Definition: Schizophrenia is a **heterogenous clinical syndrome** that involves a constellation of signs and symptoms

- Characterised by **delusions, hallucinations, disorganized speech** (e.g., frequent derailment or incoherence), grossly **disorganized or catatonic behaviour** and **negative symptoms** (i.e., diminished emotional expression or avolition)

History

Emil Kraepelin gave two clinical types: **Dementia praecox, and Manic depressive illness.** He described Dementia Pracox as a loss of the inner unity of the activities of intellect, emotion, and volition; and stated that it has an early onset & deteriorating coarse (Kaplan & Sadock, 1994 SOP).

In 1911, the term ***schizophrenia,*** was introduced by **Eugen Bleuler**. He proposed the name to denote a "**splitting" of psychic functions,** which he considered to be the core feature of the illness. Unlike Kreplin he stated that the disease need not always have a poor prognosis. He gave four **primary symptoms** ("the Four As") were ***abnormal associations, autistic behavior and thinking, abnormal affect,*** **and** ***ambivalence.*** He considered **hallucinations, delusions, social withdrawal, and diminished drive** as **secondary manifestations** of the illness ((Kaplan & Sadock, 1994 CTP).

Kurt Schneider gave the **"first-rank symptoms"**

1. **Audible thoughts**: Auditory hallucinations of a person's thoughts being spoken aloud
2. **Voices arguing or discussing:** Auditory hallucinations of two or more voices arguing or discussing, usually about the person experiencing the hallucination
3. **Voices commenting on patient's actions**: Auditory hallucinations commenting on a person's behaviors
4. **Somatic passivity**: Tactile or visceral hallucinations that are imposed by some external agent; can be combinations of different somatic hallucinations
5. **Thought withdrawal**: Sensation of thoughts being actively removed from a person's mind
6. **Thought insertion**: Thoughts inserted into a person's mind by some external agent
7. **Thought broadcasting:** The sense that a person's thoughts are experienced as real phenomena by others— the thoughts are made audible, or may be experienced by others through telepathy
8. **Made feelings**: Feelings that are not a person's own are imposed on that person by an external agent
9. **Made impulses or drives:** An impulse for action is imposed on a person by some external agent

10. **Made volitional acts**: A person's actions are from and are controlled by an external agent; the person is a passive participant in the action
11. **Delusional perception:** A perception that has a unique and idiosyncratic meaning for a person, which leads to an immediate delusional interpretation

Epidemiology

The **lifetime prevalence of schizophrenia is about 1%** which means that about one person in 100 will develop schizophrenia during their lifetime (Kaplan & Sadock, 1994).

Schizophrenia is **equally prevalent in men and women (Kaplan & Sadock, 1994).**

However, the two genders differ, in the onset and course of illness. **Onset is earlier in men than in women**

Onset

The disease onset, is **late adolescence or early adulthood, with 18 to 30 years of age being the peak** time for the onset of the illness (Tandon et al., 2009). In men, there is a peak in cases of schizophrenia between ages 20 and 24. The incidence of schizophrenia in women peaks during the same age period but they also have a second peak around 40 years age. **The outcome for female schizophrenia patients is better than that for male schizophrenia patients** (Kaplan & Sadock, 1994 SOP).

Clinical Features

1. **Delusions**
2. **Hallucination**
3. **Negative symptoms:** Represent a loss or diminution of normal functions.
    - **Affective flattening or blunting**-inability to express emotions, or understand & recognize displays of emotion from others
    - **Alogia –** Poverty of speech
    - **Abulia:** loss of motivation
    - **Avolition:** loss of will; inability to initiate and persist in goal-directed activities)
    - **Apathy**
    - **Anhedonia** (asociality) – loss of the ability to experience or derive pleasure from activities or relationships; loss of interest or pleasure.

