

Epidemiological aspects of schizophrenia in a CAPS in Rondônia, Brazil

Aspectos epidemiológicos da esquizofrenia em um CAPS de Rondônia, Brasil

Aspectos epidemiológicos de la esquizofrenia en un CAPS de Rondônia, Brasil

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Resumo

Introdução. A esquizofrenia é um transtorno neuropsiquiátrico que altera a percepção, o pensamento, as emoções e a consciência. É a forma mais comum de psicose, afetando cerca de 20 milhões de pessoas em todo o mundo. **Objetivo.** Identificar o perfil epidemiológico de pacientes diagnosticados com esquizofrenia em Porto Velho, Rondônia. **Método.** Estudo descritivo, transversal, com abordagem qualiquantitativa, realizado em um Centro de Atenção Psicossocial (CAPS). **Resultados.** Foram coletados dados de 200 prontuários de pacientes ativos, com foco em variáveis como sexo, idade, estado civil, escolaridade, religião, diagnóstico CID-10, tratamento farmacológico e histórico familiar. Desses, 47 prontuários (23,5%) referiam-se a transtornos do espectro da esquizofrenia (CID-10: F20-F29), sendo 53,2% do sexo masculino e 46,8% do sexo feminino, com média de idade de 45±3 anos. A maioria dos pacientes era solteira (57,4%), não havia concluído o ensino fundamental (38,3%) e se identificava como católica ou evangélica (27,7% cada). A esquizofrenia não especificada (F20) (40,43%) e a esquizofrenia paranoide (F20.0) (17,02%) foram os diagnósticos mais frequentes. O tratamento farmacológico foi registrado em 97,9% dos casos, e 9% apresentavam histórico familiar de transtornos mentais. **Conclusão.** Compreender esse perfil auxilia no melhor planejamento de estratégias de saúde pública e na melhoria dos serviços de saúde mental.

Unitermos. Esquizofrenia; perfil de saúde; perfil epidemiológico; sinais e sintomas

Abstract

Introduction. Schizophrenia is a neuropsychiatric disorder that alters perception, thought, emotions, and consciousness. It is the most common form of psychosis, affecting around 20 million people worldwide. **Objective.** To identify the epidemiological profile of patients diagnosed with schizophrenia in Porto Velho, Rondônia. **Method.** It is a descriptive, cross-sectional study with a qualitative-quantitative approach, conducted at a Psychosocial Care Center (CAPS). **Results.** Data were collected from 200 medical records of active patients, focusing on variables such as sex, age, marital status, education, religion, ICD-10 diagnosis, pharmacological treatment, and family history. Of these, 47 records (23.5%) referred to schizophrenia spectrum disorders (ICD-10: F20-F29), with 53.2% male and 46.8% female, and a mean age of 45±3 years. Most patients were single (57.4%), had not completed primary school (38.3%), and identified as Catholic or Evangelical (27.7% each). Unspecified schizophrenia (F20) (40.43%) and paranoid schizophrenia (F20.0) (17.02%) were the most

frequent diagnoses. Pharmacological treatment was recorded in 97.9% of cases, and 9% had a family history of mental illness. **Conclusion.** Understanding this profile supports better planning of public health strategies and improvements in mental health services.
Keywords. Schizophrenia; health profile; epidemiological profile; signs and symptoms

Resumen

Introducción. La esquizofrenia es un trastorno neuropsiquiátrico que altera la percepción, el pensamiento, las emociones y la conciencia. Es la forma más común de psicosis, afectando a aproximadamente 20 millones de personas en todo el mundo. **Objetivo.** Identificar el perfil epidemiológico de los pacientes diagnosticados con esquizofrenia en Porto Velho, Rondônia. **Método.** Se trata de un estudio descriptivo, transversal, con un enfoque cualitativo-cuantitativo, realizado en un Centro de Atención Psicosocial (CAPS). **Resultados.** Se recopilieron datos de 200 historias clínicas de pacientes activos, enfocándose en variables como sexo, edad, estado civil, nivel educativo, religión, diagnóstico CIE-10, tratamiento farmacológico y antecedentes familiares. De estos, 47 registros (23,5%) correspondían a trastornos del espectro de la esquizofrenia (CIE-10: F20-F29), con un 53,2% de hombres y un 46,8% de mujeres, y una edad media de 45 ± 3 años. La mayoría de los pacientes eran solteros (57,4%), no habían completado la educación primaria (38,3%) y se identificaban como católicos o evangélicos (27,7% cada uno). La esquizofrenia no especificada (F20) (40,43%) y la esquizofrenia paranoide (F20.0) (17,02%) fueron los diagnósticos más frecuentes. El tratamiento farmacológico se registró en el 97,9% de los casos, y el 9% tenía antecedentes familiares de enfermedad mental. **Conclusión.** Comprender este perfil contribuye a una mejor planificación de estrategias de salud pública y al fortalecimiento de los servicios de salud mental.

