SCHIZOPHRENIA

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07/2003

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1 . Introduction

Psychosis " loss of contact living with reality " (Minkowski). Chronicle dissociative

- "Schizophrenia"="Iseparated,Isplits","spirit"(GreekFRENOS) (Bleuler,1906).
- Dissociation of thought ("Spaltung"Bleuler) reached the During the thinking type dislocation loss the fluid and coherentse quence ideas ("looseningassociations") and interruptions unannounced ("dam").

Historical Kraepelin (1856-1926)

- "Dementiapraecox"(1896);
- "Loss of the indoorunit,"butalso
- " Inevitableloss"
- Three clinical forms:paranoid, hebephrenic, catatonic.

Bleuler (1857-1939)

- "Basic Symptoms"
- Dissociation intra psychic";
- "Autism" dissociation of Moi outside world. "Symptoms accessories"
- Delirium, hallucinations,catatonia;
- Depressive decompensation or manic; Impaired judgment and reasoning;
- "Pragmatic deficit."
- Other clinical forms: "schizophreniasimple."3. Definition Many clinical form sand scalable.
- Varying intensities disorders.

No single definition; Group heterogeneous: Sd schizophreniform; Group of schizophrenia or dissociative psychosis. "To gether disorders dominated the discordance, verbalin coherence, ambivalence, autism, delusionalideas, poorly systematized hallucination sand deep emotional disturbances in the sense of

detachment and strangeness off feelings; disorders that tend to evolve to wards a deficit and dissociation personality"(Ey).

4 . General

Independent intellectual level will.

Related to achronice volutionary potential and notine vitable change and loss determined (onsensusconference 994).

Serious psychiatric illness:

- Consider ablemental suffering Highmortality (suicide+++)
- Family and social impact + + +Auto-dangerous>>>hetero dangerosite.The+stigmatizedmental illness.

Therapeutic methods + in + effective : drug therapies patient groups (HDJ, CATTP) .

Importance of support early.

5 . Epidemiology

Prevalence:0.8to1.3% ofthegeneralpopulation.Universal distribution. Sex ratio identical.

Troubles began between 20 and 35 years+inearlyman. Mortality + ++

- 2-8%diebysuicidethe10 eres years (RR=12);
- Mortality from cardiovascular, respiratory and infectious.

6 . Clinic (1) Classic description :

- Dissociation (commoncore); Paranoid delusions;
- Autism.

Current description:

- Dissociation (disruptionthinking); Positive (orproductive)
- Negativesigns (orloss)

6 . Clinic (2) dissociation

Psychic alteration, type dislocation of the three constituent fields an individual:

- thought
- affects
- Behavior
- Loss of harmonious relationsconsistent and logical relationships between these three dimen Leads to the existence of feelings or idea so contradictory actions and expressed at the same time! sions . Synonyms: <<discrepancy >>, <<Ambivalence>>, << disruption>

6 . Clinic (3) dissociation

Provision of the psyche to achieve simultane ously psychic states opposite;

- Dissociation of thought
- emotional Mismatch
- Ambivalence behavior.

Oddity ("bad touch " or "Contact psychotic "). Impenetrability, hermetic , unpredictability. Detachment From Reality: withdrawal or blunted affect, listlessness and aboulia or decline autism.

6 . Clinic (4) dissociation

<<I never hear voice, they tell me but insults .>>

- I'm stronger than everyone, God, he harassed me and pierces the brain. >>

6 . Clinic (5) dissociation

Dissociation of thought

Disorders duringt hinking (alterations the ideational flow):

- Acceleration, deceleration, suddensuspension (dam) or progressive(mentalfading);
- Loss of spontaneity, increased time latency responses, poverty of speech or silence,
- parasites ideas,verbal pulse soliloquy.
- Disorders of thought content:
- Loosening of associations,the difference speech,blurring of thought;
- Inconsistencies answers to side;
- Illogical thinking,unreal or magical;
- Abstract metaphorical symbolic speech,weird;
- Morbid rationalism (detached reasoning real).

6 . Clinic (6) dissociation

<<All this is related to the brain paralysis causing left,as you know in as a doctor, a blood frozen laughing my veins my moods.>>

6 . Clinic (7): dissociation Dissociation of thought (cont.)

- Attention deficit disorder and concentration:distractibility, BUTNOTDTS,ORCONFUSION
- Language disorders:
- Deconstruction of language
- Phonetic changes: timbre, intonationan drhythm (mannerism) and semantic syntax;
- Fallacies (changes the meaning of words);
- Neologisms (new words);
- Wordsbag (same word with different meanings);
- Precious and mannered language

- Maximum schizophasia: neolangage.

