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Early Diagnosis of Schizophrenia

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The term "schizophrenia" includes a range of conditions which vary both in symptomatology and outcome. It generally implies that at some time in the course of the illness some of the following symptoms have been present: disturbances in perception (particularly auditory and somatic hallucinations), in thinking (a confusion or interruption of the usual trains of thought and the formation of delusions), and motor performance (excitement, retardation, and the expression of abnormal experiences by gesture). Just how many ingredients are required, how specific they have to be, and what course the disease must take in order to qualify for the diagnosis of schizophrenia will not be discussed in any detail. Instead, this article will concentrate on three themes; those groups of people who are particularly at risk, the early signs of the illness, and the pros and cons of early diagnosis.

Groups at Risk

The most important fact to remember is that *in its early stages schizophrenia is a rare disease*. A general practitioner will see, on average, about one new case every three years. On the other hand, because the condition afflicts people early in life and often runs a chronic or recurrent course, patients accumulate, and a general practitioner can expect to have several affected patients, with a variable degree of handicap, on his list. The incidence rate is the same for both sexes, but for men the peak risk period is early adulthood, and the disease is commoner among bachelors, whereas for women the risk is more evenly spread through life and between the single and the married. In Britain, as in most countries, schizophrenia is commoner among immigrants from abroad—West Indians, for example.^{1 2}

The typical "identikit" picture of the pre-schizophrenic is of an outsider who has made few if any lasting friendships with either sex, and whose lack of social skills has reduced him (or her) to solitary activities for which he has no particular aptitudes or even liking and to defensive attitudes of fear or scorn of society in general. Other vulnerable groups seem to be bachelors living with dominating mothers, women after childbirth, and women in late-middle-age who have been divorced, or widowed (often after an unhappy marriage), or are spinsters living in guilt-edged insecurity lest various sexual skeletons should emerge from their cupboards.

Nevertheless, even in these groups early schizophrenia remains a rare disease, and the psychiatric disturbances of such people are much more likely to be due to depression or anxiety states and the difficult adjustments of their personalities to altering circumstances.

Early Symptoms

What then are the early symptoms and how can they be recognized? It is important to distinguish between pre-monitory but non-specific symptoms and the first appearance

of more specific ones. Non-specific symptoms can include practically any psychiatric disturbance, but particularly common are irritability, restlessness, depression, hypochondriasis and withdrawal, often accompanied by a reduction in the person's usual skills or performance, as the following cases illustrate.

Mr. A, a married press-operator aged 28, became depressed over a matter of a few weeks and went to his doctor complaining that he felt miserable and had lost his sexual desire. He was given a tranquillizer. Two weeks later he told his wife that his workmates were talking about him. Within a few days he became overactive, suspicious, and misinterpreted everyday events as evidence of a conspiracy against him. He was then admitted to hospital, where he made a rapid recovery.

Miss B, a girl of low intelligence (I.Q. 75), complained of depression and concern that her "glands" were not working. She was finally admitted to a psychiatric hospital, where she failed to improve. Her hypochondriacal preoccupations were rather bizarre and clearly related to feelings of sexual inadequacy. Within a year she had developed clear-cut schizophrenic symptoms, and she remains psychotic and severely handicapped, though out of hospital, eight years later.

Mr. C, a lanky, shambling boy of 19, stopped work and began to spend most of his time in bed. His family took no action about this for a year, by which time Mr. C. was spending nearly all his time in his bedroom, emerging only for meals. He then became acutely excited, shouting out about the second coming, in which he thought he was to be personally involved. Soon after admission to hospital he returned to his usual extremely withdrawn but not unfriendly self. He is now working, but his life is totally without any external incident. His only interactions with a person other than those at home or at work are his visits to outpatients, which he never misses, although he rarely volunteers any remark.

In these three cases there was a period of abnormal behaviour prior to the emergence of more florid psychotic symptoms. In the first case the patient reported his delusional suspicions to his wife, and it is possible that he was entertaining these when he first saw his doctor.

Other people close to the patient are often important sources of information. The general practitioner is well placed to draw on these sources, and he will have to decide when to do so. The abnormal experiences of many patients may be confined to certain situations—in many cases the home. Mrs. D, for instance, came to her general practitioner complaining of feeling depressed and anxious in her flat. Every evening she felt apprehensive as she left her place of work, where she held an important clerical post. Her husband then told her doctor that she was convinced that people in the flats were annoying her deliberately and were spying on her with machinery. She was experiencing somatic and auditory hallucinations at home, but as soon as she left her flat these ceased completely.

In some cases it is the employer who has most information. The relatives who lived with Miss E, always an unsociable and irritable person, had noticed that over the past year or two she had become more withdrawn and was neglecting herself. They suggested that she went to her general practitioner, who gave her a tranquillizer. They were surprised when she was admitted

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to hospital from her place of work. There, "Molly" was a well-known character whose industry at washing up more than compensated for the fact that she frequently shouted at imaginary voices and accused her workmates of making remarks behind her back. Her sudden admission was precipitated by her threatening violence for the first time.

