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Main Discussion Post

Paranoid Schizophrenia is a chronic subtype of Schizophrenia that is characterized by the presence of delusional thoughts and is often associated with hallucinations. Some traits that correspond with Paranoid Schizophrenia are thought distortion, grandiosity, suspicion, weariness, and distrust (Daston, King, & Armitage, 2003). Additional symptoms include the belief that others are plotting against them, obsessive thoughts, severe anxiety, anger outbursts (stemmed from delusional thoughts & auditory or visual hallucinations), and possible thoughts to want to harm themselves or others. The two prominent symptoms that are most associated with this disorder are the persecutory delusions and auditory hallucinations that suggest that others are trying to hurt him/her, make demands, or make cruel and demeaning comments towards the individual. Because of the constant distrust and belief that others are conspiring against him/her, he/she may lash out and attempt to harm others but they believe it to be an act of self-defense. Like most psychotic disorders, there is no clear understanding of the cause. However, risk factors that may increase the chances of one being diagnosed with Paranoid Schizophrenia are a family history of psychotic disorders, exposure to viral infection while in the womb, stress in early childhood, history of abuse, or use of psychoactive substances (Gluck, 2017). This subtype is no longer included in the DSM-5 however can still be used as a diagnosis by specifying that the individual with Schizophrenia presents with strong paranoid traits (Hooley, Butcher, Nock, & Mineka, 2017).

Delusional Disorder can be defined as one experiencing ongoing “false and absurd” beliefs/delusions that are often bizarre in content;however the individual will continue to believe these thoughts contrary to evidence of the truth (Hooley et al., 2017). The DSM-5 criterion that need to be met to be diagnosed with DD are the presence of one (or more) delusions with a duration of at least one month, criterion A for Schizophrenia has never been met, the delusional thoughts do not lead to an impairment to one’s behaviors/daily lives, if manic or depressive episodes have occurred- they have been brief compared to the duration of the delusions, and the delusions are not attributed from a medical condition, other mental health diagnoses, or substance abuse. DD can be specified by 7 additional subtypes: Erotomanic (the belief someone is in love with them), Grandiose (having great talent or has made a great discovery), Jealous (his/her spouse is unfaithful), Persecutory (being conspired against, cheated on, spied on, followed…etc.), Somatic (related to bodily functions and sensations), Mixed (more than one delusional subtype presents), and Unspecified (when no one subtype predominates) (American Psychiatric Association, 2013). Some suggested causes of DD are a history of psychosis disorders in the family, abnormalities of the brain that lead to a development of distorted perceptions/delusions, substance abuse, stress, isolation…etc. (Marneros, Pillmann, & Wustmann, 2012).

I chose these two disorders because I feel they would be the most difficult to differentiate as they present with similar and overlapping symptoms. First and foremost, both disorders present with delusional thoughts, however, delusional disorder can be acknowledged for itsmultiple subtypes and not

just a paranoid/persecutory delusion as Paranoid Schizophrenia does. Additionally, Paranoid Schizophrenia often presents with auditory hallucinations while Delusional Disorder can present with some hallucinations but they are not prominent or related to the delusional theme (APA, 2013). The two disorders also share common characteristics such as severe anxiety, thoughts of wanting to harm themselves or others, obsessive thoughts, weariness of others, poor interpersonal relationships; the one thing that sets these two disorders apart is that Delusional Disorder does not interfere with one’s abilities or cause an impairment to their lives (Hooley et al., 2017). Marneros, Pillmann, & Wustmanndiscuss how the two disorders are so similar that there has been research conducted to determine whether or not Delusional Disorder is just a form/subtype of Paranoid Schizophrenia (2012).

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Response to HScheer

Well written overview!!! I discussed delusional disorder also which seems to be that this disorder is related to all schizophrenia disorders. Because delusional behaviors are the most common symptom each and every patient that may be suffering from some sort of schizo-disorder will more than likely experience delusions first. Delusional behaviors can occur at a young age; it is more prevalent in older adults. However, I read that a common characteristic of delusional disorder is the appearance of normality (APA,2013). Which I do find to be true, although I have come in contact with a few people who have experience delusional behaviors but wasn't diagnosed with schizophrenia.

