Table of Contents

1. Schizophrenia: A Diagnostic Overview
   by Robert L. Spitzer and Jean Endicott .................. 7

2. Bleuler Discusses Schizophrenia
   by Manfred Bleuler ........................................ 18

3. Etiologies of Schizophrenia
   THE IMPLICATIONS OF HERITABILITY
   by Fini Schulsinger ......................................... 24

   ARE THE ORIGINS ORGANIC? — A MEDCOM FORUM
       Biochemical Etiologies: A Review
       with Seymour S. Kety .................................... 30
       MEDCOM Interviews Hildegard Rand Maricq
       Subject: Nailfold Capillaries ........................... 38
       An Organic Concept
       by Robert G. Heath ........................................ 44
       MEDCOM Interviews Arnold J. Friedhoff
       Subject: The Pink Spot ................................... 50

   SOCIOCULTURAL ASPECTS
       Family Dynamics
       by Lyman C. Wynne ....................................... 54
       Class Environment
       with Melvin L. Kohn ....................................... 60

   ANALYTIC ETIOLOGY: A PRIMER
   by Otto Allen Will Jr. .................................... 64

4. Schizophrenia: The Therapies
   A BROAD PERSPECTIVE
   by Jonathan O. Cole ....................................... 70

   ON PSYCHOTROPIC DRUGS
   by Leo E. Hollister ......................................... 78

   A SEMINAR ON PHARMACOLOGY
   with Thomas Ban, Jonathan O. Cole, and Leo E. Hollister ... 82

5. Hospital Trends in Schizophrenia
   by Morton B. Wallach ....................................... 89

Selected Bibliography
Some references suggested by the authors for your
further reading ................................................. 96

Self-Evaluation Section .... in pocket of back cover (removable)
An opportunity to learn what you've learned
Chapter 1

SCHIZOPHRENIA: A DIAGNOSTIC OVERVIEW

What is schizophrenia?
And is it common?
Is there a typical course?
And what are the reliable diagnostic methods?
And more... by Robert Spitzer and Jean Endicott

Jean Endicott
Robert L. Spitzer
Ossler once remarked that to know syphilis is to know medicine; so it can be said that to know all the varieties of schizophrenic disturbance is to know psychiatry.

Despite the lack of a generally accepted definition of the concept, it is agreed that schizophrenia refers to a serious psychiatric disorder of major public health importance. It tends to be chronic and usually leads to considerable disability. Moreover, it usually involves disturbances in one or more basic physiological functions which are essential to comfortable and efficient adaptation.

What Is Schizophrenia?

The ability to correctly perceive the self and the external world may be impaired by “sensory perception” in the absence of external stimuli (hallucinations) or by idiosyncratic false beliefs (delusions). Thinking is often disorganized and illogical. Emotional responses to people and events are usually inadequate or inappropriate. Relationships with other people tend to be either nonexistent, shallow, or idiosyncratic.

There is nearly always disturbance in some aspect of self-initiated goal-directed activity. It may take the form of inadequate interest or drive, poor judgment in formulating a practical plan, or inability to successfully complete a course of action.

Onset and Course of Illness

Although the onset and course of the illness are extremely variable, usually some difficulties are seen in childhood or adolescence. Excessive daydreaming, no close friends, and poor academic performance often characterize these patients. In addition, a change in personality may be noted by friends and relatives. Secondly, the onset of overt symptomatology typically occurs in adolescence or early adult life. This is useful in distinguishing schizophrenia from depressive illnesses and from many chronic brain syndromes, which often have their onset in middle or late life.

Three typical courses. The first of the three typical courses is characterized by an insidious onset and progressive deterioration without acute exacerbations; the second has an insidious onset and a chronic course broken by exacerbations; and the third has an acute onset followed by recurrent episodes with increasing residual impairment between the episodes.

In each of the typical patterns there is no return to completely normal functioning; this is consistent with Bleuler’s view that the process can stop or regress but never disappear. However, there are patients who—following an acute psychotic episode indistinguishable from a typical schizophrenic episode—appear to recover without any residual symptomatology. It is unclear how many patients fall into this pattern and whether or not such patients should be considered schizophrenic.

