Schizophrenia

Psychology, Psychotherapy

This paper will provide a history of schizophrenia, case study, genetics and treatments, and criteria of this disorder. Schizophrenia facts about this disorder are, probable causes, and its symptoms. This will give the reader a brief description of historical overview; which discusses how schizophrenia came to be identified as a unique illness. The views of psychiatrists pivotal to making this identification are described. The paper then goes on to discuss how effective treatment for schizophrenia and delineates how the notion of what should be constitute effective treatment that has changed over the years.

The paper also explores various medications that were used to treat the condition. Introduction of the Disorder If you ever met anyone with Schizophrenia you find that it is an extremely puzzling condition, the most chronic and disabling of the major mental illnesses. In my readings and research about one percent (approximately) of the population develops schizophrenia during their lives. With the sudden onset of severe psychotic symptoms, the individual is said to be experiencing acute schizophrenia. What does Psychotic really mean, first is a person out of touch with reality, or unable to separate real from unreal experiences.

Schizophrenia is a disorder characterized by loss of touch with reality, thought disorders, delusions, hallucination, and affective disorder. Schizophrenia is my disorder of choice as it is a severe, chronic, and often disabling brain disease. While the term Schizophrenia literally means, " split mind," it should not be confused with a " split," or multiple, personality. It is more accurately described as a psychosis a type of illness that causes severe mental disturbances that disrupt normal thought, speech, and behavior.

The first signs of schizophrenia usually appear as shocking or radical changes in behavior. Others may have severe psychotic symptoms listed above. But many people also show " negative" symptoms (Durand, Barlow, 2007), such as decreased emotional arousal, mental activity, and inability to socialize. Many Psychiatrists often mentioned that Schizophrenics often report a sense of strangeness and confusion about the source of their sensations. They feel great loneliness, anxiety, and an overwhelming sense of being disconnected from others. (Guy, Johnson, 2006)

Having a conversation with a schizophrenic person may be very frustrating as they will think and communicate incoherently, jumping from one idea mixing a " disorganized speech” (Durand, Barlow, 2007). It is common for schizophrenics to be very suspicious and paranoid and they will protect their belongings as noted on page 479 of our text Essentials of Abnormal Psychology (Durand, Barlow, 2007). They may sense that their thoughts are stolen, broadcast aloud, or replaced by new information from strangers seeking to control their behavior.

They may describe voices that speak directly to them or criticize their behavior. Background on Schizophrenia In the early 19th Century a German Psychiatrist Emil Kraepelin in 1899 added to John Haslam, Phillippe Pinel and Benedict Morel that gave us today the description and categorization of Schizophrenia (Durand, Barlow, 2007). Kraepelin's notions were found in the ideas of Swiss psychiatrist Eugene Bleuler. According Bleuler (Durand, Barlow, 2007), the man who actually coined the term schizophrenia, stated that the illness did not necessarily lead to deterioration over time, but the splitting of the mind.

In his discussion of the history of schizophrenia and its treatment stated that the real work on the identification of schizophrenia as a unique condition began with German psychiatrist Emil Kraepelin who combined all the symptoms under a single diagnosis, calling the condition " dementia praecox" which meant dementia in the early years of life. Kraepelin observed that older people with dementia exhibited emotional dullness, loss of inner unity and that they would at times laugh or cry without apparent reason; he also noted that the symptoms worsened with time (Durand, Barlow, 2007). DSM-IV on Schizophrenia

Diagnostic criteria for Schizophrenia: DSM IV per the online source; A. Characteristic symptoms: Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated): (1) Delusions (2) hallucinations (3) disorganized speech (e. g. , Frequent derailment or incoherence) (4) grossly disorganized or catatonic behavior (5) negative symptoms, i. e. , Affective flattening, alogia, or avolition.

Note: Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other. B. Social/occupational dysfunction: For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care is markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement) (Michael, MD, DSM-IV, 2000).

How Schizophrenia has been studied According to Mental Health America (2010) schizophrenia can be divided into five subcategories. These five categories are paranoid schizophrenia, disorganized schizophrenia, catatonic schizophrenia, residual schizophrenia, and schizoaffective disorder. Charles R. Lake (Lake, 2008) says that of the five subcategories " paranoid remains the most common subtype of schizophrenia" (p. 1151) (Lake, 2008). Young men are usually diagnosed with paranoid schizophrenia in their late teens or early twenties.

Women do not usually show signs of paranoid schizophrenia until they are in their twenties or early thirties. When looking at the comparisons of schizophrenia between males and females there is little difference. Incidence rates of schizophrenia vary widely across many case studies and throughout many countries. Moreover, no consistent pattern of gender differences in incidence rates of schizophrenia has been detected. Indeed, most studies have reported that incidence rates are similar in males and females.