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Good  job on your discussion post this week Haylie, I also discussed paranoid schizophrenia in my post as well. People with paranoid delusions are unreasonably suspicious of others. This can make it hard for them to hold a job, run errands, have friendships, and even go to the doctor. Delusions are beliefs that seem real to you, even when there's strong evidence they aren't. Paranoid delusions, also called delusions of persecution, are rooted in fear and anxiety.

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Schizophreniform disorder is a category that is reserved for schizophrenia-like psychoses that last at least a month but do not last for 6 months (American Psychiatric Disorder, 2013). The characteristics symptoms for schizophreniform disorder are similar to those of schizophrenia. However, schizophreniform is different from schizophrenia because of the duration of the illness. The duration of illness includes prodromal, active and residual phases. Schizophreniform is similar to the development of schizophrenia. People who are diagnosed with SD usually recover within a 6-month period but if no recovery is made, the patient then is diagnosed with schizophrenia. (APA, 2013)

Delusional disorder is characterized by bizarre delusional behaviors which are false. Many people who are given the diagnosis DD behaves normally. Their behavior does not indicate incompetence or performance deficiencies. Some subtypes of delusional behavior include somatic (related to body sensations and functions), grandiose (having greater talent), jealous (unfaithful partner/spouse), persecutory (being lied on or stalked), and erotomanic (belief that someone is in love with them) or mixed (more than one delusional subtype present).  People with DD usually develops schizophrenia. The person must experience the symptoms for must last for than a month, in order to be diagnosed with DD and is prevalent in older adults. DD has a more familial relationship with both schizophrenia and schizotypal disorder. (APA, 2013)

These two disorders are closely related and the only thing that differs is the duration of illness. Both disorders can be diagnosed as schizophrenia if not carefully looked into.

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Whitney, what's the reason that DD can be misdiagnosed as schizophrenia, in your opinion?

It's helpful to bear in mind that it's pointless trying to argue about delusions. If you could convince a patient to change his mind about a delusion, then it's not a delusion! The defining criterion for delusions is that they are beliefs that are strongly held, despite no evidence to support them, or evidence to the contrary. As a clinician we aim to move towards awareness. For example for the patient to accept that, yes he believes the government is out to get him, but he accepts that it's his illness and the government is probably not out to get him. I had a patient who had a body-related delusion so I referred him to the GP to check everything is all right, and then we discussed that the GP wouldn't say 'everything is ok' if it wasnt. We then had an interesting conversation about the light in the GPs room not being bright enough, so maybe the GP did not see things clearly ... but in the end the patient accepted that the GP wouldn't risk doing such shoddy work. However my patient still believed things there was something wrong with him - but also accepted that it was probably a delusion.

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Response

Hi Whitney,

Great post! I researched Schizophreniform Disorder as well but compared it to Schizoaffective Disorder. Regarding your information on Delusional Disorder (DD), I found an article that talks about a study that tested whether DD is truly separate from Paranoid Schizophrenia (Marneros, Pillmann, & Wustmann, 2012). They found that it is definitely separate and contains several differences. For example, DD patient’s age at onset is significantly higher than those diagnosed with Schizophrenia, and DD patients have a better long-term outcome than Paranoid Schizophrenic patients. Overall, the only similarity they share is the delusions the patients experience. The majority of the other Schizophrenic symptoms do not occur in DD at all.

