Demystifying schizophrenia

JOHN ELLARD AM, RFD, FRACP, FRANZCP, FRPsych, MAPS

Over time the diagnosis of schizophrenia has changed, but is a strict categorisation of the condition really necessary?

I have the greatest respect for GPs. Everyone who crosses the threshold of my consulting room has first been assessed by someone else; however, GPs have to take on whoever turns up. Not only that, but the number of diseases described grows, and the measures for both diagnosing and managing them grow exponentially. The same exponential growth is happening in the specialist fields of medicine; one cannot expect generalists to keep up with it all when specialists are battling as well.

This may matter little when the disorders concerned are rarely encountered or associated with little disability, but it does matter when the disorder in question is both common and disabling. Psychiatrists have a particular duty to clear the air. In 1996 the Harvard School of Public Health, on behalf of the WHO and the World Bank, published a 10-volume study of current patterns of mortality and disability from diseases and injury for all regions of the world.[1] One table from that report will serve our purpose (see opposite).

Five of the 10 leading causes of disability are psychiatric, and psychiatrists have a heavy responsibility in doing something to lighten that burden. Obviously, if these disorders are that common then GPs will be at the heart of the struggle. Much is being written at the moment about depression, so I thought that it would be worth attempting to demystify schizophrenia, for there are some important points to be made about this common condition.

Dr Ellard is the Editor of Medicine Today, and a consultant psychiatrist, Sydney, NSW.

Limitations of strict categorisation

The first point to be made is that there is no reason to be burdened by trying to remember the precise description of schizophrenia as set out in the relevant diagnostic manuals. Like many disorders, the description of schizophrenia has changed as the years have passed. There is no doubt that psychoses of one kind or another have been around for millennia. However, if one turns to the psychiatric textbooks of past centuries and – more importantly – to such case notes as are extant from those days, it is very difficult to find cases that conform to the present diagnostic categorisations of schizophrenia.

I have examined the evidence in detail previously.[2] To summarise, it seems clear that what we might now describe as schizophrenia was rare before the 18th century. At the beginning of that century there was an explosion in the prevalence of psychosis, which is well recorded in the writings of the day. Just before this time there were 5 million people in England and 30 patients in the Hospital of St Mary of Bethlehem (Bedlam).

Recent changes

In my own time schizophrenia has changed significantly. Catatonia was once a common presentation. The hallucinatory voices were not in the patients' heads, but in the outside world. Patients spent hours knocking on walls and trying to get under floorboards to discover those abusing and taunting them. There are many other differences; to put it shortly, those presenting in the first half of the 20th century were much more disturbed and dangerous than is usually the case now.

There was another shift in the 1960s, when the illness at presentation became less florid. I happened to be travelling around the world at that time and everywhere I went psychiatrists had noticed it. There are some hypotheses about why this happened, but no one knows the answer.

Again, there used to be a very clear division between bipolar disorder and schizophrenia; now the boundary is unclear and we have the hybrid 'schizoaffective disorder'. There may be differences in definition from one country to another. I am not up to date in the Russian nomenclature, but less than 20 years

Table. The leading causes of disability in the world, 1990[1]

	Number of cases (millions)	Percentage of total
All causes	472.7	
Unipolar major depression	50.8	10.7
Iron deficiency anaemia	22.0	4.7
Falls	22.0	4.6
Alcohol use	15.8	3.3
Chronic obstructive pulmonary disease	14.7	3.1
Bipolar disorder	14.1	3.0
Congenital anomalies	13.5	2.9
Osteoarthritis	13.3	2.8
Schizophrenia	12.1	2.6
Obsessive compulsive disorders	10.2	2.2

ago the category of 'sluggish schizophrenia' contained disorders which we might think of as anxiety disorders, depression, personality disorders and the like.[3]

I could go on, but the point I am making is that GPs in their daily duties do not need to be troubled by the thought that they have not a clear categorisation of schizophrenia in their minds. Those who believe that there is such a thing are exhibiting faith rather than scholarship.

What needs to be done?

The prevalence of schizophrenia is about 1% of the population. An exact figure cannot be determined because of the uncertainty of description and the difficulties in case finding. Granted that, any busy GP will encounter the disorder with some frequency.

It is not usually difficult to determine that someone has a psychotic illness. There will be hallucinations, delusions, disorganised thinking, and so on. Such an illness is the result of a brain disorder, so the first step is to determine those patients who have coarse brain disease, whether it be infective, neoplastic, vascular, degenerative or what you will. Sometimes the differentiation will be easy, sometimes difficult – modern investigative techniques can be very helpful.

The metabolism of the brain can be disorganised by chemicals. Especially in adolescents and young adults, one will need to think of the florid psychoses caused by misuse of stimulant medication and the paranoid disorders which sometimes follow the heavy and prolonged use of cannabis. Misuse of alcohol can cause several syndromes, usually in postadolescence, but they are relatively uncommon.

If the psychosis is not due to coarse brain disease or misuse of chemicals, can the psychotic phenomena be understood in terms of distortions of the world produced by severe depression? Are the delusions those of poverty, hopelessness and personal wickedness? Are the hallucinatory voices accusatory and demeaning?