On the other hand, when gender differences are detected, incidence rates are higher among the males. In my forty-six years I only met males who had Schizophrenia are seen by Brooklane Health Services in Hagerstown, Maryland www. brooklane. org. DSM-IV Criteria for Schizophrenia Taking from the new proposed DSM-5 edition dated March 2nd, 2011 it states " Schizophrenia A. Characteristic symptoms: Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated).

At least one of these should include 1-3 1. Delusions 2. Hallucinations 3. Disorganized speech 4. Grossly abnormal psychomotor behavior, such as

catatonia 5. Negative symptoms, i. e. , restricted affect or avolition/asociality B. Social/occupational dysfunction: For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).

C. Duration: Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i. e. , active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e. g. , odd beliefs, unusual perceptual experiences).

D. Schizoaffective and Mood Disorder exclusion: Schizoaffective Disorder and Mood Disorder With Psychotic Features have been ruled out because either (1) no Major Depressive or Manic Episodes have occurred concurrently with the activephase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods. E. Substance/general medical condition exclusion: The disturbance is not due to the direct physiological effects of a substance (e. g., a drug of abuse, a medication) or a general medical condition.

F. Relationship to a Pervasive Developmental Disorder: If there is a history of Autistic Disorder or another Pervasive Developmental Disorder or other communication disorder of childhood onset, the additional diagnosis of Schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated). Introduction Case Study Project I was in disarray when I met a person who was diagnosed with Schizophrenia back in 1993, as my significant other brother has just been diagnosed.

I witnessed many types of behaviors, temperaments and acting out on many different occasions, and I will say some were scary moments and Police had to be called in and he had to be detained. I am focusing on Schizophrenia and I will look at estimates of the global schizophrenia prevalence vary between, but a relatively recent meta-analysis of all available data found the annual and lifetime prevalence to be 0. 33% and 0. 4%, respectively (Saha, Chant, Welham, and McGrath, 2005).

Prevalence rates also vary significantly between urban and rural areas, developed and undeveloped regions, and whether a person has migrated during their lifetime, with migrants, urban dwellers, and persons living in developing economies having the highest risk of developing schizophrenia. Schizophrenia Etiology Patients who eventually receive a diagnosis of schizophrenia may present with negative symptoms first, including a flat affect, apathy, depression, increasing social isolation, poverty of speech, and difficulty thinking (Rigby and Alexander, 2008).

Psychosis, which represents the positive symptoms of schizophrenia, tends to develop later and involve disturbances in thought processes, content, and

perceptions. The symptoms of schizophrenia expressed by patients vary considerably, due to the variety of unrelated risk factors contributing to disease prevalence. By far the biggest risk factor is a family history, which explains approximately 80% of all cases (Kvajo, McKellar, and Gogos, 2011).

However, identical twin studies have revealed only a 50% chance that both twins will develop the disease, suggesting a number of other factors modify genetic risk. Human genetic association studies have revealed a total of 1008 genes and 8788 polymorphisms are associated with an increased risk of schizophrenia, although the majority of these still require independent validation (Kvajo, McKellar, and Gogos, 2011). These association studies have also revealed that a percentage of sporadic cases of schizophrenia also have a genetic component (congenital).

The pathways affected by these mutations include neurotransmission, cell adhesion, and RNA processing. The primary neurotransmitter pathways affected include the dopamine (DA), glutamate, and gamma amino butyric acid (GABA), which are critical for the proper brain development (O’Donnell, 2011). Differences have also been identified in how the prefrontal cortex functions; primarily altered modulation of GABA interneuron and pyramidal neuron activity by DA, delayed prefrontal cortex maturation, and cortical thinning. The excitatory activity of

N-methyl-D-aspartate (NMDA) receptors in the prefrontal cortex is normally countered by DA stimulation of inhibitory GABA interneuron activity, an activity that becomes increasingly important for adult cognitive performance. For this reason, cognitive deficits associated with schizophrenia can’t be detected until the adolescent period because the

interneuron system remains immature until this period. Importantly, many of the schizophrenia susceptibility candidate genes have been shown to be important for cortical interneuron development in animal models (O’Donnell, 2011).

For Example, mice null for erbB4, or harboring a dominant-negative form of the disrupted-in-schizophrenia 1 (DISC1) gene, have reduced numbers of interneurons that are also functionally impaired. The result is a desynchronized and disinhibited cortex. Accordingly, mice lacking the NR1 subunit to the NMDA receptor, which is selectively expressed on cortical interneurons, suffer from sensorimotor gating deficits, working memory deficits, hyperlocomotion, enhanced response to stimulants, and a number of other symptoms commonly observed in schizophrenia patients.