4. **Disorganisation:** Formal thought disorder-disorganisation of thought form
    - Tangentiality
    - Circumstantiality

- Derailment/loose associations
- Flight of ideas
- Neologism
- Word salad
- Echolalia
- Clang associations

5. **Bizarre and catatonic behaviour**: describe all the ones under catatonic schizo below

Diagnostic Criteria

The diagnostic **symptoms of schizophrenia are according to ICD-10 are**:

A. Thought echo, thought insertion or withdrawal, and thought broadcasting

B. Delusions of control, influence, or passivity, clearly referred to body or limb movements or specific thoughts, or sensations; delusional perception

C. Hallucinatory voices commenting on the patient's behaviour, or discussing the patient among themselves,

D. Persistent delusions of other kinds that are culturally inappropriate and completely impossible, such as religious or political identity, or superhuman powers

E. Persistent hallucinations in any modality, accompanied either by fleeting or half-formed delusions without clear affective content

F. Breaks or interpolations in the train of thought, resulting in incoherence or irrelevant speech, or neologisms

G. Catatonic behaviour, such as excitement, posturing, waxy flexibility, negativism, mutism, or stupor

H. Negative symptoms such as **apathy, poverty of speech,** and **blunting or incongruity of emotional responses**, usually resulting in **social withdrawal and lowering of social performance;** it must be clear that these are not due to depression or to neuroleptic medication;

I. Significant and consistent change in the overall quality of some aspects of personal behaviour, which may manifest as loss of interest, aimlessness, idleness, a self-absorbed attitude, and social withdrawal.

A minimum of **1 very clear symptom** (and usually two or more if less clear-cut) from any of the symptoms (A) to (D), OR at least 2 symptoms from (E) to (H), should have been clearly present for most of the time during a **period of 1 month or more.**

Conditions in which symptoms are present but for **less than 1 month duration** should be diagnosed in the first instance as **acute schizophrenia-like psychotic disorder**. Symptom (I) in the above list applies only to the diagnosis of Simple Schizophrenia (F20.6), and a duration of at least 1 year is required.

Subtypes of Schizophrenia

1) Paranoid Schizophrenia

Commonest type of schizophrenia in most parts of the world. The clinical picture is **dominated** by **paranoid delusions**.

a) Delusions of persecution, reference, grandiosity, bodily change, or jealousy are common examples.
b) Hallucinatory voices that threaten the patient or give commands are also seen.
c) Hallucinations of smell, taste, or of sexual or other bodily sensations; visual hallucinations may occur but are rarely predominant.
d) Disturbance of affect, volition, & speech and catatonic symptoms are not prominent.

The general **criteria for a diagnosis of schizophrenia must be satisfied. In addition delusions & hallucinations are prominent**

The **onset** of paranoid schizophrenia is usually **insidious, & late adulthood** as compared to the other subtypes of schizophrenia. The **course** of paranoid schizophrenia may be **episodic,** with partial or complete remissions, **or chronic.** In **chronic cases,** the florid symptoms persist over years and it is difficult to distinguish discrete episodes.

2) Hebephrenic or Disorganised Type

Characterised by the following features, in addition to the general guidelines of schizophrenia described earlier:

1. Thought is **disorganised and speech rambling and incoherent**. Delusions and hallucinations are fragmentary and changeable.
2. A**ffective changes are prominent** (inappropriate, blunted, shallow affect, often accompanied by senseless giggling, self-absorbed smiling, grimaces), mannerisms, ‘mirror-gazing’ (for long periods of time), tendency to remain solitary, and behaviour seems empty of purpose and feeling, poor self-care and hygiene, markedly impaired social and occupational functioning, extreme social withdrawal and other oddities of behaviour.

ICD-10 recommends a period of **2 or 3 months of continuous observation** for a confident diagnosis of disorganised (or hebephrenic) schizophrenia to be made. Hebephrenia should normally be diagnosed for the first time only in adolescents or young adults.

