Module 12: Schizophrenia Spectrum and Other Psychotic Disorders

Module 12 Outline

12.1. Clinical Presentation
12.2. Epidemiology
12.3. Comorbidity
12.4. Etiology
12.5. Treatment

Module 12 Learning Objectives

- Describe how schizophrenia spectrum disorders present. Describe the epidemiology of schizophrenia spectrum disorders.
- Describe comorbidity in relation to schizophrenia spectrum disorders.
- Describe the etiology of schizophrenia spectrum disorders.
- Describe treatment options for schizophrenia spectrum disorders.

12.1 Clinical Presentation

Section 12.1 Learning Objectives

- List and describe distinguishing features that make up the clinical presentation of schizophrenia spectrum disorders.
- Describe how schizophrenia presents.
- Describe how schizophreniform disorder presents. Describe how schizoaffective disorder presents.
- Describe how delusional disorder presents.

Section 12.1 Key Terms

Affective flattening: Reduction in the range of emotional expression; reduced display of emotional expression.

Alogia: Poverty of speech or speech content.

Anhedonia: Inability to experience pleasure.

Apathy: General lack of interest.

Asociality: Lack of interest in social relationships.

Avolition: Lack of motivation to engage in goal-directed behavior.

Catatonic behavior: The decreased or complete lack of reactivity to the environment.

Circumstantial speech: Where the focus meanders to other related topics but eventually comes back to the topic of discussion.

Delusions: Fixed beliefs that are not amenable to change in light of conflicting evidence.

Delusions of grandeur: Fixed belief that one has exceptional abilities, wealth, or fame; believe that one is God or other religious saviors.

Delusions of control: Fixed belief that others control one's thoughts/feelings/actions.

Delusions of thought broadcasting: Fixed belief that one's thoughts are transparent and everyone knows what one is thinking.

Delusions of persecution: Fixed belief that one is going to be (or is being) harmed, harassed, plotted or discriminated against by either an individual or an institution; it is the most common delusion.

Delusions of reference: People with this type of delusion belive that specific gestures, comments, or even larger environmental cues are directed directly to them.

Delusions of thought withdrawal: Fixed belief that one's thoughts have been removed by another source.

Derailment: The illogical connection in a chain of thoughts.

Disorganized thinking: Disjointed thoughts, a collapse or sudden stop in thought process, randomly spoken words, and complete incoherence.

Erotomanic delusion: When an individual reports a delusion of another person being in love with them.

Hallucinations: A false sensory experiences that can occur in any of the five senses: hearing (auditory hallucinations), seeing (visual hallucinations), smelling (olfactory hallucinations), touching (tactile hallucinations), and tasting (gustatory hallucinations).

Illogicity: The tendency to provide bizarre explanations for things.

Jealous delusion: Revolves around the conviction that one's spouse or partner is/has been unfaithful.

Negative symptoms: In schizophrenia, the inability or decreased ability to initiate actions, speech, express emotion, or feel pleasure.

Positive symptoms: In schizophrenia, symptoms that are an over-exaggeration of normal brain processes.

Prodromal symptoms: Precede the active phase of the disorder and are "subthreshold" forms of psychotic symptoms that do not cause significant impairment in functioning, with the exception of negative symptoms.

Psychosis: A loss of contact with reality.

Residual symptoms: Present after remission and are "subthreshold" forms of psychotic symptoms that do not cause significant impairment in functioning, with the exception of negative symptoms.

Schizoaffective disorder: Characterized by the psychotic symptoms included in schizophrenia and a concurrent uninterrupted period of a major mood episode—either a depressive or manic episode.

Schizophrenia: A Long-term mental disorder of a type involving a breakdown in the relation between thought, emotion, and behavior, leading to faulty perception, inappropriate actions and feelings, withdrawal from reality and personal relationships into fantasy and delusion, and a sense of mental fragmentation.

Schizophreniform disorder: Similar to schizophrenia, except for the length of presentation of symptoms; considered an "intermediate" disorder between schizophrenia and brief psychotic disorder.

Somatic delusions: Delusions involving bodily functions, organs, or sensations.

Speech retardation: Where the individual may take a long time before answering a question or expressing one's thoughts.

Section 12.1 Key Takeaways

- Schizophrenia spectrum disorders are characterized by delusions, hallucinations, disorganized thinking (speech), disorganized or abnormal motor behavior, and negative symptoms.
- Delusions are beliefs that do not change even when conflicting evidence is presented and can be of grandeur, control, thought broadcasting, persecution, reference, and thought withdrawal.
- Hallucinations occur in any sense modality and most individuals recognize that they are not real. Disorganized thinking, abnormal motor behavior, catatonic behavior, and negative symptoms such as affective flattening, alogia, anhedonia, apathy, asociality, and avolition are also common to schizophrenia spectrum disorders.
- Schizophrenia is characterized by delusions, hallucinations, disorganized speech, disorganized/abnormal behavior, or negative symptoms.
- Schizophreniform disorder is considered an "intermediate" disorder between schizophrenia and brief psychotic disorder as the symptoms are present for at least one month but not longer than six months.
- Schizoaffective disorder is characterized by the psychotic symptoms included in schizophrenia and a concurrent uninterrupted period of a major mood episode—either a depressive or manic episode.
- Delusional disorder requires the presence of at least one delusion that lasts for at least one month in duration to include erotomanic, grandiose, jealous, persecutory, and somatic.