Palabras clave. Esquizofrenia; perfil de salud; perfil epidemiológico; signos y síntomas

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INTRODUCTION

Schizophrenia is a chronic and idiopathic psychotic disorder that affects approximately 1% of the global population and is recognized as one of the most significant psychiatric conditions with worldwide impact. Its onset typically occurs between the second and third decades of life, a critical period for social and professional development, leading to substantial impairments in social, occupational, and functional domains. The hallmark symptoms of schizophrenia include delusions, hallucinations, affective blunting, and cognitive dysfunction. According to the

Diagnostic and Statistical Manual of Mental Disorders (DSM-5), delusions may present as persecutory, grandiose, or involving a sense of control. While auditory hallucinations are the most prevalent, other sensory modalities may also be involved. Affective blunting is characterized by a diminished expression of emotions and a reduced capacity to experience pleasure. Furthermore, cognitive dysfunction is marked by impairments in attention, working memory, and executive functions, which hinder the ability to make decisions and solve problems effectively¹.

Despite advances in the understanding of the disorder, its etiology remains only partially elucidated and is attributed to the interaction of genetic, neurobiological, and environmental factors². Individuals with a family history of schizophrenia have an increased risk of developing the condition, with rates reaching 10% to 15%, in contrast to the general prevalence of 1% to 2%³. In addition to genetic predisposition, factors such as perinatal complications, maternal infections during pregnancy, early life stressors, and the use of psychoactive substances, particularly cannabinoids, are widely associated with the onset of the disorder⁴.

In Brazil, the Ministry of Health estimates that approximately 1.6 million people live with schizophrenia⁵, facing not only clinical challenges but also social stigma, exclusion, and barriers to accessing appropriate treatment. Data from the Mental Health Information Report indicate that schizophrenia is among the leading causes of care provided

at Psychosocial Care Centers (CAPS) and represents one of the main reasons for psychiatric hospitalization within the Unified Health System (SUS)⁶. However, the lack of epidemiological studies in certain regions of the country continues to limit understanding of the local context, hindering the development of targeted and effective public policies.

The scarcity of epidemiological studies in certain regions of Brazil, such as the state of Rondônia, poses additional challenges to public health, hindering early diagnosis and the planning of effective care policies. In this context, the present study aims to characterize the epidemiological profile of patients diagnosed with schizophrenia in the municipality of Porto Velho, Rondônia, contributing to the expansion of knowledge about the disorder and the improvement of healthcare strategies in the region.

METHOD

Study Type

This is a descriptive cross-sectional study with a qualitative-quantitative approach, conducted in a population of individuals with mental disorders, with an emphasis on those diagnosed with schizophrenia.

The study was approved by the Research Ethics Committee (CEP/FIMCA) under approval number 6.801.914 and CAAE 78843824.8.0000.0012.

Study Location

The present study was developed in collaboration with the Madeira-Mamoré State Psychosocial Care Center, located in the municipality of Porto Velho, Rondônia. This unit is part of the Psychosocial Care Network (RAPS) within the Unified Health System (SUS) and has statewide coverage, serving users from all municipalities and districts in Rondônia. The center targets individuals aged 18 years or older who present severe and persistent mental disorders, including but not limited to patients with schizophrenia, bipolar affective disorder, and other psychotic disorders.

The organizational structure of the unit consists of a multidisciplinary team that includes psychiatrists, psychologists, nurses, occupational therapists, social workers, and nursing technicians and assistants. The service aims to promote social reintegration of users, support continuous treatment, prevent psychiatric hospitalizations, and ensure care in freedom, according to the guidelines of the national mental health policy.

Sample

The study population consisted of 200 patients receiving care and follow-up at the Madeira-Mamoré State Psychosocial Care Center unit in Porto Velho, Rondônia. Sampling was performed by convenience and followed the following inclusion criteria: (1) Age between 18 and 65 years; (2) Both sexes; (3) Diagnosed with schizophrenia, schizotypal disorder, or delusional disorder (ICD-10: F20 to

F29); (4) Residing in Porto Velho and having an active follow-up profile at the unit. Individuals with primary etiologies of other mental disorders and/or receiving care at other units were excluded.