6 . Clinique (8): dissociation

<<Ibeg you Xyxyxy after you, I'm Indebted to your Fortunately, you détonament good, Perfidious Albion Saved, IN' m finally apéjurisatis fied, thank you EPA fitête.>>

6 . Clinic (9) dissociation Emotional discrepancy

- Contact Cold,distant and detached;
- Emotional numbingand withdrawal;
- But also brutal emotional reactions,
- Paradoxical and unpredictable: anger disproportionate unmotivated laughter;
- Emotional Ambivalence:"I Love Mother, I would like to see her dead."
- Ambivalences behavior
- Mannerisms and quirks of mimicry, the attitudes and behavior;
- Gestures Indecisive, uncoordinated, dysharmonie use, overloaded;
- Paramimies: grins, smiles discordant stereotypies;
- Emphatic emotional expression with loss natural;
- Overall, mismatched look.

6 . Clinique (10) dissociation

- Catatonic syndrome: dissociation psychomotor extreme:
- Negativism psychomotor
- Clinophobia,
- Attitude fixed and prostrate fall, silence; Muscle stiffness;
- Opposition (jaw clenched, refusing to hand tense, forced eye closure, avoidancephysics…)
- Catalepsy
- Immobility and waxy flexibility with conservation attitudes imposed;
- Loss ofmotorinitiative
- Psychomotor inertia
- Passivity, suspension actions;
- Paradoxical suggestibility (échomimie, echopraxia, echolalia).
- Hyperkinesia
- Verbal and motor stereotypies;
- Violent impulses verbal and gestural (self and héréroagressives);
- Discharges drive classic unpredictable.

6 . Clinique (11): Paranoid delusions inconstant;

Discharges drive classic unpredictable. Discharges drive classic unpredictable.

- Non specific theme;
- Persecution, influence, mystical, hypochondria…Typical: transformations assets (dysmorphophobia) depersonalization derealisation etgrinds body (disembodiment) anxiety+++

6 . Clinique (12): paranoid delusions Polymorphic mechanisms (see course BDA)

- Auditory hallucinations and cenesthetic C++
- Insights, interpretations, illusions, imagination;
- Common mental automatism;
- Rare visual hallucinations.
- Non- formal systematized: fuzzy speechdiffluent, contradictory, inconsistent. Invades the life of the subject

6 . Clinique (13): paranoid delusions

Strong support

Intense emotional involvement with psychotic anxiety (major,floating+/ abnormal behavior).Typical:no mood congruent to delirium (affective mismatch)

6 . Clinique (14): paranoid delusions

"I am themes senger of God to destroy the earth,for she loves me, I know it told me they want me kill, I know too much about him, he talks, told me every thing I have to do, I found how to bring peace, I know how to do, it is necessary install violins around and play,play,play…"

6 . Clinique (15): Autism

Removing the patient to with in oneself, loss of vital contact with reality, absence of communication, confinement in a inner autistic rêverie;

Listlessness, aboulia, clinophilia, loss of interest.

6 . Clinique (16) :signs positive andnegative

Positive (productive) Delusions, hallucinations; Psychomotor agitation.

Negative signs (loss).

- Listlessness, aboulia, clinophilia, carelessness;
- Loss of interest and pleasure; Loss of speech,of thought;
- Emotional indifference (athymormie); Socio- emotionalisolation;
- Risk socialization/marginalization.

7 . Clinical forms

- Paranoid schizophrenia: The common+form;
- Dissociation + delirium +++
- Start of tenbrutal (BDA); After 20 years;
- Good sensitivity to NLP.

Hebephrenic schizophrenia (negative or loss):

- SCHZ20%;
- Dissociation+loss+signs+++
- Often start early (between15 and 20 years) and insidious;
- Less sensitivetotreatment.

- Schizophrenia "disorganized": dissociation + +

7 . Clinical forms (2)

Schizoaffective disorder:

- Intermittent evolution cruises (intervals almost free);
- Alternatingmanic and depressive episodes atypical, that is to say with elimination
- and/ordelirium incongruent with mood;
- Oftenafamilyhistory of PMD and /or SCHZ;

+/-Negativesigns;

- Interest mood stabilizers+++Simple schizophrenia:
- Prevalence of autism with loss interests and initiatives;
- Significant restrictions on family relationships and social;
- Moderate Dissociation,very few ideas delirious;
- Development deficit.

7 . Clinical forms (3)

- Catatonic form:
- Catatonic access;
- Very rare but severe+++
- Life-threatening;
- Interest ECT + ++Other forms:
- Pseudo- neurotic schizophrenia;
- Pseudo psychopathique schizophrenia.

8 . Positive diagnosis

Dissociative syndrome +/- delusional syndrome

Alteredlevelofpreviousoperation (work,social relations,personal care).Evolution> 6months. Start after 15 years.

Noorganic disorder or takentoxic No mood disorder predominant.

9 . Evolution and prognosis (1) Methods beginning

- abrupt (50-65%) BDA
- Thymic atypical access. Insidious and progressive:
- Downturns;
- Change sinemotions and personality;
- Delusions;
- Behavioral disorders;
- Takingtoxic.