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In this week discussion, two types of schizophrenia will be discussed and the two that will be discussed are paranoid schizophrenia and disorganized schizophrenia. Paranoid schizophrenia is when an individual has delusions or false beliefs that another individual is after them or after someone close to them. Paranoid schizophrenia is also seen as the most common type of schizophrenia and many people with this type of schizophrenia suffer from hallucinations. Individuals who are diagnosed with schizophrenia disorder usually recover within several months and if the individual does not get better, the individual is diagnosed with schizophrenia. (APA, 2013)   Hallucination becomes a major problem as well because the individual may get nervous or anxious about a situation that may occur. Disorganized schizophrenia is also one of the types of schizophrenia and it is very chronic and it also last a long time. Disorganized schizophrenia also has some factors of delusions and lack of emotions. It is also characterized by some thoughts and behaviors.

            Paranoid schizophrenia and disorganized schizophrenia are similar in many ways. They both have some delusions and hallucinations issues and they are considered types of schizophrenia.  They both have flat affect, the individual may not be able to show or experience any emotions. Paranoid schizophrenia and disorganized schizophrenia has active behavior, the person may become very active, but the behavior that they engage in has no focus or purpose. Paranoid and disorganized schizophrenia suffers from similar symptoms including agitations and hallucinations. Paranoid Schizophrenia is a chronic subtype of Schizophrenia that is characterized by delusional thoughts and according to the DSM-5 it is no longer a part of it but can still be diagnose. Both paranoid and disorganized schizophrenia disorder runs within a family and may be inherited. An individual with a close family member that has schizophrenia is more likely to have schizophrenia. Both paranoid and disorganized schizophrenia disorder are treated by medication and they are also treated by therapy and help from a family member. According (Hooley, 2017) individuals with schizophrenia disorder has more of the paranoid symptoms.

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Comparing Psychotic Disorders

Schizophreniform disorder is in the schizophrenic family it’s a psychotic disorder that shares the same symptoms as schizophrenia. Schizophreniform develops more rapidly and is displayed for a shorter amount of time, less than 6 months, also an impact on the individual’s social, occupational and academic functionalities. It’s considered a provisional diagnosis to see if symptoms improve or progress into schizophrenia. Some symptoms include hallucinations, delusions, disorganized speech, catatonia, flat affect, loss of interest of social relationships and inability to feel pleasure. Most individuals who are diagnosed with schizophreniform will be diagnosed with schizophrenia down the line. The diagnostic criteria are at least 1 symptom has to be majority present during a period of 30 days. Symptoms can be present less than 30 days if they were treated. There cannot be symptoms of mixed mood (manic or depressed). Or can be effects from substance abuse or drug use or medical issue. A good prognosis for this disorder would to onset symptoms present within the first month before changes in behavior is noticed. No issues with occupational and social functions (APA 2013).

Schizoaffective disorder has both mood symptoms and psychotic symptoms which are major features. This disorder is broke down into two subgroups, bipolar type and depressive type. These are considered the hallmarks of schizoaffective disorder. It’s believed that schizoaffective should be its own disorder (Pagel Baldessarini, Franklin, Baethge, 2013). In order for this disorder it is diagnosed the individual must display by significant mood episodes. Hallucination and delusions must be present for a 2 week time frame.  As with schizophrenia these symptoms cannot be a result of alcohol or drug use or medical issue. Also impairments in occupational, social and academic functions can be present but it is not required for an accurate diagnosis.  The severity of the disorder in an individual is measured by the frequency of the symptoms. A scale is used to measure from 0 to 4, 4 being the most severe. Both schizoaffective and schizophrenia share the symptoms of hallucinations, delusions, disorganized speech and behaviors. One specific symptom is late night binge eating. Another factor individual who have biological relatives who are diagnosed with either bipolar or schizophrenia are more likely to be diagnosed with schizoaffective disorder (APA 2013).

For the most part both of these disorders share the same symptoms. The time frames for symptoms to be present are different. But as a whole they are very similar. Both can progress into other disorders and are treated accordingly.