The first cases identified as schizophrenic were all functioning at a psychotic level; they exhibited severe personality disorganization and impaired capacity to recognize reality. For this reason, schizophrenia is
regarded as one of the "psychoses" and is listed in the psychiatric nomenclature next to the other psychoses—psychoses associated with organic brain syndromes, major affective disorders, paranoid states, and psychotic depressive reaction. However, it is now well recognized that many patients for whom the diagnosis of schizophrenia is justified are not always in fact functioning at a psychotic level. This is particularly true in the early or convalescent stages of the illness.

It should be noted that "psychotic" describes a level of functioning of a patient in which there is personality disorganization and impaired capacity to recognize reality, and "psychosis" is a term applied to a condition, such as schizophrenia or manic-depressive illness, which typically is associated with a psychotic level of functioning at some period of the illness. Thus a patient may have a psychosis but not be psychotic.

A Bit of History

Although some abnormal behavior described in ancient literature might now be labeled schizophrenia, scientific study of the disorder began in the 19th century. Morel, in 1865, described an adolescent boy who had been bright and active but became gloomy, silent, withdrawn, and apathetic. He expressed hatred for his father and thought of killing him. Morel termed this condition démence précoce. Kahlbaum, in 1868, described cases in which strange motor disturbances were prominent and called the condition katatonie. In 1887, Hecker described a condition characterized by silly regressive behavior, for which he coined the term hebephrenia.

Kraepelin. The genius of Emil Kraepelin lay in his recognition of the essential unity of these separate conditions. In 1887 he used the term dementia praecox to emphasize the deterioration of certain aspects of mental functioning and its usual onset in adolescence. The fundamental disturbance was in affect—an impoverishment of feelings and interests with no tonic, and hebephrenic—that are still recognized today. Kraepelin contrasted this chronic and usually deteriorating condition with episodic disorders in which the primary disturbance was either a depressed or an elated mood, now referred to as major affective illnesses such as manic-depressive disorders.

Bleuler. In 1911 the Swiss psychiatrist Eugen Bleuler published his classic book, Dementia Praecox or the Group of Schizophrenias. He enlarged the concept described by Kraepelin to include milder cases which did not show any of the florid signs of the condition nor marked deterioration. For such cases he added a fourth subtype—simple.

Whereas Kraepelin emphasized the early onset, deteriorating course, and lack of affective responsiveness, Bleuler felt that the fundamental disturbance was "a splitting of the psychic functions," hence his term schizophrenia. He divided symptoms into primary and secondary categories. The primary symptoms "are present in every case and at every period of the illness, even though, as with every other disease symptom, they must have attained a certain degree of intensity before they can be recognized with any certainty."

The four As. According to Bleuler, four primary symptoms are characteristic of the disease and are found, as such, in no other condition: disturbances in association and affect, ambivalence, and autism.

Association. By association disturbance, now often called "schizophrenic thought disorder," Bleuler referred to the tendency of peripheral, marginal, or irrelevant features of a total concept to set off associations which interfere with logical goal-directed thinking. For example, a normal person could associate the name Mary with (1) Mother of Christ, (2) Mary Had a Little Lamb, or (3) Merry Christmas, but these associations would not interfere with his ability to think about a specific person whose name happened to be Mary. A schizophrenic's thoughts about a person named Mary might be a jumble of associations about these or other irrelevant features. As a result, thinking becomes confused, bizarre, incorrect, and abrupt. Mild thought disorder can make the speech vague or difficult to follow. In severe thought disorder the speech may be totally incomprehensible. Often there are sudden interruptions in the flow of thinking—called blocking—which the patient is at a loss to explain or may attempt to explain by a de-
clusion that his thoughts are being taken from him by some external force.

Affect, ambivalence, autism. By disturbance in affect, Bleuler meant both the lack of affective response and the presence of affect which is inconsistent with thought or action. By ambivalence, he was referring to the virtually simultaneous conscious occurrence of opposing thoughts, emotions, or impulses. Bleuler coined the term "autism" to refer to the tendency to withdraw from involvement with the external world and to become preoccupied with ideas and fantasies which are egocentric and illogical, and in which objective facts then tend to be obscured, distorted, or excluded.