The **onset** is **insidious,** usually starts between the **ages of 15 and 25 years** and tends to have a poor prognosis because of the rapid development of "negative" symptoms, particularly flattening of affect and loss of volition.

The **course is progressive and deteriorating**. Hebephrenic schizophrenia has one of the worst prognoses among the various subtypes of schizophrenia.

3) <u>Catatonic type</u>

Prominent psychomotor disturbances are essential and dominant features

The general criteria for a diagnosis of schizophrenia must be satisfied. Catatonic symptoms may occur in the context of any other subtype of schizophrenia, but for a **diagnosis of catatonic schizophrenia one or more of the following behaviours should dominate the clinical picture:**

A. **Stupor** (marked decrease in reactivity to the environment and in spontaneous movements and activity) or **mutism**;
B. **Excitement** (purposeless motor activity, not influenced by external stimuli)
C. **Posturing** (voluntary assumption and maintenance of inappropriate or bizarre posture)
D. **Negativism** (resistance to all instructions or attempts to be moved, or movement in the opposite direction)
E. **Rigidity** (maintenance of a rigid posture against efforts to be moved);
F. **Waxy flexibility** (maintenance of limbs and body in externally imposed positions); and
G. Other symptoms such as **command automatism** (automatic compliance with instructions), and **perseveration of words and phrases.**

'PEN ROWS'

4) <u>Undifferentiated Schizophrenia</u>

Patients who clearly have schizophrenia cannot be easily fit into one type or another. This category should be reserved for disorders that:

A. Meet the general criteria for schizophrenia
B. Either without sufficient symptoms to meet the criteria for any 1 of the subtypes or with so many symptoms that the criteria for more than one of the subtypes are met.

5) **<u>Post-schizophrenic depression</u>**

A depressive episode, which may be prolonged, arising in the aftermath of a schizophrenic illness. Some symptoms of Schizophrenia are still present be it "positive or negative," but do not dominate the clinical picture. This depressive disorder is associated with an increased risk of suicide.

The diagnosis should be made only if:

A. The **patient has had a schizophrenic illness** meeting the general criteria for schizophrenia in the **past 12 months**;

B. **Some schizophrenic symptoms are still present**; and

C. The **depressive symptoms are prominent and distressing**, fulfilling at least the criteria for a depressive episode, and have been **present for at least 2 weeks**.

If the **patient no longer has any schizophrenic symptoms, a depressive episod**e should be diagnosed. If **schizophrenic symptoms are still florid and prominent**, the diagnosis should remain that of the appropriate schizophrenic subtype.

6) Residual Schizophrenia

The following requirements should be met:

A. Prominent **"negative" symptoms**, i.e. psychomotor slowing, blunting of affect, passivity and lack of initiative, poverty of quantity or content of speech, poor nonverbal communication by facial expression, eye contact, voice modulation, and posture, poor self-care and social performance;

B. Evidence in the past of at least **one clear-cut psychotic episode** meeting the diagnostic criteria for schizophrenia;

C. A period of at least **1 year** during which the **intensity and frequency of florid symptoms** such as delusions and hallucinations have been **minimal or substantially reduced** and the "**negative" symptoms have been present**;

D. **Absence of dementia or other organic brain disease** or disorder, and of chronic depression or institutionalism sufficient to explain the negative impairments.

7) **Simple Schizophrenia**

An uncommon disorder in which there is an **insidious but progressive development** of symptoms. **There is no history of Delusions and hallucinations** or other manifestations of an earlier psychotic episode**.** The **characteristic "negative" features of residual schizophrenia (e.g. blunting of affect, loss of volition)** develop without being preceded by any overt psychotic

symptoms and with **significant changes in personal behaviour, manifest as a marked loss of interest, idleness, and social withdrawal over a period of at least one year.**

Etiology

Biological factors

Genetics

Schizophrenia and schizophrenia-related disorders occur at an increased rate among the biological relatives of patients with schizophrenia. The prevalence of schizophrenia in the **first-degree relatives** (parents, siblings, and offspring) of a proband with schizophrenia is **about 10%**. For **second-degree relatives** who share only 25 percent of their genes with the proband (e.g., half-siblings, aunts, uncles, nieces, nephews, and grandchildren), the lifetime prevalence of schizophrenia is **closer to 3 percent**.

