

19/1/19

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Thesis For M.D. Degree in Psychiatry

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Title : Affective Symptoms In Schizophrenia

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### ACKNOWLEDGEMTN

I am grateful to Professor **Dr. Ahmed Okasha** for suggesting the subject, constructing the methodology, supplying the references and for his kind permission to examine the patients in Okasha hospital and for his evaluation, appraisal, support and encouragement from beginning to end.

I would like to thank Professor **Dr. Adel Sadek** for supplying many references and for his kind guidance and advice.

I wish to thank **Dr. Abdel-Moneim Ashour** for training on the present state examination and methodological supervision.

Thanks are also due to **Mr. Mahros Salama**, the social worker, for completing the social data of the patients, and to **Dr. Gamal Bilal** and **Dr. Abdin Mohamed** for permission to examine their patients and for **Mrs. Soher Shahin**, clinical psychologist for statistical advice, and for serving as independent rater on Hamilton rating scale at the beginning of the study.

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## INTRODUCTION

Schizophrenia is the heart land of psychiatry and the core of it's clinical practice. Every layman knows that the term means 'split-mind' and his concept of madness is largely based on the oddities and abnormalities of those who suffer from this enigmatic illness. Because it is a relatively common condition, which often cripples people in adolescence or early adult life, it probably causes more suffering and distress and blights more lives than most cancers; and because it cripples people in their youth without greatly reducing their life expectancy it constitutes a huge burden on health services.

### Historical Introduction

Ancient Egyptians recognized symptoms attributed to heart disease which can resemble the present schizophrenic symptoms (Okasha; mental disorders in pharaonic Egypt, 1978) Hippocrates 460-375 B.C had initiated the classification of mental disorders into mania, melancholia and phrenitis which is probably named now schizophrenic disorders.

The earliest unambiguous descriptions date only from the end of the 18th century and it was further hundred years before the syndrome was defined with clarity. That crucial step was achieved by Emil Kraepelin, Professor Psychiatry at the University of Munich, in the 5th (1896) edition of his Lehrbuch. In 1856 Morel had coined the term demence precoce to describe an adolescent patient, once bright and active, who had slowly lapsed into a state of silent withdrawal.

In 1868 Kahlbaum had described the syndrome of "Katatonie" and two years later Hecker had also described "Hebephrenie" Kraepelin saw the importance of Koch's work for general medicine and it's implication for psychiatry, he separated

insanity into two groups - those who tend to deteriorate and those who tend to improve.

Thus, having subdivided the patients on the basis of outcome.

Kraepelin (1899) called the two categories dementia praecox embraced Kahlbaum's catatonia, Hecker's hebephrenia and dementia paranoides, manic depressive insanity, pursued a fluctuating course with frequent relapses but full recovery after each.

Eugen Bleuler (1911) published his 'Dementia praecox or the Group of schizophrenias' moved away from the disease entity model and introduced the concept of syndrome into psychiatric nosology.

Kraepelin had assumed that dementia praecox was a disease of the brain, and speculated that it might be an endocrine disorder of some kind.

Bleuler, influenced by the writings of Sigmund Freud and the infant school of psychoanalysis, thought of schizophrenia in psychological rather than in neuropathological terms. He coined the term schizophrenia, meaning "splitmind", because he believed that the disorder was due to a "loosening of association" between different psychic functions, affecting both the transition from one idea to the next in thought and speech and the coordination between emotional, volitional (conative) and intellectual (cognitive) processes in general. He also drew a distinction between the thought disorder, the blunting or incongruity of affect, the autism and the pervasive ambivalence of the disorder, which he regarded as the 'fundamental symptoms', and the more obvious hallucinations, delusions and catatonic phenomena which for him were accessory phenomena of lesser importance. This led him to conclude that schizophrenia could develop and be diagnosed in the absence of hallucinations and delusions, and so to add fourth

type, simple schizophrenia, to the hebephrenic, catatonic and paranoid forms recognized by Kraepelin.

The cardinal defect of Bleuler's concept of schizophrenia it's lack of clear boundaries, he provided little evidence to justify his belief that his "fundamental symptoms", were indeed fundamental.

He wrote (Bleuler 1950 'By the term dementia praecox or schizophrenia we designate a group of psychoses whose course is at times chronic, at times marked by intermittent attacks, which stop or retrograde at any stage, but does not permit a full restitutio and integrum.