9 . Evolution and prognosis (2) Evolution

- 25 %"favorable" 50%:Intermediate

- Recurrent bouts;
- Achievement variable affective domains social and professional.
- 25%:very pejorative
- Delirium and/or losss disabling; Social degradation+++
- Need help almost permanent (mental institution)

9 . Evolution and prognosis (3)

Changes significantly favorableif antipsychotic treatment the earliest possible,dosage effective and foratimesuf ficient (25years).

- Mortality
- Suicidal risk+++
- 10%ofTS, 5% mortality SCHZ;
- Secondary raptus delusional and/oranxious.
- Mortality from cardiovascular,respiratory and infectious diseases.

9 . Evolution and prognosis (4)

Favorable prognostic factors:

- Late-onset
- Sudden onset Female
- Triggers
- Previous personality socially well suited
- Lack of emotional in difference
- Importance of mood disorder sand delusional (/negativesigns)

10 . Etiology?

No single known cause. Multifactorial.

Theory of vulnerability. Assumptions:

- Genetics
- Neurobiological (the or ydopamine) Brain neuroanatomical
- Developmental andviral
- Psychodynamic (psychoanalysis).

11 . Therapeutic principles (1)

Paraclinical: eliminate organicity + + + and pretreatment

- Standardbiology,+/thyroid
- +/-Liver
- Syphilisserology ECG
- CT scan withoutinjection EEG
- Blood andurinetoxic
- Alcohol

+/-Hepatitis and HIV serology.

Projective psychological tests Personality: Rorschach+++, +/-IQ (Waiss).

11 . Principles of treatment (2) Therapeutic goals:

- Prevention of physical damage (Accesscare,negligence) Prevent suicide
- Fight against the negative symptoms
- Reduce social exclusion, homelessness, addictive behavior, delinquency
- Maintaining autonomy
- Promote emotionalan drelational network Socio-professional integration.
- Medical therapies
- Chemotherapy
- Psychotherapy
- Sociotherapy

11 . Therapeutic principles (3)

- Reasons for hospitalization, +/- SPDT even SPDRE:
- Diagnostic assessment and establishment of a medication early disease
- Catatonic syndrome
- Massive anxiety, severe depression, suicide risk
- Acute exacerbation of dissociation, a delirium or loss signs Behavioral

  disorders (hetero agressivite)
- Failed Entourage or pathogen Poor adherence
- Drug resistance.

11 . Principles of treatment (4) Chemotherapy

- Preferably monotherapy with minimal dose effective în one dose in the evening
- Antipsychotics +++
- Anti delirants and anti déficitaires
- ZYPREXA®(olanzapine), RISPERDAL®(risperidone) SOLIAN®(amisulpride).
- Conventional neuroleptics Antidelirants
- HALDOL®(haloperidol), FLUANXOL®(flupentixol) CLOPIXOL®(zuclopenthixol)… And sedative sideeffects
- Available in drops,PC,Imandquickactiondelay(NA Pevery 2 to 4 weeks so bad compliance)

  Anxiolytic and sedative
- TERCIAN®(cyamemazine) NOZINAN®(levomepromazine) Loxapac®(loxapine)...

Side effects;

- Available in drops, Pc and IM fastaction (in emergency). If resistant schizophrenia
- Clozaril®(clozapine) orally; Monitoring NFS+book (risk of agranulocytosis).

11 . Therapeutic principles (5)

Safety monitoring and side effects+++ Coprescriptions

- Correctors
- Antiparkinsonian: LEPTICUR®, AKINETON Delay®,ARTANE®...
- Antihypertensive:HETP-A-MYL®
- Anti-hyposialorrhee: Sulfarlem® Laxatives
- Other psychotropic
- Anxiolytics:benzodiazepines(Seresta®,Tranxene®),carbamates(Equanil®) Hypnotics
- IMOVANE®, STILNOX®,
- MEPRONIZINE®…
- Antidepressants:ZOLOFT®, Seropram®, EFFEXOR®
- Mood stabilizers:TERALITHE®(lithium) Depakote®,DEPAMIDE®,TEGRETOL®

11 .Therapeutic principles(6)

- Place of ECT
- Catatonic syndrome emergency the rapeutic+++
- Melancholia syndrome: emergency the rapeutic++
- Psychomotor agitation extremenon-controllable(rare).

11 . Therapeutic principles (7) Psychotherapies

- Information and education about the disease
- Individual:consultations with supportive psychotherapy+++
- Group+++ (HDSHDJ, CATTP)
- Arttherapy,occupational therapy Cognitive(CBT) Family social reintegration
- Therapeutic workshops (ATP, WTA) CAT, sheltered employment
- Occupational centers
- Homes and apartments therapeutic
- Measuremen to fasset protection (guardianship) Disabled adult allowance(AAH)
- Groups of families.

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