Twin studies also provide evidence for the role of genetics in the etiology of Schizophrenia. The concordance rate for monozygotic twins (identical twins) is 46% and for dizygotic twins is 14% (Kaplan & Sadock, 1994).

However, if schizophrenia were exclusively a genetic disorder, the concordance rate for identical twins would, of course, be 100%; but that is not the case. This implies that while genetics do play an important role in disease development, they are not the whole story; environmental factors are also equally important. Support for which has been provided by **'The Finnish Adoptive Family Study of Schizophrenia**'(Tienari et al., 1987, 2000, 2004). In this study the researchers followed-up the adopted-away children of all women in Finland who were hospitalised for schizophrenia. As they grew to adulthood, the functioning of these children was compared with that of the control sample of adoptees whose biological mothers were psychiatrically healthy. Over the course of a 21-year follow-up, the index adoptees developed more schizophrenia and schizophrenia-related disorders than did the controls.

One of the measures that the researchers looked at was **communication deviance-** measure of how understandable and "easy to follow" the speech of a family member is. Vague, confusing, and unclear communication reflects high communication deviance. Children who were at genetic risk and who lived in families where there was high communication deviance showed high levels of thought disorder at the time of the follow-up. In contrast, the control adoptees who had no genetic risk for schizophrenia showed no thought disorder, regardless of whether they were raised in a high- or a low-communication-deviance family. **What was surprising, was that children who were at a**

high-risk & who were raised by adopted families low in communication deviance, were found to be healthier than other groups (Carson, & Butcher, 2017)

Biochemical Factors (Kaplan & Sadock, 1994).

- A neurotransmitter implicated in schizophrenia is dopamine. The **dopamine hypothesis of schizophrenia posits that schizophrenia results from too much dopaminergic activity.** Anti-psychotic drugs that block dopamine (D_2) receptors have been found to be useful in the treatment of schizophrenia. Moreover use of drugs like amphetamines or coacine have been seen to increase dopamine activity in the brain leading many to experience psychotic symptoms like hallucinations.
- **Serotonin** excess can cause both positive and negative symptoms in schizophrenia.
- **Glutamate** is an excitatory neurotransmitter that is widespread in the brain. Many studies hypothesise that glutamate may be implicated in schizophrenia, as drugs such as intake of phencyclidine or PCP (angel dust) produces an acute syndrome similar to schizophrenia.
- Other neurotransmitters that may be implicated but support for which are inconclusive include **GABA, AcTH & norepinephrine.**

Structural and Functional Brain Abnormalities

- **Loss of Brain Volume:** MRI studies of patients with schizophrenia show about a **3 percent reduction in whole brain volume** relative to that in controls (Kaplan & Sadock, 1994; SOP)
- **Lateral and third ventricular enlargement**
- **Reduced volume of cortical gray matter**

Regions of the Brain

1) Studies of postmortem brain samples from schizophrenia patients have shown a **decrease in the size of the limbic system,** including the amygdala, the hippocampus, and the para-hippocampal gyrus (Kaplan & Sadock, 1994; SOP). The **hippocampus is not only smaller in size in schizophrenia but is also functionally abnormal** as indicated by disturbances in glutamate transmission.
2) The **basal ganglia** and **cerebellum** may also be implicated in schizophrenia. Many patients with schizophrenia show odd movements, which include an awkward gait, facial grimacing, or stereotypies. Because the basal ganglia and cerebellum are involved in the control of movement, disease in these areas is implicated in the pathophysiology of schizophrenia.