The disease is characterized by a specific type of thinking, feeling and relation to the external world which appears nowhere else in this particular fashion.

In Europe the Norwegian psychiatrist Gabriel Langfeldt sought to distinguish between schizophrenia and what he called schizophreniform psychoses on the basis of a detailed study of the symptomatology of the illness and presented evidence to suggest that the two had quite different outcomes, and indeed that the ECT and insulin coma therapy, the main treatment of the 1940s, had no influence on the course of schizophrenia itself. (Langfeldt 1960)

Kurt Schneider was of great influence and focused attention on the earlier acute stage of the illness and described a number of 'symptoms of the first rank' (see table 1) which he considered to be diagnostic of schizophrenia in the absence of overt brain disease (Schneider, 1959).

Table 1. Kurt Schneider's 'symptoms of the first rank'.

1. Auditory hallucinations taking any one of the three specific forms:

- a. Voices repeating the subject's thoughts out loud, or anticipating his thoughts.
  - b. Two or more hallucinatory voices discussing the subject, or arguing about him referring to him in the third person.
  - c. Voices commenting on the subject's thoughts or behaviour, often as a running commentary.
2. The sensation of alien thoughts being put into the subject's mind by some external agency, or of his thoughts being taken away (Thought insertion or withdrawal).
  3. The sensation that the subject's thinking is no longer confined within his own mind, but instead shared by, or accessible to others (Thought broadcasting)
  4. The sensation of feelings, impulses or acts being experienced or carried out under external control, so that the subject feels as if he were being hypnotized, or had become a robot.
  5. The experience of being a passive and reluctant recipient of bodily sensations imposed by some external agency.
  6. Delusional perception - a delusion arising fully fledged on the basis of a genuine perception which others would regard as commonplace and unrelated.
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Many studies have provided data that schneiderian's criteria can be found in other disorders than schizophrenia and may be absent in many schizophrenics, so it's reliability has been questioned and it's validity in the diagnosis of schizophrenia ranges between 60-70 percent.

## DEFINITION OF SCHIZOPHRENIA

The ambiguity and confusion caused by the unresolved differences between Kraepelin's and Bleuler concepts of schizophrenia, and the subsequent development of several other differences as well. It is not however possible to give a strict theoretical definition of a central concept of schizophrenia. Their manifestation are multidetermined as to aetiology, pathogenesis, Course, and outcome. Even clinically useful diagnostic groupings do not necessarily constitute a scientific classification of illness.

To be scientific the nosology must be based on aetiology and pathogenesis. The international pilot study on schizophrenia, organized by the World Health Organization (1973), did show that it was possible to create an operational definition of such a core group. By means of a standard technique for interviewing patients (Wing, Cooper and Sartorius, 1974). The advantage of a central operational definition is that it provides a sound basis for comparing groups of patients and therefore for testing hypotheses about causation, pathology, treatment or prognosis.

Currently, the first three are the most widely used definition of schizophrenia at least for research purposes.

1. The St. Louis Criteria (Feighner et al, 1972), the key requirements are that the subject should have been continuously ill, though not necessarily psychotic, for at least 6 months and should not have prominent manic or depressive symptoms. The only psychotic symptoms required are delusions or hallucinations of almost any type, or clear cut thought disorder. The subject, is however required to possess 3 of 5 characteristics, which include being unmarried, under 40, and having had a poor premorbid social adjustment.

2. The Research diagnostic criteria (RDC) (Spitzer et al, 1975) only demands a two week duration of symptoms but requires the presence of either thought disorder or hallucinations or delusions of particular kind, several of which are in fact schneiderian first rank symptoms. It also stipulates that prominent affective symptoms must not be present simulataneously.
3. The American Psychiatric Association's (DSM.III)Criteria (American Psychiatric Association, 1980) is similar except that onset must have been (continuously present for 6 months) before the age of 45 and signs of illness must have been continuously present for 6 months.