The difficulty is to detect when these non-specific symptoms are accompanied by more specific ones. Intense and defensive withdrawal, self-preoccupation, and a lack of emotional involvement with others are all suspicious signs, but they are certainly not enough to make the diagnosis. In early schizophrenia such behaviour is often due to an impairment in concentration and in perception which leaves the patient puzzled and bewildered. Some general questions that make it clear that the doctor is aware of these difficulties and understands them will help the patient to talk about his experiences, which he may interpret in delusional terms. For instance he may think that the interference in his concentration is due to his thoughts being "taken away" or to others deliberately altering his thoughts or putting strange thoughts in his mind, while his perceptual disturbance may lead him to think that "something strange is going on," that people are not what they seem or that they may be other people in disguise. At this stage it is very common for the patient to have the characteristic double insight of early schizophrenia. The explanations of his experiences vary both in type and in degree of certainty, and he wavers in his choice.

Positive Evidence

A definite diagnosis must be based on positive evidence of abnormal perception and thinking, as judged by the patient's own account and behaviour and the reports of others, and never on just the "quality of rapport" or "blunting of affect," which are extremely unreliable. They give rise not only to false positives but also to false negatives, since it is a mistake to think that blunting of affect is a *sine qua non* of schizophrenia.

Mr. F is one of a large family of street vendors. He came to the hospital complaining of many classical schizophrenic symptoms. A solitary man with few friends outside his family, he made excellent rapport with the staff and patients. Partly because of his warmth and geniality, the diagnosis of schizophrenia was questioned at first, but it has been confirmed by the subsequent course of his illness.

When there is a hint either from the patient or from others that the patient is preoccupied with abnormal thoughts or experience the general practitioner should attempt to elucidate these further if he has the time and skill. The examination required to do so need involve no more pain or affront to the dignity than does the palpation of a tender abdomen. How much or how little information will be obtained in either procedure will depend on the tact and skill of the examiner. But the general practitioner is in a difficult position. Firstly, because of the comparative rarity of psychotic states, the interviewing which is relevant to them may have been allowed to atrophy from disuse or lack of positive reward even if it was part of his original repertory. Secondly, it is sometimes the case that patients talk more freely to an unfamiliar doctor than to a familiar one. Thirdly, particularly in younger patients, a sense of alienation from the family is common, and the family doctor may be too closely identified with the parents to be regarded as a possible confidant.

In such cases the general practitioner's time may be best spent in persuading the patient to see a psychiatrist for a diagnostic opinion. In those cases in which his suspicions are highly aroused or he is fairly confident of the diagnosis a psychiatric opinion should be obtained by a domiciliary visit if necessary. If he does find himself having to treat an acute psychotic episode on his own—and there are probably a number of such states which settle quite rapidly on phenothiazines—he should not regard the patient as "schizophrenic," and it is advisable that the patient be seen by a psychiatrist when he has recovered.

Pros and Cons of Early Diagnosis

The advantages and disadvantages of early diagnosis can best be discussed with reference to Wing's useful distinction between primary and secondary handicap in schizophrenia.

The primary handicaps are the symptoms of the disease process itself and include altered and abnormal perceptions, disturbances in thinking, retardation, and excitement. In theory early diagnosis should lead to better results and less primary handicap. It is certainly true that those patients who bring themselves or are brought for treatment with only a short previous history have a better outlook than those with a long one. But this has always been so, and is at least partly due to the fact that the early cases have become excited and obviously disturbed, and this type of symptomatology generally carries a good prognosis. The good results of early treatment may therefore be partly a function of the natural history of the disease. Nevertheless, the treatments now available for schizophrenia are certainly more effective than they have been in the past, and every patient should have the opportunity of being assessed for treatment as soon as possible. This may prevent not only primary but also secondary handicaps.

The latter are the social and psychological consequences of the illness itself or of its treatment. In the past one of the major secondary handicaps was the effect of a prolonged stay in the monotonous but undemanding environment of a mental hospital. Nowadays this is a comparatively rare event, and the main handicaps arise from the attitudes which the patient takes towards himself as the result of being a "psychiatric case," and which other people such as his family, his employer, or his doctor take towards him. Thus the general practitioner's role in preventing secondary handicap has become increasingly important.

After a terrifying but not particularly severe coronary thrombosis a patient's subsequent recovery may be drastically influenced by whether the general practitioner talks about "taking it very easy" or about a "gradual return to full activity." In the same way the family may adopt all sorts of disabling attitudes in the ferment of emotion which generally precedes and accompanies the procedure of first admission to hospital. They include anxiety, guilt, hostility, rejection, and denial. The general practitioner is often best placed to deal with these, as he knows their origins, and in moments of crisis people are susceptible to guidance. A refusal to recognize their anxiety, or vague reassurance, will only make the patient and family suspect the worst, but they can often be helped by a realistic appraisal of the problems involved. The following are some of the more important.