3) T**halamus** show evidence of **volume shrinkage** in the region whereas others suggest **anatomical abnormalities in the prefrontal cortex** (Kaplan & Sadock, 1994; SOP)

4) Evidence is growing that schizophrenia also involves problems with **white matter, which may result in difficulty in the proper functioning of the cells.** Since Nerve fibers are covered in a myelin sheath which acts as an insulator as well as increases the speed and efficiency of conduction between nerve cells.

Prenatal Factors

- Persons who develop schizophrenia are more **likely to have been born in the winter and early spring** and less likely to have been born in late spring and summer. Studies have pointed to **gestational and birth complications, exposure to influenza epidemics, maternal starvation** at the time of pregnancy during these months as possible cause (Kaplan & Sadock, 1994; SOP).
- **Rhesus (Rh) incompatibility** occurs when an Rh-negative mother carries an Rh-positive fetus. Incompatibility between the mother and the fetus is a major cause of blood disease in newborns. Interestingly, Rh in-compatibility also seems to be associated with increased risk for schizophrenia.
- If a mother experiences an **extremely stressful event l**ate in her first trimester of pregnancy or early in the second trimester the risk of schizophrenia in her child is increased
- Greater paternal age - 60 years above

Psychosocial and Cultural Factors

Psychoanalytic Theories

1) **Sigmund Freud** postulated that schizophrenia resulted from **developmental fixations early in life**. These **fixations produce defects in ego development**, which contributed to the symptoms of schizophrenia.

2) Acc to **Margaret Mahler,** there are **distortions in the reciprocal relationship between the infant and the mother**. The child is unable to separate from, and progress beyond, the closeness and complete dependence that characterize the mother-child relationship in the oral phase of development. As a result, the person's identity never becomes secure.

3) **Harry Stack Sullivan** viewed schizophrenia as a **disturbance in inter-personal relatedness.** The patient's massive anxiety creates a sense of unrelatedness that is transformed into distortions, which are usually, but not always, persecutory in nature.

Psychoanalytic theory also postulates that the **various symptoms of schizophrenia have symbolic meaning** for individual patients. **For example,** fantasies of the world coming to an end may indicate a perception that a person's internal world has broken down. Feelings of inferiority are replaced by delusions of grandeur & omnipotence.

Learning Theories

According to learning theorists, children who later have schizophrenia **learn irrational reactions and ways of thinking by imitating parents who have their own significant emotional problems.**

- In learning theory, the poor interpersonal relationships of persons with schizophrenia develop because of poor models for learning during childhood.

Family Dynamics

1. **Double Bind:** The double-bind concept was formulated by **Gregory Bateson and Donald Jackson** to describe a hypothetical family in which **children receive conflicting parental messages** about their behavior, attitudes, and feelings. Acc. to Bateson's hypothesis, **children withdraw into a psychotic state to escape the unsolvable confusion of the double bind.** An example of a double bind is a parent who tells a child to provide cookies for his or her friends and then chastises the child for giving away too many cookies to playmates.
2. **Schisms and Skewed Families**: **Theodore Lidz** described two abnormal patterns of family behavior. In one family type, with a prominent **schism between the parents, one parent is overly close to a child of the opposite gender.** In the other family type, **a skewed relationship between a child and one parent involves a power struggle between the parents** and **the resulting dominance of one parent.** These dynamics stress the tenuous adaptive capacity of the person with schizophrenia.
3. **Pseudomutual or Pseudohostile Families**: As described by **Lyman Wynne,** some families **suppress emotional expression** by consistently using pseudomutual or pseudohostile verbal communication. In such families, a unique verbal communication develops, and **when a child leaves home he has to relate to other persons, problems may arise. The child's verbal communication may be incomprehensible to outsiders.**
4. **Expressed Emotion:** Parents or other caregivers may behave with overt **criticism, hostility, and over-involvement** toward a person with schizophrenia. Many studies have indicated that in **families with high levels of expressed emotion, the relapse rate for schizophrenia is high.**