The secondary symptoms are not necessarily present at any given moment in the illness, and may never appear. They are not unique to the illness and are seen in other conditions. However, when present they are easy to recognize and are therefore of great diagnostic use. They include such symptoms as delusions, illusions, and hallucinations, which often are the symptoms of immediate concern to either the patient, his family, or others.

The concept expanded. Some later workers have continued to expand the concept to include cases that neither Kraepelin nor Bleuler would have considered schizophrenic. For example, there is general agreement that there are patients whose clinical pictures include features associated both with manic-depressive illness and schizophrenia. Such patients are now classified as "schizophrenic, schizoaffective type." In addition, there are some clinicians who include cases that many would still classify as severe neuroses or personality disorders. Such patients are often referred to as "borderline schizophrenics" and are classified officially — along with other patients who have never displayed any secondary symptoms — as "latent type."

Psychiatrists in Europe tend to use the more restricted concept of schizophrenia associated with Kraepelin, while those in the United States are more strongly influenced by Bleuler and others, and apply the diagnosis more loosely.

MAKING THE DIAGNOSIS

Symptomatology
At the present time, the diagnosis of schizophrenia must be made on the basis of a clinical evaluation of the course and symptomatology. Although a single

<table>
<thead>
<tr>
<th>Latent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Undifferentiated</td>
</tr>
<tr>
<td>Childhood</td>
</tr>
<tr>
<td>Schizoaffective</td>
</tr>
<tr>
<td>Residual</td>
</tr>
<tr>
<td>Chronic Undifferentiated</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Simple</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hebephrenic</td>
</tr>
<tr>
<td>Catatonic</td>
</tr>
<tr>
<td>Paranoid</td>
</tr>
</tbody>
</table>

**Fig 2 Classification of Schizophrenia**
psychiatric examination may be sufficient, repeated examination or additional information from other informants is often necessary. Other conditions which can account for the clinical picture must be ruled out.

For example, both schizophrenia and alcoholism can produce auditory hallucinations. However, if the patient has had a chronic deteriorating course and has flatness of affect, this can be used to rule out the diagnosis of alcoholic hallucinosis. Similarly, both schizophrenia and involuntary melancholia can produce delusions of bodily disease. If the patient functioned well up to the involutional period, the diagnosis of schizophrenia is highly unlikely. However, this should not lead the clinician to overlook the possibility of the patient's having schizophrenia and some concurrent psychiatric condition such as alcoholism, or even an acute or chronic brain syndrome.

**Primary vs secondary.** The attempt of Bleuler to specify some symptoms as primary, that is, present in all cases, was an important contribution to our understanding of the nature of the schizophrenic disturbance. But in fact their presence or absence cannot always be relied upon when making the diagnosis. First of all, there are some cases in which the presence of some practically pathognomonic secondary symptoms clearly establishes the diagnosis, yet Bleuler's primary symptoms cannot be clearly demonstrated.

The reverse is more difficult; mild forms of the so-called primary symptoms — such as losing one's train of thought, temporary blocking, and confused or illogical thinking — are commonly seen in nonschizophrenics, particularly when they are fatigued or anxious.

The diagnosis of schizophrenia is extremely likely when practically pathognomonic symptomatology is found. This includes some of the primary symptoms of Bleuler, such as flat affect and thought disorder, and a few specific symptoms, such as the delusion that everyone knows what the patient is thinking, which are seen only in schizophrenia. Unfortunately, the few symptoms in this category are rarely seen except in florid or chronic cases in which there is little difficulty in arriving at a diagnosis. They are of least value when they are most needed — in the early stages, where diagnosis is most difficult.

Some symptoms are very suggestive of schizophrenia, since they rarely occur in other conditions. Other symptoms are common in schizophrenia but are also seen in other psychoses — delusions of various kinds are common in organic brain syndromes and psychotic depressive illnesses. Symptoms such as phobias, obsessions, and compulsions are often seen in schizophrenia, but they may also be indicative of a neurotic disorder. Finally, there are some very common schizophrenic symptoms — such as anxiety or depression — which are of no diagnostic value, since they are common in many other conditions.