'A gate of the Puertojanian palace' by Spanish blacksmith Pedro Alsonso Ruiz who had schizophrenia. He was admitted to the hospital, Casa del Nuncio, in 1916 and remained there until his death in 1941.

Psychotic depression is not rare: it requires most urgent treatment because the risk of suicide is substantial.

The next step

Having excluded the foregoing, it is probable that one is left with one of the schizophrenic group of psychoses. Searching for the right name is a waste of time for the reasons I have given above: the task is to do something about it.

Those suffering from this illness have brain disease. Neuroimaging studies have shown structural abnormalities in various parts of the brain and there is a suggestion that particular abnormalities may be associated with particular syndromes in schizophrenia.[4] There is also some evidence that the changes (especially loss of grey matter volume) can be progressive.[5] Perhaps early vigorous treatment will prevent or slow the progression; no-one knows. The neuroimaging available is essentially for research; the diagnosis is clinical.

Therefore, if one has a psychotic patient with coarse brain disease and chemical misuse and severe depression have been eliminated, a diagnosis of schizophrenia is almost certain to be correct. Most patients will be young – postadolescence or aged in their 20s – but there can be schizophrenia

of late onset. Psychiatric referral for these patients is indicated, but not always possible. Some patients will refuse to see a psychiatrist, others will live in remote areas where psychiatrists are not to be found, and sometimes all the local psychiatrists will be booked up for weeks. Since we are dealing with a relatively common disorder and reaching a correct diagnosis will usually not be difficult, GPs need to feel confident about the next step.

Management

Putting aside the occasional acutely disturbed or dangerous presentations, the management of schizophrenia is no more complex than that of many other disorders. In a way it resembles the management of type 1 diabetes. In both cases medication is at the centre of the process, but there is more to it. One does not prescribe insulin and tell the patient to come back in a month or so to see how things are going. Similarly, one does not prescribe an antipsychotic with the same advice. There is much need for education, both for the patients and for their families.

In any disorder which responds to medication there will always be those patients who respond better to one medication than they do to the others. This can happen in schizophrenia; one needs to be aware of it and respect patients' preferences when there is no good reason not to do so. However, in most cases the GP should not hesitate to start patients on one of the newer antipsychotics, which are at least as effective as the older antipsychotics and their side effects are less. This is not to say that they have none, but generally patients find them more acceptable. Depot preparations are useful if there is a problem with compliance.

The exception is clozapine (Clopine, Clozaril, SBPA Clozapine), which will sometimes produce improvement where nothing else will but which has concerning haematological side effects. It is a very useful medication but best left to psychiatrists. In any case its use in Australia is restricted to specific populations.

The other new preparations do have individual idiosyncrasies, as do patients, but they are not sufficient to make it unwise for GPs to use them after the usual look at the prescribing information.

Needless to say, it would be wise to have a psychiatric review in due course. In many cases, however, the GP will be the one supervising the patient's progress after psychiatric consultation or after discharge from psychiatric hospital. With the medication now available generally this will be no more of a problem than managing many other chronic illnesses.

The question of the causation of schizophrenia is interesting but not relevant to this discussion. The probability is that it is an illness due to a combination of genetic factors and a host of others ranging from prenatal and obstetric complications to major events during one's life. It is both multifactorial and uncertain. In any case, relevant agents may come and go – for example, viral infections may be relevant and they certainly change from century to century.

The psychosocial interventions possible cover a wide range with targets ranging from finding employment to producing a detailed knowledge of the illness and its management in both the patient and the family. Central to them all is a supportive and trusting relationship with the therapist. It is a very large topic. Those wishing to inform themselves will find a useful summary in the *Schizophrenia Bulletin*.[6]

Conclusion

My purpose in writing this article has been to attempt to demystify some of the things which I do and which GPs cannot avoid doing. Nothing in medicine is simple but it can be made more complicated than it is if one works on it. Schizophrenia is a common, serious and disabling disorder. Most patients with this condition will be looked after by their GP. With a few basic principles GPs should be able to diagnose schizophrenia and look after their patients efficiently. MT

In a forthcoming issue of Medicine Today we shall be publishing a detailed article on the management of schizophrenia.

References

1. Murray CJL, Lopez AD, eds. Global burden of disease. A comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020. Cambridge, Massachusetts: Harvard University Press, 1996.
2. Ellard J. Did schizophrenia exist before the eighteenth century? Aust N Z J Psychiatry 1987; 21: 306-318.
3. Merskey H, Shafran B. Political hazards in the diagnosis of "sluggish schizophrenia". Br J Psychiatry 1986; 148: 247-256.
4. Sigmundsson T, Suckling J, Maier M, et al. Structural abnormalities in frontal, temporal, and limbic regions and interconnecting white matter tracts in schizophrenic patients with prominent negative symptoms. Am J Psychiatry 2001; 158: 234-243.
5. Mathalon DH, Sullivan EV, Lim KO, Pfefferbaum A. Progressive brain volume changes and the clinical course of schizophrenia in men: a longitudinal magnetic resonance imaging study. Arch Gen Psychiatry 2001; 58: 148-157.
6. Schizophrenia Bulletin 2000; 26.