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Schizophrenia and Schizoaffective Disorder are very similar in nature. Both disorders are categorized under Schizophrenia Spectrum and other Psychotic Disorders in the DSM (APA, 2013). A spectrum disorder is based upon the theory that all the disorders under the category share similar traits or symptoms. A spectrum disorder is further assumed that the mechanism causing the disorder is the same, but the specific patterns of each subtype are all based upon a core group of more unique symptoms or behaviors that may develop over time (Hooley, Butcher, Nock, Mineka, 2017) and (APA, 2013).

The core features of both schizophrenia and schizoaffective disorders involve hallucinations, delusions, disorganized speech, negative symptoms, such as a depressed state of mind, severe dysfunction in behavior, social and cognitive abilities, or a catatonic state. The ability to take care of oneself, such as grooming is also diminished. Because these disorders are similar in nature, the importance of watching the client over time is of vital importance. With time, a diagnosis may change based upon the severity of symptoms or new behaviors. For example, schizoaffective disorder can only be diagnosed if criterion A of schizophrenia has been met. The difference in the diagnosis of schizoaffective disorder and schizophrenia is when a mood disorder develops over an extended period of time and is pervasive.

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Rachelle,

            I enjoyed reading your post.  While researching schizophrenia and schizoaffective disorder, I came across some significant factors.  The American Psychiatric Association (2013) notes the importance of assessing cognition, depression, and manic symptoms to make vital distinctions between schizoaffective disorder and other disorders.  Due to such similar characteristics in schizoaffective disorder and schizophrenia, analyses in these areas are important to distinguish the differences.  With schizoaffective disorder, impairments in functioning are frequent but it is not a requirement as it is in schizophrenia (American Psychiatric Association, 2013).  This can add to the difficulty in defining which diagnosis an individual has because if there are significate issues in daily activities it would complicate the distinction.  While poor insights and negative symptoms can be present in schizoaffective disorder, it is more prominent and severe with schizophrenia (American Psychiatric Association, 2013).  Evaluating the symptoms and the consequences they have on the individual’s life can be a determinant between schizophrenia and schizoaffective disorder.  Since the two disorders are so similar, looking for the slightest difference can make a big impact on diagnosis.

Thanks Rachelle!

Mallory

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**RE: Discussion - Week 10**

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            Schizophrenia and other psychotic disorders are alike in many ways.  The differences however, are prominent enough to ensure accurate diagnoses.  Schizophrenia and delusional disorder both require the presence of delusions for at least one month (American Psychiatric Association, 2013).  These individuals feel as though their thoughts are factual when they are actually false and irrational.  The variance being schizophrenia also includes hallucinations, disorganized speech, and catatonic behavior (American Psychiatric Association, 2013).  Another difference arises in daily life functioning abilities.  Behaviors for those with delusional disorder are not described as obviously bizarre or impaired while those with schizophrenia experience major disturbances in this area for at least six months (American Psychiatric Association, 2013; Hooley, Butcher, Nock, & Mineka, 2017).  Meaning, an individual with delusional disorder would present much better than someone with schizophrenia.  While delusional disorder and schizophrenia encompass similar qualities, schizophrenia is much more complex and requires additional criteria.

            Features associated with schizophrenia and delusional disorder also vary a great deal.  Those with delusional disorder may have social, work, or marital issues due to their delusions as well as developing an irritable or dysphoric mood (American Psychiatric Association, 2013).  This is in large part due to the disagreements about the individual’s delusions since they so firmly believe they are true.  Erotomania is a subtype of delusional disorder described as a great love for a person who is usually famous (Hooley et al., 2017).  Erotomania is a part of the delusions experienced by the individual.  Features of schizophrenia are more extensive.  Inappropriate affect, disturbed sleep patterns, and lack of interest in food are usual symptoms (American Psychiatric Association, 2013).  These effects can be obvious indicators when trying to identify if someone is schizophrenic.  Other issues these individuals face are memory impairments, phobias, abnormalities in sensory processing, and lower attention spans (American Psychiatric Association, 2013).  These are just some of the many features associated with schizophrenia.  Few of the features are shared among both disorders making it easier to identify the individual’s diagnosis.

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