**Psychological tests.** Despite years of attempts to develop specific physiological tests that would aid in detecting schizophrenia, no such tests are yet available. The use of psychological tests, particularly to identify thought disorder, is of questionable value and should never be relied upon exclusively. During diagnostic interviews patients are often asked to explain the meaning of common proverbs, such as "a rolling stone gathers no moss." For many years it was assumed that the inability to give a reasonable generalization was suggestive of a schizophrenic thought disorder. More recent work has indicated that low intelligence, cultural background, and organic factors are very common reasons for incorrect responses, and thus proverbs have little, if any, diagnostic value.

The differential diagnosis between schizophrenia and acute or chronic use of hallucinogens is increasingly important. Such drugs as LSD or marijuana, or stimulants such as the amphetamines, often produce acute reactions that are symptomatically quite similar to an acute schizophrenic episode or chronic reactions that resemble chronic undifferentiated schizophrenia.

**Subtypes**

Schizophrenia is divided into various subtypes. The classic types of Kraepelin and Bleuler have been supplemented over the years by additional categories. The standard subdivision of schizophrenia described here leaves much to be desired. First of all, many patients do not obviously fit into any of the subtypes. Second, the clinical picture often changes
during an episode or from one episode to the next, so that the subtype is not very stable over time. Finally, the subtypes offer information of only limited value for management, treatment, and prognosis. Many other systems for subdividing schizophrenia have been proposed. These are designed to be useful for either prognosis or treatment; however, none has gained wide acceptance.

Assignment of a patient to a given subtype is based on presenting symptomatology, course, and the patient's age at onset of the disease. However, the relative importance of these three variables differs among the subtypes. Childhood type is based solely on age of onset. The classic subtypes—paranoid, catatonic, and hebephrenic—are based almost entirely on presenting symptomatology. The remaining subtypes involve both symptomatology and features associated with the course.

**RELIABILITY OF DIAGNOSIS**

In the absence of definitive criteria for making the diagnosis of schizophrenia, it is not surprising that

<table>
<thead>
<tr>
<th>TABLE 1—DIAGNOSTIC VALUE OF DIFFERENT SYMPTOMATOLOGY IN SCHIZOPHRENIA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Symptom</strong></td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Flat affect</td>
</tr>
<tr>
<td>Thought disorder</td>
</tr>
<tr>
<td>Delusional influence or creativity</td>
</tr>
<tr>
<td>Halucinations of thoughts being broadcast over radio or television</td>
</tr>
<tr>
<td>Delusional misidentification with a familiar sounding name</td>
</tr>
<tr>
<td>Excessive slouching and postural rigidity</td>
</tr>
<tr>
<td>Waxy flexibility</td>
</tr>
<tr>
<td>Posturing</td>
</tr>
</tbody>
</table>

**A. Symptomatology typically pathognomonic of schizophrenia.** When present the diagnosis is commonly likely.

**B. Symptomatology seen in schizophrenia and rarely in other conditions. When present the diagnosis is very likely.**

- Affective
  - Lack of feeling, interest, concern, or emotion.
  - Common in schizophrenia, Rule-out sign, emotional or organic disorder.

- Inappropriate affect
  - Affect which is incongruous in light of situation or content of thought.
  - Common in schizophrenia, Rule-out sign, historical or organic disorder.

- Autism
  - Persistent tendency to withdraw from involvement with the external world and to become preoccupied with ideas and fantasies which may be in conflict with the reality in which objective facts are to be obscured, distored, or excluded.
  - Common in schizophrenia, Rule-out sign, autistic schizophrenia.

- Catatonic stupor
  - Marked decrease in reactivity to environment and reduction in activity, commonly associated with persistent ideation, delusions, and delusional misidentification.
  - Common in schizophrenia, Rule-out sign, delusional personality.

- Neologisms
  - Invention of new words.
  - Common in schizophrenia, Rule-out sign, delusional personality.
the reliability — agreement among clinicians as to the presence of the condition in a given patient — is not as high as would be desired. Reliability is higher, of course, when the clinicians are well trained, have sufficient information, and are focusing their attention on diagnostic discriminations.

