

Differential Diagnosis

We have purposely only touched on the delusions, hallucinations, excitements, incongruous conduct, and stupor which mark the advanced disease, or the acute schizophreniform reactions. What is more difficult is to indicate the differential diagnosis. This includes prolonged and turbulent adolescence, hypochondriacal anxiety, obsessional states, criminal tendencies, slowly developing intracranial disease, and, most important of all, hysteria and depressions.

If we bear in mind how often schizophrenia is a gradual process, and how the cardinal symptom is disordered thought, we shall realize that the mind has time to marshal all its resources against the mental undermining which these strange thoughts imply. It may well be found that modern empirical treatments are effective because they help the mind's defences. All the different mental syndromes we have just enumerated may be essential accompaniments of the disease, representing the results of an attempt to limit it.

The distinction from an unusually turbulent adolescence, with impulsive and thoughtless acts, wild accusations, scenes, and psychopathic behaviour, rests upon the maintenance of affective sympathy. If we accept the youth's premises (false though they be) might we have done the same? With the neurotic we should answer, "Yes." With the schizophrenic we should answer, "No"; with him one premise at least or its resultant act is inexplicable and more often strange if not "clear balmy."

Hypochondriacal anxiety is very common in the teens and twenties. In the non-psychotic it emerges as a sign or warning of emotional conflict, and, though it may have features of strangeness in the neurotic, these can be explained by lay ignorance or superstition.

Obsessional neurosis is a most thorny problem, especially since the more bizarre compulsions lead on to the psychosis. As Stengel has pointed out, the obsessional ruminations, philosophizing, writing, or rituals may be defensive against the disease. What we find in the non-psychotic is obsessional anxiety with marked insight into the symptom's abnormality—"It is absurd to have to check this, but I simply must"—or the persistence of an original fear which is used to justify an unwillingness to travel, for example, or to alter a course. Frequently the obsessions have been present with long intermissions. The obsessional concerns of the early schizophrenic are more speculative than anxiety-producing. They justify rumination, but this is odd, detached, without meaning to us, but with much personal meaning to the sufferer. Again we are aware of the safety-curtain between us and the stage upon which the schizophrenic drama is being enacted.

Two widely held misconceptions must be dismissed. The first is that the affect is incongruous, shallow, or absent. At the beginning it may be wholly appropriate to the odd beliefs, a little later depression is wholly reasonable, and suicide not uncommon, often executed with a macabre flavour which is the sign-manual of schizophrenia (e.g., disasters at public schools).

The second must be to deny the erroneous belief that hysterical manifestations do not accompany schizophrenia. The anxiety generated by the self-observed changes may be apparently dismissed by the sixteen-year-old schoolgirl, yet thought disorder is so disturbing that it may result in conversion symptoms and produce apparently "hysterical" physical sensations. Such

symptoms tend to be less clamant than in the hysteroid personality. Anything odd about the flavour of a hysterical complaint in an adolescent who has recently lost interest, lies abed, and is becoming dreamy, must not be dismissed.

Two rare manifestations merit mention: fugues may initiate the illness; and, in my opinion, self-mutilators are schizophrenics. There are many anxious, hysterical, obsessional persons whose symptoms arise because they are fighting for months or years their secret detachment and misunderstanding of others, which not only perplex them, but which they know at the beginning have a bizarre flavour cutting them off from human sympathy. It is our privilege to be approached and receive their anxious secrets and act as if we believe *puto nihil alienum humani est*.

Cerebral abscess and intracranial neoplasm may commence with thought disorder and go on to abnormalities of conduct. Careful neurological examinations must be made. Psychopathic personalities and defectives when in difficulties may behave in strange and unpredictable fashion. Here one must emphasize that an adequate history is essential, not of the illness alone, but of the person's past achievements and clinical history. It is here that we need to envisage something of his cultural background.

After one has canvassed all the possibilities presented by the patient, one is often left with little certitude except that the relatives will be loath to co-operate in accepting hospital treatment. Schizophrenia, despite all its implications, is a disorder which should be met by ordered hope, great patience, and readiness to press for observation of the sufferer in suitable surroundings. Now there are not only hopeful methods of treatment, there are diagnostic aids with investigation by barbiturate injections and tests such as the Rorschach which can clarify this difficult field.

One final word: severe temporary stress (such as military conditions) and frustration may produce extremely paranoid conduct, impulsiveness, ill-matched aims. In our present post-war society these reactions in the harassed partners of a marriage seem commoner than they were. They may certainly proceed to an irreversible schizophrenia or an irreversible frigidity. Considerable expenditure of time and energy spent in elucidating such cases may not pay a large dividend yet a worthwhile one.

Correction.—We much regret that owing to a printer's error the dose of phenobarbitone was wrongly given as 1 g. instead of 1 gr. in the second paragraph under the cross-heading of "Treatment" at p. 1443 of Brigadier Boyd's article on "The Dysenteries."

Nurses and nursing auxiliaries engaged in periods of training or taking refresher courses in the National Hospital Service Reserve will not, while so engaged, be liable to pay national insurance contributions as *employed persons* except when they render services in the reserve for 24 hours or more in any contribution week (National Insurance (Classification) Amendment Regulations, 1951). The nurse or auxiliary who does less than 24 hours' service in the week will in general (if she has no other employment in that week for which an employed person's contribution is payable) remain liable to pay a contribution in Class 3 or, if ordinarily a self-employed person, in Class 2. The regulations do not affect the liability for payment of industrial injuries contributions. These contributions are payable no matter how short the period of employment.