usually pattern of illness during first 5 yrs after diagnosis generally indicates the future course. With each relapse, there is further worsening in patient’s baseline functioning.

- Other important conditions included under the section schizophrenia and related disorders are persistent delusional disorders, acute and transient psychotic disorders and schizo-affective disorders.

### 2.9 ANSWERS TO SELF ASSESSMENT QUESTIONS

**Self Assessment Questions 1**

1) Severe mental illness refers to mental health problems that are persistent, result in moderate to severe disability and may require treatment for long time. Mental health problems in severely mentally ill persons manifest as psychosis.

2) Psychosis is a psychiatric condition in which a person has hallucinations, delusions, disorganised behaviour and impaired reality testing.

**Self Assessment Questions 2**

1) International Classification of Diseases (ICD -10)

**Self Assessment Questions 3**

1) Hallucination is false perception without any stimulus which means a person may perceive something that does not exist in reality e.g., he/she may start hearing voices of people talking when there is no one around. These can occur in all five senses like sound, sight, smell, touch and taste and are called auditory, visual, olfactory, tactile and gustatory hallucinations.

2) Delusion is firmly held false belief that cannot be corrected by any amount of reasoning or evidence to the contrary. This belief cannot be explained by the person’s educational, social and cultural background. Delusions may be of many types e.g. delusion of persecution, grandiosity etc.

3) Signs seen on psychiatric examination of schizophrenia are:

   i) Psychosis: typical auditory hallucinations are running commentary, commanding, third person and thought echo and typical delusions are bizarre delusions, delusion of control, delusions of thought withdrawal and insertion, delusion of thought broadcast and delusion of thought disorder.

   ii) Formal thought disorder.
iii) Catatonic signs: odd and awkward postures, grimacing, mannerisms, echolalia, echopraxia, mute, stupor.

iv) Negative signs: anhedonia, apathy, alogia, avolition, and asociality.

v) Cognitive impairment.

Self Assessment Questions 4
1) The types of schizophrenias are paranoid, hebephrenic, catatonic and undifferentiated types.

Self Assessment Questions 5
1) The risk is about 10% in siblings of patients with schizophrenia. If both parents are affected, the risk in children of having schizophrenia is 50%. Twin studies show that rate of having schizophrenia in non identical and identical twin of patients with schizophrenia is 8-12% and 50% respectively.

Self Assessment Questions 6
1) For improving the drug compliance, following steps can be taken:
   - Family members and patients should be adequately educated about the prescribed medications.
   - Most of these drugs can be given in a single night time dosage and can be scheduled according to the patient’s daily routine and work.
   - Oral intake of these medicines by patients needs to be carefully observed as some of them may not swallow the tablets and later on throw away the tablets.
   - Some drugs are available as long-acting depot injections which may be repeated at an interval of 2-4 weeks.

2) Psycho education involves educating them about symptoms of schizophrenia, treatment options available, clearing misconceptions, ensuring drug compliance, encouragement and motivation by family members, following daily structured routine, course of schizophrenia, identifying signs of relapse.

Self Assessment Questions 7
1) The presence of certain factors confer good prognosis, these are: female gender, late age of onset, good premorbid social functioning and work histories, acute presentation with positive symptoms, married, history of maintaining stable job, good support system and family history of mood disorders.

Self Assessment Questions 8
1) Persistent delusional disorders, Acute and transient psychotic disorders and Schizo-affective disorders

2.10 UNIT END QUESTIONS
1) Discuss in detail the clinical features of schizophrenia.

2) Examine the myths related to schizophrenia. How can the awareness regarding these facilitate the treatment and rehabilitation of schizophrenic patients?

3) Discuss the treatment for schizophrenia.
2.11 SUGGESTED READINGS


