LATEST QUESTIONS & ANSWERS ON SCHIZOPHRENIA

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1. HOW IS SCHIZOPHRENIA DIAGNOSED? HOW CAN I TELL IF SOMEONE HAS SCHIZOPHRENIA?

The diagnosis of schizophrenia is a clinical one, made through the observation of characteristic signs and symptoms and the exclusion of other causes for these (Box 1). It often takes a period of time to be certain of the diagnosis as the various manifestations evolve with the course of the illness.

The peak age of onset of schizophrenia is 15 – 25 years in men and 20 – 30 years in women. It is often preceded by a prodromal phase of vague symptoms, some odd behaviours and a decline in functioning at school or work and interpersonally.

No diagnosis is made at this stage – other possible medical, substance related or psychiatric causes must be excluded, and the person observed for the development of stronger signs of schizophrenia. Management revolves around the presenting symptoms and the precipitating and perpetuating stressors. It usually consists of psychosocial interventions with low doses of medication if indicated, until the diagnosis becomes more definite.

The symptoms of schizophrenia may be broadly categorised as:

a. Positive symptoms, or a distortion of reality perception:
   - Delusions
   - Hallucinations

b. Negative symptoms, or psychomotor poverty:
   - Poor responsiveness in affect – the facial expression is very restricted, response times are delayed and there is little emotion in the response
   - A lack of motivation – the person is apathetic at home and in other environments
   - Very limited speech and a lack of movement. The lack of movement is not due to the extra-pyramidal side effects of medication, but rather to a lack of spontaneity.
   - Social withdrawal.

c. Disorganisation of thoughts or actions:
   - Incoherent or illogical speech – the train of thought is difficult to follow and may derail completely from the topic.
   - Disordered clothing and belongings
   - A lack of purpose to actions – e.g. aimless wandering or pacing

d. Cognitive dysfunction, particularly of executive functioning:
   - Deficits in attention and concentration, particularly in shifting concentration from one activity to another
   - Poor problem solving, planning of tasks and abstract thinking
   - Memory and learning deficits, e.g. of working memory

None of these symptoms are specific to schizophrenia. They all have many other causes; therefore, it is not possible to simply "tell if someone has schizophrenia." When a person exhibits one or more of these symptoms, schizophrenia may be considered as a possible diagnosis. It is imperative that other causes are ruled out, especially as antipsychotic medication has significant adverse effects which may be worse in people with other medical or psychiatric conditions.

The differential diagnosis is broad and includes the following:

a. Another medical condition
   - Delirium due to any cause.
   - Psychosis due to another medical condition which may be neurological e.g. epilepsy and sub-cortical dementias, infectious, e.g. HIV/AIDS, endocrinological, e.g. hyperthyroidism and hypercortisolism, or metabolic e.g. uraemia

b. Substances
   - Acute intoxication or withdrawal
   - Substance induced psychotic disorders, e.g. from cannabis and amphetamine related compounds

c. Cultural influences
   - Cultural expressions of distress
   - Culture bound syndromes, e.g. ukuthwasa or amafufunyane

d. Other psychiatric disorders
   - Other psychotic disorders, e.g. brief psychotic disorder, schizoaffective disorder
   - Affective (mood) disorders, e.g. bipolar disorder, depression with psychotic features
   - Disorders of communication, e.g. autistic spectrum disorders
   - Personality factors, either when in crisis or with extreme lack of co-operation

In addition to the above, the negative symptoms may also be caused by severe depression; severe anxiety disorders, e.g. social anxiety disorder; side effects of medication, especially antipsychotics and other neurodevelopmental or neurological disorders. Lastly, caution must be exercised in diagnosing schizophrenia in people with intellectual impairment. Intellectually impaired people are often unable to verbalise emotional and psychological distress and anxiety. They may therefore express their feelings in an aggressive and illogical manner, particularly if they have been victims of trauma, abuse or neglect.

2. WHAT IF THE FAMILY MEMBER REFUSES TO SEE A DOCTOR?

Lack of insight into the disorder is a core feature of schizophrenia, especially with respect to delusional thinking. Usually, if the auditory hallucinations are distressing to the individual, they will want help to get rid of them. People with prominent negative symptoms often do not resist going to a doctor, but those with disorganised thoughts may become aggressive when confronted with their behaviour and the need for medical care.

Key to getting a family member to the doctor is to understand what his or her needs are, i.e. to understand what is distressing them, and to speak to those needs in a non-confrontational collaborative manner.

