Recognising Schizophrenia

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Schizophrenia is and has always been a subject of controversy. From whether it is a singular disease or a spectrum of 'schizophrenias' to the appropriate way to manage these patients and even to some, its very existence (1).

What can be agreed on is that it can be a highly disabling condition (2), carrying significant morbidity and mortality (3). Its symptoms and course can be hugely distressing to both the patient and their family, and the economic loss is vast.

The course of schizophrenia is widely variable and the believed prognosis varies from study to study but most seem to be not far off the rule of thirds (4) where roughly a third make a complete or near complete remission, a third have a recurrent, intermittent course and a third have a chronic course of gradually worsening symptoms.

There are a number of variables that can be predictors of good or bad prognosis. Poor prognosis is suggested by a slow, insidious onset, an earlier age (below 20) at onset, negative symptoms, being socially isolated, having an irregular employment record, being male and not being married (5).

One other factor believed to increase the likihood of a poor outcome is a long length of episode prior to assessment (5). For this reason it is important that primary care doctors are confident at being able to recognise psychotic symptoms in a patient so that a referral can be made earlier in the course of their disease. As a GP you will be asked to see a mother's teenage son on the grounds that they are concerned he is behaving strangely.

This article will walk through the main symptoms of schizophrenia so that you will be able to make a more confident referral to secondary care. We will discuss the broad categories of symptoms as well as discussing how to have a better suspicion of schizophrenia.

Symptoms of schizophrenia can be divided into positive and negative symptoms (6). Positive symptoms tend to be seen first, with negative symptoms usually seen in those with chronic schizophrenia. As already mentioned, negative symptoms are an indicator of poor prognosis. Positive symptoms are those such as hallucinations (in any modality) and delusions of persecution, of reference or of grandiosity. Negative symptoms are those such as lack of motivation, social withdrawal, apathy, formal thought disorder and (rarely seen now due to antipsychotics) catatonia.

Positive symptoms include auditory hallucinations, delusions and disorder of thought.
Hallucinations are defined as a perception without a stimulus. Hearing voices can be very distressing and the patient may be visibly tortured by his voices, especially if they are abusive in content (6). It is worth asking if the patient hears anything when no-one is around or if they hear things no-one else can hear. You should ask about the content of the voices, if they recognise the voices, how many there are and if they talk directly to them or among themselves. Ask if the voices sound as though they are coming from outside or inside their head. Sometimes people may describe hearing their neighbours through the walls. It is worth asking how clearly they can hear their neighbours and whether they can hear them equally clearly throughout the whole house. Asking if they speak constantly or if they commentate on the patient may be of further help.

Delusions are fixed, firmly held, false beliefs not in keeping with the patient's cultural or socio-economic background (6). They can be delusions of persecution, for example by MI5 or the mafia. They can be delusions of grandiosity, for example the belief of being very wealthy or being a messiah. They can be delusions of passivity, for example of their thoughts or actions being controlled by some outside force. Delusions can become complex over time as the disease progresses and as such a deep, detailed system of delusions can be indicative of chronic schizophrenia (7).

Thought disorder can present in a number of forms. They can vary in the level of disorder from knight's move thinking where the subject can jump to a topic merely obliquely related to word salad, where the words are all jumbled and no sense can be made. Completely new words, called neologisms, can be made.

Whilst the concept is less popular now, 'Schneiders first rank symptoms' (8) are symptoms believed by some to be highly specific for schizophrenia and as such to have a high positive predictive value.

They are:

- Audible thoughts
- Thought withdrawal
- Thought Insertion
- Thought broadcast
- Delusions of control
- Commentary voices
- Arguing voices

However the first rank symptoms do not include a symptom found in 97% of patients with schizophrenia, lack of insight (4). If the patient is demanding a diagnosis of schizophrenia you should be more sceptical.

Schizophrenia is a stressful and much stigmatised diagnosis. As such it is a diagnosis that should not be made lightly. A careful history should be taken. How fixed is the patient's beliefs? Could they be deemed reasonable within their own culture (which may differ from their parents)? Are their thoughts completely impossible? Just how fixed are their thoughts?
A good collateral history can also make all the difference, not just from one family member, but from as many as possible. Do the concerns of unusual behaviour all stem from one person or is the whole family concerned?
While taking a history you should be thinking of doing a basic mental state examination. How does the patient appear? Are they dressed appropriately? Is their behaviour normal or bizarre? Is their speech disorganised? How is their mood? Are they focused on beliefs of persecution or grandiosity? Are they responding to things you cannot hear? How much insight do they have into the situation? How orientated are they in time, place and person?
As in all branches of medicine, taking a careful history and examination will lead to a more accurate assessment and confident referral.

GP comment

What have I learned from this paper?

1. Insidious onset of schizophrenia under 20 years of age with social withdrawal is likely to have a poor prognosis.

2. Lack of insight, together with evidence of abnormal thought processes such as audible thoughts, thought insertion or delusions of control would strongly suggest a diagnosis of schizophrenia.

3. As in other branches of medical practice, a good history and careful examination of the patient are invaluable in establishing the diagnosis and confirming the need for specialist referral.

4. Positive symptoms are more likely to be seen in the acute presentations while negative symptoms of schizophrenia occur more often in chronic cases.

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