Sociocultural Factors

- Being raised in an **urban environment** seems to increase a person's risk of developing schizophrenia.
- Research is also showing that recent **immigrants have much higher risks** of developing schizophrenia than do people who are native to the country of immigration.
- People with schizophrenia are twice as likely as people in the general population to smoke cannabis. This finding has led many researchers to study the **causal link between cannabis abuse and the development of psychosis.** Evidence suggest that compared to those who had never used cannabis, young men who were heavy cannabis users by the time they were 18 were more than 6 times more likely to have developed schizophrenia 27 years later (Zammit et al., 2002).

Prognostic Factors

Good Prognosis	Poor Prognosis
• Late onset	• Young onset
• Obvious precipitating factors	• No precipitating factors
• Acute onset	• Insidious onset
• Good premorbid social, sexual, and work histories	• Poor premorbid social, sexual, and work histories Withdrawn, autistic behavior
• Mood disorder symptoms (especially depressive disorders)	
• Married	• Single, divorced, or widowed
• Family history of mood disorders	• Family history of schizophrenia
• Female Sex	• Male Sex
• Good support systems	• Poor support systems
• Positive Symptoms	• Negative symptoms
	• Neurological signs and symptoms
	• History of perinatal trauma
	• No remissions in 3 years
	• Many relapses
	• History of assaultiveness

Premorbid & Prodromal Signs & Symptoms (Kaplan & Sadock, 1994; SOP)

Premorbid signs and symptoms appear before the prodromal phase of the illness.

The differentiation implies that premorbid signs and symptoms exist before the disease process begins itself and that the prodromal signs and symptoms are a part of the evolving disorder.

Premorbid personality is characterized:

1. Schizoid or schizotypal personalities characterized as quiet, passive and introverted
2. Children may have few friends.
3. Adolescents may have no close friends or do not participate in group activities.
4. They may enjoy solitary activities like watching movies and television, listening to music, or playing computer games to the exclusion of social activities.

Prodromal signs and symptoms:

1. **Somatic Complaints:** such as headache, back and muscle pain, weakness, and digestive problems. The initial diagnosis may be malingering, or somatization disorder.
2. Family and friends may eventually notice that the **person has changed and is no longer functioning well in occupational, social, and personal activities.**
3. During this stage, a patient may **begin to develop an interest in abstract ideas, philosophy, or religious questions**
4. Additional prodromal signs and symptoms can include **markedly peculiar behavior, abnormal affect, unusual speech, bizarre ideas, and strange perceptual experiences.**

Treatment

1) Pharmacological Approaches

Antipsychotic drugs have been developed for the treatment of schizophrenia. The common property that they all share is their ability to **block dopamine D2 receptors in the brain. Antipsychotics diminish positive symptoms and reduce relapse rates**.

First generation antipsychotics (neuroleptics) such as chlorpromazine and haloperidol were used earlier. However, **side effects** of these medications include **drowsiness, dry mouth, and weight gain**. Many patients also experience ***extrapyramidal side effects*** (EPS). Long term treatment may also lead to ***tardive dyskinesia*.**

Second-Generation antipsychotics such as clozapine are now commonly used. These have lesser side-effects particular EPS. However, it is not that these are side-effect free; **common side effects**

include drowsiness and considerable weight gain. Diabetes is also a very serious concern and in rare cases, clozapine also causes a life-threatening drop in white blood cells. For this reason, patients taking this medication must have regular blood tests.

2) **Hospitalization** in some cases may be needed either for stabilization of medications; for patients' safety because of suicidal or homicidal ideation; or grossly disorganized or inappropriate behavior, including the inability to take care of basic needs such as food, clothing, and shelter.

3) **Electroconvulsive therapy** (ECT) has been studied in both acute and chronic schizophrenia and has been found to be useful.