Procedure

Sociodemographic data were collected through the analysis of physical medical records of patients followed by the clinical team at CAPS II Madeira-Mamoré. The variables analyzed were: (1) Age, (2) Sex, (3) Educational level, (4) Marital status, (5) Religion, (6) ICD-10 diagnosis, (7) Use of pharmacological therapy, and (8) Family history.

To ensure privacy and data security, all data collection was conducted anonymously, without direct identification of individuals.

Statistical Analysis

Statistical analyses were performed using JASP software (Version 0.19.3). Categorical variables were compared using the chi-square test or Fisher's exact test, as appropriate. For continuous variables, medians, minimum, and maximum values were calculated. A p-value <0.05 was considered statistically significant.

RESULTS

A total of 200 physical medical records from patients receiving care and treatment at the CAPS II Estadual Madeira-Mamoré unit in Porto Velho, Rondônia, were

reviewed. Of these, 39 records were excluded for not meeting the inclusion criteria, yielding a final sample of 161 eligible records. Among these, only 29% (47/161) corresponded to patients diagnosed with schizophrenia, schizotypal disorders, or delusional disorders (ICD-10: F20 to F29).

The analysis demonstrated that, of the 47 patients evaluated, 46.80% (22/47) were female and 53.20% (25/47) were male, with a mean age of 45 ± 3 years. The majority of patients were single (57.40%), possessed incomplete primary education (38.30%), and identified as either Catholic (27.70%) or Evangelical (27.70%; Table 1).

The most prevalent diagnosis was unspecified schizophrenia (F20), accounting for 40.43% (19/47) of the sample, followed by paranoid schizophrenia (F20.0), representing 17.02% (8/47). The least prevalent types included hebephrenic schizophrenia (F20.1), schizotypal disorder (F21), other persistent delusional disorders (F22.8), and mixed-type schizoaffective disorder (F25.2), each corresponding to 2.13% (1/47) of the sample (Table 2).

Among the 47 patients included in the study, 70% (33/47) presented an exclusive diagnosis of schizophrenia, schizotypal disorder, or persistent delusional disorder, whereas 30% (14/47) exhibited comorbid psychiatric and behavioral conditions in addition to their primary diagnosis.

Table 1. Sociodemographic characteristics of patients diagnosed with schizophrenia, schizotypal disorder, or delusional disorder at CAPS II Madeira-Mamoré, Porto Velho, Rondônia.

Variable	Qty n = 47 (%)	CI (95%)	P Value (≤0.05)
Gender			
Female	22 (46,80)	0,606	0,338
Male	25 (53,20)		
Age Group			
18 – 25	2 (4,26)	1,232	0,037
26 – 35	8 (17,02)		0,951
36 – 45	9 (19,15)		0,675
46 – 55	14 (29,79)		0,027
56 – 65	10 (21,28)		0,438
N/I	4 (8,51)		0,171
Marital Status			
Single	27 (57,40)	3,149	1
Married	13 (27,70)		
Divorced	2 (4,30)		
N/I	5 10,60)		
Educational Level			
No Formal Education	4 (8,50)	1,562	0,439
Incomplete Primary Education	18 (38,30)		0,000
Complete Primary Education	2 (4,30)		0,109
Incomplete Secondary Education	5 (10,60)		0,716
Complete Secondary Education	9 (19,10)		0,198
Incomplete Higher Education	1 (2,10)		0,044
Complete Higher Education	3 (6,40)		0,234
N/I	5 (10,60)		0,716
Religion			
Christian	2 (4,30)	1,698	0,109
Evangelical	13 (27,70)		0,003
Catholic	13 (27,70)		0,003
Other	10 (21,30)		0,089
N/I	9 (19,10)		0,198

CAPS = Psychosocial Care Center; N/I = Not Identified; Qty = Quantity; CI = Confidence Interval.

As detailed in Figure 1, the most prevalent associated mental disorder was Mild Intellectual Disability (F70), representing 21.43% of the comorbid cases, followed by Bipolar Affective Disorder, current episode manic with psychotic symptoms (F31.2), observed in 14.29% of the patients. The remaining disorders each accounted for 7.14% of the comorbidities identified.

Table 2. Diagnostic distribution according to ICD-10 of schizophrenia, schizotypal disorders, and delusional disorders (F20 to F29) among patients at CAPS II Madeira-Mamoré, Porto Velho, Rondônia.