**Clinician Concurrency: 75%**

Reports of the reliability of the diagnosis of schizophrenia vary widely. On the average, if one psychiatrist diagnoses a patient as schizophrenic, the probability that another psychiatrist will concur is 75%. Although the reliability of the diagnosis of schizophrenia is far from satisfactory, it is in the range reported for the reliability of many other non-psychiatric medical diagnoses based on clinical judgment rather than on specific tests.

**Computer Programs**

The use of computer programs to improve the reliability of psychiatric diagnosis has the advantage that, given the same description of the patient, a

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Definition</th>
<th>Diagnostic Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delusions</td>
<td>Abnormal, irrational, and delusional beliefs, ideas, or perceptions, which are not examined and cannot be explained by ordinary human experience or rational thought.</td>
<td>Rule out organic and constitutional factors, especially when the hallucinations are based on the patient's medical condition.</td>
</tr>
<tr>
<td>Auditory hallucinations</td>
<td>False sensory impression of sound through the auditory pathways of the brain.</td>
<td>Rare in schizophrenia. Very rare in other organic conditions.</td>
</tr>
<tr>
<td>Auditory hallucinations</td>
<td>False sensory impression of sound in the body. Examples: Patient feels electricity is being sent through him.</td>
<td>Common in schizophrenia. Most diagnostic when voices: Unusual, not consistent with the patient's beliefs, and particularly delusional.</td>
</tr>
</tbody>
</table>

Symptomatology commonly seen in schizophrenia and other conditions. When present, the diagnosis is likely:

- **Delusions**: Conviction, whether rational or irrational, of something contrary to ordinary reality. Delusional thoughts are resistible in many instances.
- **Sensory Impression**: Sensory impressions in the absence of external stimuli, occurring during the waking hours.
- **Disorientation**: Incorrectly identifying objects or persons.
- **Inappropriate Smiling**: An expression of positive affect not consistent with the patient's internal state.
- **Avoidance of contact or involvement**: Withdrawal from social or interpersonal interactions.
- **Interpersonal Relationships**: Relationships with relatives, friends, and other people. Social withdrawal may be apparent.
- **Deterioration of Adaptation**: With progressive deterioration of personal and social functioning, a person's environment becomes increasingly impoverished.
- **Depression**: Marked or persistent sadness, hopelessness, and/or loss of interest in activities.
- **Deterioration with illness**: Includes separation from real or imagined physical appearance; fear of becoming ill; lack of health.

Prevalent in all other conditions, in rare cases, suggestive of schizophrenia: Inability to tolerate stress, inability to tolerate indecision, difficulty between level of functioning and background or previous achievements.

Rule out depressive illness, and hypochondriacal neurosis. Bilious or incomprehensible complaints or beliefs are suggestive of schizophrenia.
computer will always yield the same diagnosis. Some procedures have employed various probability models or other statistical techniques; others use a decision tree model similar to the differential diagnostic process used in medicine.

Decision tree. In the decision tree model, the computer program consists of a series of questions, each of which is either true or false. The result of each question rules out one or more diagnoses or groups of diagnoses and determines the next question to be asked. The questions are similar to those a clinician would ask, for example: “Is there evidence of an organic brain syndrome?” or “Is there evidence of a pathognomonic sign of schizophrenia?” Such programs have been very successful in simulating the clinical diagnostic process to the extent that agreement between the computer-derived diagnosis and clinical diagnosis is approximately the same as between the diagnoses or two clinicians.