PSYCHOSOCIAL THERAPIES

Psychosocial therapies include a variety of methods to **increase social abilities, self-sufficiency, practical skills, and interpersonal communication** in schizophrenia patients.

The **goal** is to enable persons who are severely ill to **develop social and vocational skills** for independent living.

1) **Social skills training:** designed to help patients **acquire the skills they need to function better on a day-to-day basis.** These skills include employment skills, relationship skills, self-care skills, and skills in managing medications or symptoms.

   Patients **learn these skills, get corrective feedback, practice their new skills using role-playing, and then use what they have learned in natural settings. Homework assignments** for the specific skills being practiced can also be given.

2) **Cognitive-Behavioral therapy**: is used to **improve cognitive distortions, reduce distractibility, and correct errors in judgment.** Working together, therapist and patient explore the subjective nature of the patient's delusions and hallucinations, examine evidence for and against their veracity, and subject delusional beliefs to reality testing.

3) **Individual Therapy:** evidence that it is helpful and that the **effects are additive to those of medication.**

4) Personal therapy: equips patients with a broad range of **coping techniques and skills in order** forestall relapse. Uses psychoeducation, self-reflection, self-awareness, exploration of individual vulnerability to stress, social skills and relaxation exercises.

6) **Dialectical Behavior Therapy:** Emphasis is placed on improving interpersonal skills in the presence of an active and empathic therapist.

6) **Vocational Therapy:** used to help patients regain old skills or develop new ones. These include sheltered workshops, or part-time employment programs.

7) **Art Therapy:** Many schizophrenia patients benefit from art therapy, which provides them with an **outlet for their constant bombardment of imagery**. It **helps them communicate with others** and share their inner, often frightening world with others.

8) **Family Therapy:** The **goal is to reduce relapse** in schizophrenia by changing those aspects of the patient–relative relationship that were regarded as central to the EE construct. This generally involves working with patients and their families to educate them about schizophrenia, to help them improve their coping and problem-solving skills, and to enhance communication skills.

9) **Group therapy:** is effective in reducing social isolation, increasing the sense of cohesiveness, and improving reality testing for patients with schizophrenia. These may be behaviorally oriented, psychodynamically or insight oriented, or supportive.

Other Psychotic Disorders

Schizotypal disorder

A disorder characterized by **eccentric behaviour and anomalies of thinking and affect** which resemble those seen in schizophrenia, though no definite and characteristic schizophrenic anomalies have occurred at any stage. The disorder runs a **chronic course with fluctuations of intensity**.

Diagnostic criteria:

A. Inappropriate or constricted affect (the individual appears cold and aloof);
B. Behaviour or appearance that is odd, eccentric, or peculiar;
C. Poor rapport with others and a tendency to social withdrawal;
D. Odd beliefs or magical thinking, influencing behaviour and inconsistent with subcultural norms
E. Suspiciousness or paranoid ideas;
F. Obsessive ruminations without inner resistance, often with dysmorphophobic, sexual or aggressive contents;
G. Unusual perceptual experiences including somatosensory (bodily) or other illusions, depersonalization or derealization;
H. Vague, circumstantial, overelaborate, or stereotyped thinking, manifested by odd speech or in other ways, without gross incoherence;
I. Occasional transient quasi-psychotic episodes with intense illusions, auditory or other hallucinations, and delusion-like ideas, usually occurring without external provocation.

- **Three or four** of the typical features listed above should have been present, continuously or episodically, **for at least 2 years**. The individual must **never have met criteria for schizophrenia** itself

Persistent Delusional Disorders

1) **Delusional disorder**

- Group of disorders **characterised by the development either a single delusion or of a set of related delusions**
- The content of delusions can be varied such as persecutory, hypochondriacal, grandiose, or jealousy.
- **Apart from actions and attitudes directly related to the delusion or delusional system, affect, speech, and behaviour are normal.**
- They must be **present for at least 3 months** and be clearly personal rather than subcultural.
- **Depressive symptoms** or even a full-blown depressive episode may be **present intermittently**, provided that the delusions persist at times when there is no disturbance of mood
- There must be **no evidence of brain disease,** no or only occasional **auditory hallucinations**, and no history of **schizophrenic symptoms** (delusions of control, thought broadcasting, etc.)