It is important not to make "You" statements such as "you are being unreasonable" or even "you are ill" but rather express concern, e.g. "It seems you are feeling very frightened right now, maybe we should see if the doctor has any ideas to help you feel safe" or "it sounds like you are feeling controlled by X, that

must be difficult to cope with. Let's see what the doctor might say about X and what they are doing to you."

It is important that the whole family participates in the affected member's care. If there are persecutory delusions towards one particular member, then others should make the attempt to get him / her into hospital. In addition, it is more containing for the individual with schizophrenia if they sense that the whole family is on an equal footing with respect to their behaviour, illness and the taking of medication.

A social worker may also be called in to assist in persuading a patient to go to hospital. Finally, should all measures fail, and especially if there is a potential danger to him/her self or others, the police are obliged to take the affected person to hospital at the family's request under the Mental Health Care Act of 2002.

3. HOSPITALISATION - WHEN AND WHY IS IT NECESSARY?

Hospitalisation is needed at the onset of the disorder, even when the symptoms are relatively mild, to assist in making an accurate diagnosis. It enables close objective observation of behaviour and thought processes as well as an extensive medical and psychological work-up. It also enables rehabilitative intervention by the occupational therapist which includes insight training regarding the disorder, the medication and how to stay well. An accurate occupational therapy assessment of the level of functioning prior to discharge is very helpful for ongoing outpatient rehabilitation.

Re-hospitalisation is necessary when recurrent psychotic episodes occur. This often occurs in the early years of the disorder as the individual struggles to accept the diagnosis and the family learns new communication styles appropriate to someone with schizophrenia. It must not be assumed that a quiet and withdrawn person is not needing hospitalisation – he or she may still be harbouring serious persecutory or other delusions which they may act upon without warning.

It is sometimes necessary to hospitalise someone during a change in medication due to intolerable side effects to prevent an acute relapse when one medication is stopped and another started. Residual symptoms, particularly depressive symptoms, may also necessitate hospitalisation in order to ascertain the response to treatment and risk of suicide.

Any suicidal threats by a person with schizophrenia need to be taken very seriously and require in-hospital assessment and management.

4. WHAT IS THE PROGNOSIS? HOW LIKELY IS IT THAT A PERSON WITH SCHIZOPHRENIA WILL EVER HAVE A "NORMAL" LIFE?

Although usually thought of as an extremely severe chronic relapsing condition, about 10% of people will only have one episode and a further 30% will have full remission between episodes. In the remaining 50%, either each episode is followed by a decline in functioning and only partial remission, or the course tends to be chronic with a progressive decline in functioning. It is the decline in social and cognitive functioning which confers the greatest disability. In addition, negative symptoms and greater disorganisation are associated with a worse prognosis than the positive symptoms.

The aim therefore is to live as normal a life as possible, similar to other chronic diseases such as diabetes mellitus or asthma. Key to this is maintenance treatment for prevention of relapse and optimisation of functioning with occupational therapy.

Good family support, without high levels of expressed emotion, acceptance of the person as they are and suitable employment (sheltered if necessary) all help to improve the course of illness. However, high levels of stigma and psychosocial stress, poor adherence to medication and concomitant substance use all contribute to a worsening course with recurrent relapses and decline in function.

Thus society at large also has a role to play in improving the prognosis by increasing awareness of the individual's suffering and reducing stigma, discrimination and psychosocial stress. **MHM**

References

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BOX 1: DSM-5 CRITERIA FOR SCHIZOPHRENIAS

A. Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be (1), (2), or (3):
   1. Delusions.
   2. Hallucinations.
   3. Disorganized speech (e.g., frequent derailment or incoherence).
   4. Grossly disorganized or catatonic behavior.
   5. Negative symptoms (i.e., diminished emotional expression or avolition).

B. For a significant portion of the time since the onset of the disturbance, level of functioning in one or more major areas, such as work, interpersonal relations, or self-care, is markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, there is failure to achieve expected level of interpersonal, academic, or occupational functioning).

C. Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or by two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

D. Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out because either 1) no major depressive or manic episodes have occurred concurrently with the active-phase symptoms, or 2) if mood episodes have occurred during active-phase symptoms, they have been present for a minority of the total duration of the active and residual periods of the illness.

E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

F. If there is a history of autism spectrum disorder or a communication disorder of childhood onset, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations, in addition to the other required symptoms of schizophrenia, are also present for at least 1 month (or less if successfully treated).