SCHIZOPHRENIA-TYPES

COURSE: PSYCHOPATHOLOGY, CC-3 (PGDCP), SEM I; Unit 4
By
Dr. Priyanka Kumari
Assistant Professor
Institute of Psychological Research and Service
Patna University
Contact No.7654991023; E-mail-Priyankakumari1483@yahoo.com

SCHIZOPHRENIA

- **CLINICAL TYPES**

  Schizophrenia can be classified into several subtypes The catatonic and hebephrenic subtypes of schizophrenia together have been called as *nuclear schizophrenia*, as they present with typical symptomatology of schizophrenia and can most frequently result in personality deterioration over time (especially if chronic). Clinical Types of Schizophrenia

  1. Paranoid schizophrenia
  2. Hebephrenic schizophrenia
  3. Catatonic schizophrenia
  4. Residual schizophrenia
  5. Undifferentiated schizophrenia
  6. Simple schizophrenia
  7. Post-schizophrenic depression
  8. Others

SCHIZOPHRENIA

Paranoid Schizophrenia

Paranoid schizophrenia is characterized by the following clinical features, in addition to the general guidelines of schizophrenia described earlier:

1. **Delusions of persecution, reference, grandeur (or 'grandiosity'), control, or infidelity (or 'jealousy')**. The delusions are usually well-systematized (i.e. thematically well connected with each other).

2. The hallucinations **usually have a persecutory or grandiose content**.

3. **No prominent disturbances of affect, volition, speech, and/or motor behaviour.**

Personality deterioration in the paranoid subtype is much less than that seen in other types of schizophrenias. The patient may be quite apprehensive (due to delusions and hallucinations) and anxious, and appear evasive and guarded on mental status examination. The onset of paranoid schizophrenia is usually insidious, occurs later in life (i.e. late 3rd and early 4th decade) as compared to the other subtypes of schizophrenia. The course is usually progressive and complete recovery usually does not occur. There may be frequent remissions and relapses. At other times, the functional capability may be only slightly impaired. The differential diagnosis is usually from delusional (or paranoid) disorders and paranoid personality disorders.

Disorganised (or Hebephrenic) Schizophrenia

Disorganised schizophrenia is characterized by the following features, in addition to the general guidelines of schizophrenia described earlier:

1. **Marked thought disorder, incoherence and severe loosening of associations. Delusions and hallucinations are fragmentary and changeable.**

2. Emotional disturbances (inappropriate affect, blunted affect, or senseless giggling), mannerisms, ‘ mirror-gazing’ (for long periods of time), disinhibited behaviour, 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. The onset is insidious, usually in the early 2nd decade. The course is progressive and downhill. The recovery from the episode is classically poor. Severe deterioration, without any significant remissions, usually occurs over time. Hebephrenic schizophrenia has one of the worst prognoses among the various subtypes of schizophrenia.

Catatonic Schizophrenia

Catatonic schizophrenia (*Cata*: disturbed, *tonic*: tone) is characterized by a marked disturbance of motor behaviour, in addition to the general guidelines of schizophrenia described earlier.

It can present in three clinical forms:

- Excited catatonia,
- Stuporous catatonia, and
- Catatonia alternating between excitement and stupor.

Excited Catatonia

This is characterized by the following features:

1. **Increase in psychomotor activity**, ranging from restlessness, agitation, excitement, aggressiveness to, at times, violent behaviour (furore).

2. **Increase in speech production,** with increased spontaneity, pressure of speech, loosening of associations and frank incoherence. The excitement has no apparent relationship with the external environment; instead inner stimuli (e.g. thought and impulses) influence the excited behaviour. So, the excitement is not goal-directed. Sometimes the excitement can become very severe, and is accompanied by rigidity, hyperthermia and dehydration, finally culminating in death.

Stuporous (or Retarded) Catatonia

This is characterized by extreme retardation of psychomotor function. The characteristic catatonic signs are usually observed. Delusions and hallucinations may be present but are usually not prominent. Not all the features are present at the same time.

Catatonia Alternating between Excitement and Stupor

This clinical picture is very common with features of both excited catatonia and stuporous catatonia alternatingly present. The onset of catatonic schizophrenia is usually acute, usually in the late 2nd and early 3rd decade. The course is often episodic and recovery from the episode is usually complete. However, residual features are present after two or more episodes. Differential diagnosis is from other causes of stupor and catatonia.

Residual and Latent Schizophrenia

Residual schizophrenia is similar to latent schizophrenia and symptoms are similar to prodromal symptoms of schizophrenia. The only difference is that residual schizophrenia is diagnosed after at least one episode has occurred.

Some Important Clinical Features of Retarded Catatonia

1. ***Mutism***: Complete absence of speech
2. ***Rigidity***: Maintenance of a rigid posture against efforts to be moved
3. ***Negativism***: An apparently motiveless resistance to all commands and attempts to be moved, or doing just the opposite
4. ***Posturing***: Voluntary assumption of an inappropriate and often bizarre posture for long periods of time
5. ***Stupor*****:** Akinesis (no movement) with mutism but with evidence of relative preservation of conscious
awareness

6. ***Echolalia***: Repetition, echo or mimic king of phrases or words heard

7. ***Echopraxia***: Repetition, echo or mimic king of actions observed

8. ***Waxy flexibility***: Parts of body can be placed in positions that will be main trained for long periods of time, even if very uncomfortable; flexible like wax

9**.** ***Ambitendency***: Due to ambivalence, conflicting impulses and tentative actions are made, but no goal

directed action occurs, e.g. on asking to take out tongue, tongue is slightly protruded but taken back again

10. **Other signs such as *mannerisms*, *stereotypies* (verbal and behavioural), *automatic obedience*** (commands are followed automatically, irrespective of their nature) and *verbigeration* (incompre hensible speech).

Undifferentiated Schizophrenia

This is a very common type of schizophrenia and is diagnosed either:
1. When features of no subtype are fully present, or
2. When features of more than one subtype are exhibited, and the general criteria for diagnosis of schizophrenia are met.

Simple Schizophrenia

Although called simple, it is one of the subtypes which is the most difficult to diagnose. It is characterized by an early onset (early 2nd decade), very insidious and progressive course, presence of characteristic ‘negative symptoms’ of residual schizophrenia (such as marked social withdrawal, shallow emotional response, with loss of initiative and drive), vague hypochondriacal features, a drift down the social ladder, and living shabbily and wandering aimlessly. Delusions and hallucinations are usually absent, and if present they are short lasting and poorly systematized. The prognosis is usually very poor.

Post-Schizophrenic Depression

Some schizophrenic patients develop **depressive features** within **12 months** of an acute episode of schizophrenia. The depressive features develop in the presence of residual or active features of schizophrenia and are associated with an increased risk of suicide. The depressive features can occur due to side-effect of antipsychotics, regaining insight after recovery, or just be an integral part of schizophrenia. It is important to distinguish the depressive features from negative symptoms of schizophrenia and extra pyramidal side-effects of antipsychotic medication.