2) **Other persistent delusional disorders**

This is a **residual category for persistent delusional disorders** that do not meet the criteria for delusional disorder. Disorders in which delusions are accompanied by persistent hallucinatory voices or by schizophrenic symptoms that are insufficient to meet criteria for schizophrenia (F20.-) should be coded here.

3) **Acute and transient psychotic disorders**

The defining features of this disorder include

A. An **acute onset (**within 2 weeks) as the defining feature of the whole group;
B. The presence of typical syndromes;
C. The presence of associated acute stress.

- There is some evidence that **acute onset is associated with a good outcome,** and it may be that the more abrupt the onset, the better the outcome. It is therefore recommended that, whenever appropriate, **abrupt onset** (within 48 hours or less) be specified.
- The **typical syndromes** that have been selected are **first**, the rapidly changing and variable state, called here “polymorphic," and **second**, the presence of typical schizophrenic symptoms.

- **Associated acute stress** is taken to mean that the first psychotic symptoms occur within about 2 weeks of one or more events that would be regarded as stressful to most people in similar circumstances, within the culture of the person concerned. Typical events would be bereavement, unexpected loss of partner or job, marriage, or the psychological trauma of combat, terrorism, and torture. "Thus we write with or without associated acute stress"
- **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 and disabling states.
- **None** of the disorders in the group **satisfies the criteria for either manic or depressive episodes**,
- **Absence of organic causation**
- **Should not be diagnosed in the presence of obvious intoxication by drugs or alcohol.**

TYPES of ATPD

1) Acute polymorphic psychotic disorder without symptoms of schizophrenia

- An acute psychotic disorder in which **hallucinations, delusions, and perceptual disturbances** are obvious but changing from day to day or even from hour to hour.
- Emotional turmoil, with intense transient feelings of happiness and ecstasy or anxieties and irritability, is also frequently present. **BUT** the criteria for manic episode, depressive episode or schizophrenia are not fulfilled.
- **Acute onset** (within 2 hours) and a **rapid resolution of symptoms**
- If the symptoms persist for more than 3 months, the diagnosis should be changed. (Persistent delusional disorder

2) Acute polymorphic psychotic disorder with symptoms of schizophrenia

- For a definite diagnosis, **criteria (a), (b), and (c)** specified for acute polymorphic psychotic disorder without schizophrenia symptoms must be fulfilled;
- in addition, symptoms that fulfil the criteria for schizophrenia (F20.-) must have been present for the majority of the time
- If the schizophrenic symptoms persist **for more than 1 month**, the diagnosis should be changed to schizophrenia

3) Acute schizophrenia-like psychotic disorder

- **Acute** psychotic disorder in which psychotic symptoms are comparatively stable and fulfil the criteria for schizophrenia **but have lasted for less than 1 month.**

- **Criteria for** acute polymorphic psychotic disorder **are not fulfilled**

4) **Induced delusional disorder**

- A delusional disorder shared by two or more people with close emotional links.
- Only one of the people suffers from a genuine psychotic disorder;
- the delusions are induced in the other(s) and usually disappear when the people are separated.

5) Schizoaffective disorders

- A diagnosis should be made only when both definite schizophrenic and definite affective symptoms are prominent simultaneously, or within a few days of each other, **within the same episode of illness,**

- **Schizoaffective disorder, manic type**

- A disorder in which schizophrenic and manic symptoms are both prominent in the same episode of illness.

- **Schizoaffective disorder, depressive type**

  A disorder in which schizophrenic and depressive symptoms are both prominent in the same episode of illness.