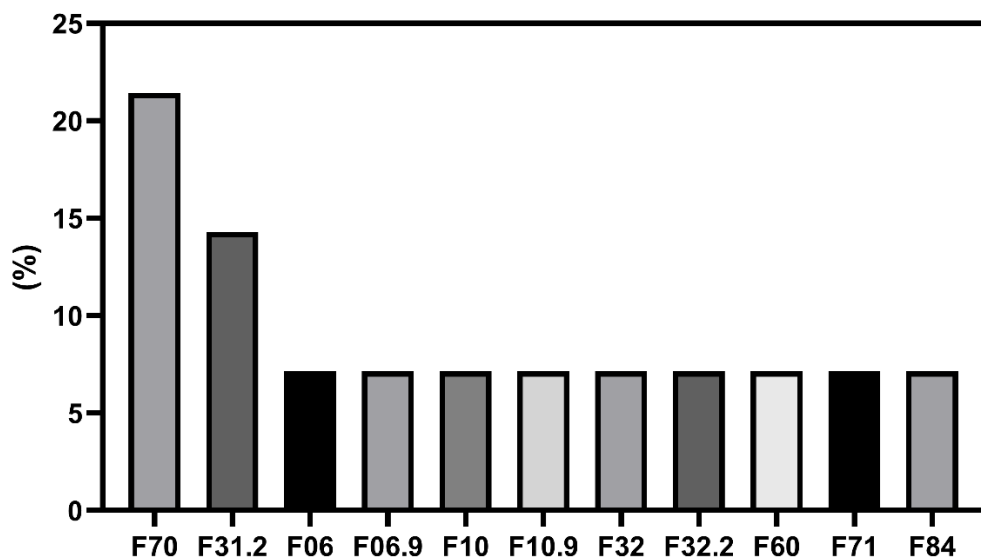
Variable	Qty n = 47 (%)
F20 Schizophrenia	19 (40,43)
F20.0 Paranoid Schizophrenia	8 (17,02)
F20.1 Hebephrenic Schizophrenia	1 (2,13)
F20.5 Residual Schizophrenia	5 (10,64)
F20.9 Schizophrenia, Unspecified	3 (6,38)
F21 Schizotypal Disorder	1 (2,13)
F22.8 Other Persistent Delusional Disorders	1 (2,13)
F23 Acute and Transient Psychotic Disorders	4 (8,51)
F25 Schizoaffective Disorders	2 (4,26)
F25.2 Mixed Schizoaffective Disorder	1 (2,13)
F29 Unspecified Nonorganic Psychosis	2 (4,26)

ICD-10 = International Classification of Diseases and Related Health Problems; CAPS = Psychosocial Care Center; Qty = Quantity.

The vast majority (97.9%) of patients receiving care at the CAPS II unit were undergoing pharmacological treatment. Only one patient had no such information recorded in their medical chart.

Furthermore, among the 47 medical records analyzed, only 9% (4/47) contained information regarding a family history of schizophrenia or other psychiatric disorders up to the second degree of kinship. The remaining 91% (43/47) either lacked this information or contained illegible records.

Figure 1. Diagnostic distribution, according to ICD-10, of mental disorders associated with schizophrenia, schizotypal disorders, or persistent delusional disorders among patients at CAPS II Madeira-Mamoré, Porto Velho, Rondônia.



ICD-10 = International Classification of Diseases and Related Health Problems; CAPS = Psychosocial Care Center.

DISCUSSION

Schizophrenia is a psychiatric disorder characterized by alterations in thought, affect, and behavior, which compromise the perception of reality⁷. The first symptoms tend to emerge in late adolescence or early adulthood and may persist throughout life, highlighting the chronic nature of the illness⁸. The prevalence and impact of schizophrenia are modulated by socioeconomic, cultural, and demographic factors, which influence both access to diagnosis and continuity of treatment⁹.

The sociodemographic analysis revealed that most individuals with schizophrenia receiving care at the unit were male, had a mean age of 45 years, were single, had not completed primary education, and identified as Catholic or Evangelical. Although a difference in sex distribution was

observed it was not statistically significant, a finding consistent with previous studies suggesting that schizophrenia does not exhibit a strong gender preference¹⁰. However, when analyzing sex-specific manifestations, differences in symptoms and behavioral patterns become evident. Males are more prone to risk behaviors and the use of licit and illicit substances, whereas females tend to display depressive symptoms, suicidal ideation, and anxiety¹¹. Furthermore, studies on hospital admissions for schizophrenia suggest a predominance of male patients, which has been directly associated with greater severity of the disorder's course in this group¹². Conversely, a study reported a rising incidence of schizophrenia and schizoaffective disorders among women, particularly in the postpartum period, suggesting that hormonal and psychosocial factors may play a key role in triggering psychosis in this population¹³.