Implications of the Diagnosis of Schizophrenia

A diagnosis of schizophrenia is regarded as ominous by most laymen, who associate it with a "split mind." Many doctors feel that "a schizophrenic" implies a career of violence and unpredictability with a shambling conclusion down a mental hospital corridor. It is certainly true that the diagnosis is a serious one, but the outlook is less gloomy than it was. About half of all first admissions make good recoveries and only about 25% remain seriously handicapped. Nevertheless, this is a substantial minority, and too optimistic pronouncements disregard a considerable burden on patients and their families. In the individual patient the prognosis is for a person rather than for a disease. The longer the history, and the greater the social maladjustment before the illness, the greater will be the problem after treatment, and the more seriously should be considered other readjustments such as living away from home, sheltered employment, or day care.

Because of its important implications the general practitioner should not "settle" for a diagnosis of schizophrenia, at least with the patient or his family, without getting a psychiatric opinion. States of psychotic excitement occur in drug intoxi-

cations, cerebral disease, and mania, while many depressed patients complain that their thinking is severely impaired, express delusions of persecution, and hear derogatory or threatening voices.

Occupational Adjustment

It is quite common for a person's performance at work to have deteriorated prior to first admission, and it may be necessary for the patient to resume work at a level considerably lower than the aspirations of himself or his family, whose attitudes may be quite unrealistic. Quite often a patient has not worked for a period of months or even years prior to coming to treatment. If he is considered able to work he should be encouraged to do so. The general practitioner may need to help with these difficult adjustments. The reason that patients should work has nothing to do with the bourgeois ethos: it is because work may be a place where a patient feels appreciated and where he gets into a circle other than his family.

Social Adjustment

A considerable number of patients are rather shy, isolated people. The general practitioner will do better to respect this than to join the chorus of friends and relatives who adjure him to "go out more" or "to get a girl friend."

In general such persons find it much easier to interact in some instrumental capacity such as in fishing, boat-building, or cycling clubs than in the alarming gatherings which demand purely social skills. For example, a patient who would find going to a dance an intolerable threat may enjoy the comparative rituals of ballroom dancing.

Personal Relationships

Many patients prefer and seek out a distant or neutral relationship and avoid a close one, and some relatives find this distressing. Spouses may find it intolerable, and indeed it is in heterosexual and especially marital adjustment that most patients and their families have their greatest difficulties. In a recent series reported by this unit 33% of the first admitted men and 9% of the first admitted women had separated during the five year follow-up period.³ The general practitioner is often in the best position to assess this situation and to anticipate at an early stage what difficulties are likely to arise and what can be done to help.

Taking Drugs

Many patients and their relatives dislike the idea of being on a drug, as it implies that they are sick. This is a perfectly understandable attitude. Nearly half of all psychiatric out-patients do not take their drugs as prescribed.⁴ It is likely that in the early stages even fewer patients take them regularly. The general practitioner will have to explain to the patient and his family that he should continue drugs for as long as they are prescribed and that the patient will not "get used to them" nor "become a drug addict." He should also be familiar with a few phenothiazines and their side-effects.

Advantages of Early Diagnosis

Early diagnosis, therefore, has two advantages. It gives the general practitioner an opportunity to help the patient and his family to make a positive adjustment to psychiatric illness, and it also allows for early intervention. This in itself is extremely valuable. Excitement, for instance, carries a good prognosis, but if this has led to aggressive or other frightening behaviour

then the patient may well return, if at all, to the secondary handicaps of a hostile or anxious family.

Dangers of Early Diagnosis

There are two main dangers of early diagnosis. The first is that it may be wrong—but once made the traditional labels get stuck on to the patient. A shy person's nervous smile becomes a "fatuous" or "incongruous" or "manneristic" giggle; his frightened withdrawal "blunting of affect"; his confused explanations "incoherence"; and his fantasies "bizarre delusions."

The second danger is that even when the diagnosis is correct the same process occurs. The patient joins the alienated ranks of "schizophrenics." An explanation is substituted for a thorough understanding of the patient's symptoms, problems, and needs, and consequently both he and his family suffer. An early diagnosis, therefore, should often be a provisional one, and it should never be allowed to obscure the patient as a person.

Co-operation with Others Involved

It is likely that a number of people, psychiatrists and social workers, will become involved with the patient and the family. The degree of communication between them and the general practitioner varies considerably, and so does the general practitioner's enthusiasm for tackling psychiatric problems. A general practitioner's role may thus vary between taking the major responsibility and doing nothing. In either event it is most likely that the patient or his family will turn to him for advice. If this conflicts with that given by other members of the team, or if they undermine the general practitioner, then the patient will suffer. The general practitioner and the rest of the psychiatric team must co-operate in a plan of treatment and keep each other informed of developments. They should start to do so as soon as the patient has been referred. Their links should not need to be forged in the heat of avoidable crises.

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- For a general review, *Recent Developments in Schizophrenia* (1967), edited by A. Coppen and A. Walk, published by the R.M.P.A., is excellent value. It costs 18s. (including postage) from Headley Bros. Ltd., Ashford, Kent.

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