INCIDENCE AND PREVALENCE

In all countries where an effort has been made to

---

**TABLE 2**—MAJOR DIFFERENTIAL DIAGNOSES OF SCHIZOPHRENIA SUBTYPES

<table>
<thead>
<tr>
<th>Schizophrenia Subtype</th>
<th>Differential Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paranoid</td>
<td>1. Involutional paranoia</td>
</tr>
<tr>
<td></td>
<td>2. Paranoid</td>
</tr>
<tr>
<td></td>
<td>3. Amphetamine-toxic psychosis</td>
</tr>
<tr>
<td></td>
<td>4. Paranoid personality</td>
</tr>
<tr>
<td>Simple</td>
<td>1. Schizoid personality</td>
</tr>
<tr>
<td>Childhood</td>
<td>1. Behavior disorders of childhood and adolescence</td>
</tr>
<tr>
<td></td>
<td>2. Withdrawing reaction</td>
</tr>
<tr>
<td>Suggestive</td>
<td>1. Manic-depressive, manic</td>
</tr>
<tr>
<td></td>
<td>2. Psychotic depression</td>
</tr>
<tr>
<td></td>
<td>3. Cyclothymic personality</td>
</tr>
<tr>
<td>Latent</td>
<td>1. Severe neurosis</td>
</tr>
<tr>
<td></td>
<td>2. Severe personality disorder</td>
</tr>
<tr>
<td>Catatonic</td>
<td>1. Retarded depression</td>
</tr>
<tr>
<td>Chronic</td>
<td>1. Chronic organic brain syndrome</td>
</tr>
<tr>
<td>undifferentiated</td>
<td>2. Chronic use of stimulants or hallucinogens</td>
</tr>
<tr>
<td>Acute schizophrenic</td>
<td>1. Severe transient emotion disturbance</td>
</tr>
<tr>
<td>episode</td>
<td>2. Acute organic brain syndrome</td>
</tr>
</tbody>
</table>

---

**TABLE 3**—PROGNOSTIC FEATURES IN SCHIZOPHRENIA

<table>
<thead>
<tr>
<th>Features</th>
<th>Good Features</th>
<th>Poor Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promorbid factors</td>
<td>Good social, sexual, and occupational adjustment</td>
<td>Superior intelligence</td>
</tr>
<tr>
<td></td>
<td>Cyclothymic personality</td>
<td>Schizoid personality</td>
</tr>
<tr>
<td></td>
<td>Superior intelligence</td>
<td>Low intelligence</td>
</tr>
<tr>
<td>Onset</td>
<td>Late in life</td>
<td>Childhood or adolescence</td>
</tr>
<tr>
<td></td>
<td>Acute</td>
<td>Insidious</td>
</tr>
<tr>
<td></td>
<td>Associated with environmental stress</td>
<td>No apparent environmental stress</td>
</tr>
<tr>
<td>Presenting symptomatology</td>
<td>Preservation of affect</td>
<td>Flat affect</td>
</tr>
<tr>
<td></td>
<td>Depressive or anxious mood</td>
<td>Absence of anxiety or depression</td>
</tr>
<tr>
<td></td>
<td>Impaired consciousness, memory, orientation, if</td>
<td>Bizarre or fragmentary delusions</td>
</tr>
<tr>
<td></td>
<td>associated with an acute episode</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Catatonic symptoms</td>
<td></td>
</tr>
<tr>
<td>Course</td>
<td>Episodic</td>
<td>Continuous</td>
</tr>
<tr>
<td>Psychopathology in parents</td>
<td>Manic-depressive</td>
<td>Schizophrenic</td>
</tr>
<tr>
<td>Subtype</td>
<td>Acute schizophrenic episode; Catatonic;</td>
<td>Simple; Hebephrenic: Chronic undifferentiated</td>
</tr>
<tr>
<td></td>
<td>Schizoaffective</td>
<td></td>
</tr>
</tbody>
</table>
determine the incidence and prevalence of schizophrenia, it has been found to be a serious public health problem. Depending upon the study, from 1 to 9 persons per 1000 have had an attack of a condition diagnosed as schizophrenia. In the U.S. approximately 1 of every 100 people will be hospitalized with a diagnosis of schizophrenia at some point during his lifetime. The incidence of new cases of schizophrenia in this country is estimated at 150 per 100,000 each year. Approximately 35 of the 150 cases are hospitalized.

One fifth are schizophrenics. A sizable proportion of patients first admitted to state and county psychiatric hospitals between adolescence and the end of the fourth decade are diagnosed as schizophrenic. The rate, unadjusted for age, is approximately 20%. Because schizophrenics tend to remain in the hospital longer or be readmitted more often — as compared with other diagnostic groups — the resident rate for schizophrenia increases for each age group up to the sixth decade. It is then overtaken by the large number of patients with organic brain syndromes associated with old age.

At any moment in time, over half of the psychiatric hospital beds in the country are occupied by individuals diagnosed as schizophrenic.