With regard to age, it is important to note that the analyzed data refer to the current age of patients at the time of follow-up rather than the age of symptom onset. A predominance of individuals in their fourth and fifth decades of life was observed, with a mean age of 45 years. This finding aligns with a study that investigated the epidemiology of schizophrenia and related disorders in northeastern Brazil¹⁴. While the onset of schizophrenia typically occurs in late adolescence or early adulthood, the average age of patients being followed in mental health services tends to be higher, reflecting the chronic nature of the illness and the

need for ongoing care¹⁵. This age discrepancy may be partly explained by the challenges of early diagnosis, as initial symptoms of schizophrenia often overlap with those of other mental disorders such as depression, bipolar disorder, or anxiety, making timely identification and intervention difficult¹⁶. Delayed diagnosis is thus a significant factor in the chronicity of schizophrenia, as prolonged untreated symptoms can lead to progressive functional and social impairments and a worsened clinical prognosis.

The predominance of unspecified schizophrenia (F20) and paranoid schizophrenia (F20.0) aligns with findings from other epidemiological studies¹⁷⁻¹⁹. The unspecified subtype often reflects more heterogeneous and complex cases that do not conform to classic clinical categories, potentially indicating a patient profile with multiple symptoms, higher treatment resistance, and greater management challenges²⁰. In the Brazilian context, schizophrenia diagnosis faces additional challenges, including a lack of up-to-date epidemiological data and a concentration of studies in specific regions such as the Southeast, particularly São Paulo. This geographic bias hinders the generalization of findings across the country²¹. Socioeconomic factors such as low educational attainment and limited access to mental health services further contribute to delayed diagnosis and poor treatment adherence, especially in underdeveloped regions²². Non-adherence to treatment, frequently exacerbated by social stigma and insufficient psychosocial support, further complicates clinical management²³.

Paranoid schizophrenia remains one of the most frequently observed subtypes in mental health services, and is more common among men. It is often associated with more socially disruptive symptoms that impair family and community integration²⁴.

Another notable finding of the present study was the high prevalence of mild intellectual disability (F70) as a comorbidity. Researches have emphasized that cognitive deficits are present from the early stages of schizophrenia, potentially preceding the first psychotic episode^{25,26}. When combined with intellectual disability, these deficits significantly worsen the prognosis. Patients with both schizophrenia and intellectual disability exhibit greater difficulty adhering to treatment, reduced understanding of their clinical condition, and an increased risk of long-term institutionalization^{27,28}.

With regard to heredity, advances in rehabilitation therapies, pharmacological treatments, and the deinstitutionalization of schizophrenia patients have contributed to increased rates of fertility and marriage among individuals with the disorder²⁹. Consequently, the number of children born to parents with schizophrenia has risen, raising important questions regarding genetic inheritance and associated risks.

Epidemiological, familial, and molecular studies have shown that genetic inheritance plays a central role in the susceptibility to schizophrenia, with heritability estimated at around 80%³⁰. The genetic contribution is evident in the

higher prevalence of the disorder among relatives, with risk decreasing as genetic relatedness declines. For instance, monozygotic twins have a concordance rate of approximately 50%, while dizygotic twins and other first-degree relatives exhibit significantly lower rates. The genetic component is further evidenced by the reduced occurrence of schizophrenia-related disorders among second and third-degree relatives, supporting the hypothesis of genetic load dispersion²⁹.

One significant limitation of this study lies in the quality of the medical records reviewed, particularly due to the presence of illegible notes that compromised the interpretation of key information and reduced the completeness of the analyzed sample. The absence of clear documentation negatively impacts the continuity and safety of care, considering that medical records serve as a fundamental tool for communication among healthcare professionals and for the construction of effective and safe therapeutic plans³⁰. In this context, the implementation of electronic medical records could help address these shortcomings by improving legibility, standardization, and data accessibility, thereby enhancing both the quality of care provided and the reliability of information used in future research.

CONCLUSION

The results presented underscore the need for public policies that are more sensitive to regional realities, capable

of guiding the implementation of more effective care strategies and the equitable distribution of resources. A detailed understanding of the profile of the population served not only enables the optimization of care provided but also supports the development of preventive and therapeutic interventions better aligned with the specific needs of these individuals.

By addressing part of the existing gap in the literature regarding schizophrenia in the Northern Region, this study provides important evidence to inform the formulation of more integrated and resolute mental health programs. Furthermore, it is expected that these findings will encourage further research in the field, consolidating a robust data foundation that allows continuous advancements in psychosocial care and the promotion of equity in mental health.

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