Langfeldt's criteria (Langfeldt, 1960)

1. A special type of emotional blunting followed by lack of initiative and altered, frequently peculiar, behaviour (more difficult to describe than to apprehend but the experienced psychiatrist regularly feels intuitively that he is confronted with a morbid personality of the genuine schizophrenic type")
2. Catatonia with "history and signs in the periods of restlessness and stupor-negativism, catalepsy, vegetative symptoms- frequently so characteristic that no doubt can exist.
3. Paranoid symptoms with depersonalization and derealization with no insight (experiencing the disturbances as originating outside himself he must experience the outside influences and changes)
4. Paranoid symptoms with primary delusions.
5. Chronic hallucinations not due to organic disease.

The New Haven schizophrenia index (Astrachan et al, 1972)

- 1 a. Delusions (other than depressive)
- b. Auditory hallucinations

- c. Visual hallucinations.
  - d. other hallucinations.
- 2
- a. Bizarre thinking
  - b. Autism or grossly unrealistic private thoughts.
  - c. Looseness of association, illogical thinking, over-inclusion.
  - d. Blocking
  - e. Concreteness.
  - f. Derealization.
  - g. Depersonalization.
3. Inappropriate affect.
4. Confusion
5. Paranoid ideation (self-referential thinking, suspiciousness).
6. Catatonic behaviour
- a. Excitement
  - b. Stupor
  - c. Waxy flexibility
  - d. Negativism
  - e. Mutism
  - f. Echolalia
  - g. Stereotyped motor activity

To be considered as having the schizophrenia syndrome, the patient must score on item 1 or 2a - 2c and must score at least 4 points. He can achieve 4 points on item 1 alone. Two points for any of 2a - 2c, but not more than a total of two points for hallucinations. One point is given for either or both 2d and 2e, and the same for items 2f and 2g and items 3 - 6.

The flexible system of Carpenter et al (1973): Five or six of the following 12 signs and symptoms are necessary depending on the threshold: audible, broadcast, or transmitted thoughts; nihilistic delusions; bizarre delusions (not comprehensible); widespread delusions, unreliable

information (was information credible?); restricted affect; poor insight; poor rapport; incoherent speech; absence of elation; absence of depressed facies; and absence of early waking.

The Catego groupings (Wing et al, 1974):

This is a set of rules, embodied in computer program, which could be applied to the observed profile of symptoms in order to obtain a reference classification, more or less equivalent to a diagnosis (Wing et al, 1974). The program is designed to process data from the Wing et al, (1967) Present-state examination which is a standard technique of interviewing patients.

There are three classes of "Certain" schizophrenia, as follows:

Class S + (Schizophrenic psychosis): The characteristic symptoms are: thought insertion, broadcast, or withdrawal; delusions of control; voices discussing the patient in the third person or commenting on his thoughts or actions; other auditory hallucinations (not affectively based); and other delusions.

If any of the first three symptoms is present the patient is automatically allocated to class S +; he is similarly allocated if both the last two are present.

Class P + (Paranoid Psychotic): The chief symptoms are delusions (other than first rank) and hallucinations (other than auditory). This class contains patients with delusions and hallucinations other than depressive or grandiose ones or those characteristic of class S+.

Class O + (other psychoses - simple or catatonic schizophrenia): The chief symptoms are catatonic symptoms and behaviour indicating hallucinations. Patients are alloca-

ted to this class only if there are no other psychotic symptoms.

In these category groupings there are also three classes of "uncertain" schizophrenia which correspond to the three main ones.

Class S ? : Voices experienced as speaking directly to the patient (not speaking about him). These voices should not be those characteristic of depression or mania.

Class P ? : Patients with delusions of persecution or reference in the absence of more diagnostic symptoms and those with only "partial" delusions

Class O ? : Patients with affective flattening, nonspecific signs of psychosis, and residual schizophrenia only.

Taylor's Criteria (Taylor et al, 1975): The following are required:

1. Formal thought disorder (blocking, non sequiturs, neologism, word approximation, and verbigration).
2. Emotional Blunting (restricted affective range and intensity with absence of emotional responsiveness, warmth, the finer ethical and moral notions, and feeling of love for friends and family).
3. Incomplete verbal auditory hallucinations or autochthonous (sudden and fully formed) delusional ideas (except for grandiose delusions of wealth or high birth or depressive ones of sin, poverty, or guilt).
4. The absence of any medical illness known to produce psychiatric symptoms (for example pernicious anaemia, Graves disease, or pellegra), unequivocal signs of coarse brain disease, and any history of hallucinogenic drug ingestion or the use of psychostimulant drugs associated with the index admission.