Section 12.1 Review Questions

1. What are the five positive symptoms identified in a schizophrenia diagnosis? Define and identify their difference.
2. What is meant by negative symptoms? What are the negative symptoms observed in schizophrenia related disorders?
3. Identify diagnostic differences between Schizophrenia, Schizophreniform, Schizoaffective, and Delusional disorder.

12.2 Epidemiology

Section 12.2 Learning Objectives

- Describe the epidemiology of schizophrenia spectrum disorders.

Section 12.2 Key Terms

N/A

Section 12.2 Key Takeaways

- Less than 1% of the general population is diagnosed with schizophrenia and 20% of these people fully recovery from the disorder.
- Both genders have an equal risk of developing schizophrenia while men typically display more negative symptoms while women present with more mood-related symptoms.
- Schizoaffective disorder, schizophreniform disorder, and delusional disorder have prevalence rates less than 0.3%.

Section 12.2 Review Questions

1. Discuss the different prevalence rates across the schizophrenia related disorders. Are there differences among the disorders? Between genders?
2. Are there differences in prevalence rates depending on symptom presentations? If so, what?

12.3 Comorbidity

Section 12.3 Learning Objectives

- Describe the comorbidity of schizophrenia spectrum disorders.

Section 12.3 Key Terms

N/A

Section 12.3 Key Takeaways

- Schizophrenia-related disorders have a high comorbidity with substance abuse disorders, anxiety- related disorders, and some medical conditions.

Section 12.3 Review Questions

1. What comorbidities exist between schizophrenia and other conditions?

12.4 Etiology

Section 12.4 Learning Objectives

- Describe the biological causes of schizophrenia spectrum disorders.
- Describe the psychological causes of schizophrenia spectrum disorders.
- Describe the sociocultural causes of schizophrenia spectrum disorders.

Section 12.4 Key Terms

Diathesis-stress model: Posits that psychological disorders result from an interaction between inherent vulnerability (e.g., genetics) and environmental stressors.

Stress cascade: A stressful situation — whether something environmental, such as a looming work deadline, or psychological, such as persistent worry about losing a job — can trigger a cascade of stress hormones that produce well-orchestrated physiological changes.

Stress-vulnerability model: Suggests that individuals have a genetic or biological predisposition to develop a specific type of disorder; however, symptoms will not present unless there is a stressful precipitating factor that elicits the onset of the disorder.

Section 12.4 Key Takeaways

- Biological causes of schizophrenia spectrum disorders include genetics, several brain structures, and the HPA axis.
- Psychological causes of schizophrenia spectrum disorders include the diathesis-stress model.
- Sociocultural causes of schizophrenia spectrum disorders include families high in expressed emotion and family dysfunction.

Section 12.4 Review Questions

1. What evidence is there to support a biological model with respect to explaining the development and maintenance of the schizophrenia related disorders?
2. Discuss the stress-vulnerability model with respect to schizophrenia related disorders.
3. How does the sociocultural model explain the maintenance (and relapse) of schizophrenia related symptoms?

12.5 Treatment

Section 12.5 Learning Objectives

- Describe psychopharmacological treatment options for schizophrenia spectrum disorders.
- Describe psychological treatment options for schizophrenia spectrum disorders.
- Describe family interventions for schizophrenia spectrum disorders.

Section 12.5 Key Terms

Tardive dyskinesia: Involuntary movements isolated to the tongue, mouth, and face; a potential side-effect of some antipsychotic medications.

Section 12.5 Key Takeaways

- Psychopharmacological treatment options for schizophrenia spectrum disorders include antipsychotic drugs such as Thorazine, Chlorpromazine, Clozaril, Risperdal, and Abilify.
- Psychological treatment options for schizophrenia spectrum disorders include CBT, the goal of which is to improve the interpretations and understandings of symptoms (and experiences) which will reduce associated distress.

- Family interventions for schizophrenia spectrum disorders include psychoeducation, problem-solving skills, cognitive-behavioral therapy (CBT), social skills training, and inpatient/partial hospitalizations.

Section 12.5 Review Questions

1. Define tardive dyskinesia.
2. What pharmacological interventions have been effective in managing schizophrenia related disorder symptoms?
3. What is the main goal of family interventions? How is this achieved?