![Graph showing incidence of schizophrenia](image)

**Fig 3** First admission rates for most mental disorders reach a peak in the second decade of life.*

**Fig 4** Schizophrenics comprise a major proportion of the hospital resident population.*

Schizophrenia
Subtypes*

295.0 Schizophrenia,
simple type
This psychosis is characterized chiefly by a slow and insidious reduction of external attachments and interests and by apathy and indifference leading to impoverishment of interpersonal relations, mental deterioration, and adjustment on a lower level of functioning. In general, the condition is less dramatically psychotic than are the hebephrenic, catatonic, and paranoid types of schizophrenia. Also, it contrasts with schizoid personality, in which there is little or no progression of the disorder.

295.1 Schizophrenia,
hebephrenic type
This psychosis is characterized by disorganized thinking, shallow and inappropriate affect, unpredictable giggling, silly and regressive behavior and mannerisms, and frequent hypochondriacal complaints. Delusions and hallucinations, if present, are transient and not well organized.

295.2 Schizophrenia,
catatonic type
295.23 Schizophrenia,
catatonic type,
excited
295.24 Schizophrenia,
catatonic type,
withdrawn
It is frequently possible and useful to distinguish two subtypes of catatonic schizophrenia. One is marked by excessive and sometimes violent motor activity and excitement and the other by generalized inhibition manifested by stupor, mutism, negativism, or waxy flexibility. In time, some cases deteriorate to a vegetative state.

295.3 Schizophrenia,
paranoid type
This type of schizophrenia is characterized primarily by the presence of persecutory or grandiose delusions, often associated with hallucinations. Excessive religiosity is sometimes seen. The patient's attitude is frequently hostile and aggressive, and his behavior tends to be consistent with his delusions. In general the disorder does not manifest the gross personality disorganization of the hebephrenic and catatonic types, perhaps because the patient uses the mechanism of projection, which ascribes to others characteristics he cannot accept in himself. Three subtypes of the disorder may sometimes be differentiated, depending on the predominant symptoms: hostile, grandiose, and hallucinatory.

295.4 Acute schizophrenic
episode
This diagnosis does not apply to acute episodes of schizophrenic disorders described elsewhere. This condition is distinguished by the acute onset of schizophrenic symptoms, often associ-
ated with confusion, perplexity, ideas of reference, emotional turmoil, dream-like dissociation, and excitement, depression, or fear. The acute onset distinguishes this condition from simple schizophrenia. In time these patients may take on the characteristics of catatonic, hebephrenic, or paranoid schizophrenia, in which case their diagnosis should be changed accordingly. In many cases the patient recovers within weeks, but sometimes his disorganization becomes progressive. More frequently remission is followed by recurrence.

295.5 Schizophrenia, latent type
This category is for patients having clear symptoms of schizophrenia but no history of a psychotic schizophrenic episode. Disorders sometimes designated as incipient, prepsychotic, pseudoneurotic, pseudopsychopathic, or borderline schizophrenia are categorized here.

295.6 Schizophrenia, residual type
This category is for patients showing signs of schizophrenia but who, following a psychotic schizophrenic episode, are no longer psychotic.

295.7 Schizophrenia, schizoaffective type
This category is for patients showing a mixture of schizophrenic symptoms and pronounced elation or depression. Within this category it may be useful to distinguish excited from depressed types as follows:

295.73 Schizophrenia, schizoaffective type, excited
295.74 Schizophrenia, schizoaffective type, depressed

295.8 Schizophrenia, childhood type
This category is for cases in which schizophrenic symptoms appear before puberty. The condition may be manifested by autistic, atypical, and withdrawn behavior; failure to develop identity separate from the mother’s; and general unevenness, gross immaturity, and inadequacy in development. These developmental defects may result in mental retardation, which should also be diagnosed.

295.9 Schizophrenia, chronic undifferentiated type
This category is for patients who show mixed schizophrenic symptoms and who present definite schizophrenic thought, affect, and behavior not classifiable under the other types of schizophrenia. It is distinguished from schizoid personality.

*Adapted from Diagnostic and Statistical Manual of Mental Disorders. Washington, American Psychiatric Association, 1968