REFRESHER COURSE FOR GENERAL PRACTITIONERS**THE EARLY DIAGNOSIS OF SCHIZOPHRENIA**

BY

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Few doctors would have trouble in accurately diagnosing a full blown schizophrenia; all doctors, including specialists, make mistakes about early cases. This paper will largely exclude those cases marked by delusions and hallucinations where clear deviation of behaviour points to a psychotic process.

A diagnosis of schizophrenia is always a serious one, but the hope that came when Bleuler suggested the substitution of the term "schizophrenia" for dementia praecox still blows through psychiatry, and the encouraging results of some modern treatments have confirmed a moderate optimism, provided early diagnosis is made.

Acute Schizophrenic Reactions

During the war it was found that some apparently acute schizophrenic reactions which occurred in battle areas in exhausted soldiers would persist so long as the men remained in the foreign theatre of war, but would cease dramatically on return to this country. These cases show how schizophrenia may apparently come on after stress, and also how the condition may remit. No one seeing such cases would call them "hysterical," though the outcome might suggest this diagnosis. They are mentioned here as examples of the acute schizophrenic reaction, with marked hallucinations and delusions, which is akin to delirious reactions and in which the prognosis seems relatively good.

Such cases had been distinguished by Langfeldt before 1939, and have since been given the dysphonic name "oneirophrenia." Stromgen found that the heredity in 77 cases of this type was quite different from that in what has been called "process-schizophrenia." Their family histories should have yielded ten cases of indubitable schizophrenia and ten of doubtful schizophrenia; in fact, they yielded only one case in which the disease was indubitable, but many cases of neurosis and psychopathy.

These acute cases always need immediate segregation, but we shall largely concentrate upon a description of those types of schizophrenia characterized by introversion, day-dreaming, and less florid behaviour disorders.

Adolescence and Schizophrenia

The cardinal symptom in established schizophrenia is disordered thought. The fundamental attitude is that the external world is threatening, damaging, mischievous. The self is altered, but not responsible; for this outside agencies are blamed. The patient speculates about the alteration in himself and defends himself against this change in a number of ways that may give the impression of being neurotic. It is wrong to think that the patient is not profoundly upset emotionally at the beginning. In the later stages, affect is lost or incongruous, but a diagnosis should be attempted before such signs of an encrusted process are clamant.

Since three-quarters of the cases of schizophrenia begin between the ages of 15 and 30, they occur when the normal person is leaving the stage of dependency for one of responsibility. Some of the difficulties in diagnosis arise for that very reason.

Myerson has described the scrutiny and derision reactions in normal adolescents and has emphasized the difficulties that even normal youths experience in the presence of others, the apprehension they feel and the suspicious attitudes they may adopt. The most shy are those who are trying most to please others. Normal adolescents may be likened to crustaceans with some carapace, but with multitudes of antennae. Their experience is limited, yet they dare not admit this. They therefore brag, become ashamed, feel frustrated, give up in despair, or seek to solve their problems by ill-directed outbursts. Few if any children go through these years without showing temporary seclusiveness. Aims have a vacillating strangeness. Attachments, deep one moment, become shattered the next, and the youngsters appear illogical, fretful, morose and unpredictable to their elders. They are suspicious of secrets or the unmaturing plans of others, and believe that they are being watched or checked when no such intent is admitted by their seniors.

The schizophrenic is incompletely equipped to cross the bridge between childhood and maturity. He uses time to think and day-dream. He develops fantasies about himself, at which his later bearing of superciliousness plainly hints, or he ruminates about normal bodily sensations until these merit the description of hypochondriacal delusions, which gradually become more and more bizarre. Lonely and sensitive, he becomes suspicious when workmates talk—it *must* be about him—or if they seem indifferent to him it is because he smells or has been miraculously deformed by secret agents.

Most of us dispel our parents' alarm, but many normal adults have shown during adolescence brief episodes of emotional instability. These can be reckoned as means of defence against the new perceptions and needs of these years. Few of us could assert that we had not felt unduly suspicious. There were periods when we secretly became hypochondriacal, we were not far from developing a fixed hysterical pain, criminal intents fled through our minds, or escapes such as truancy or sprees. We have not carried our fancies into execution because we have been endowed with the common sense which comes from security of school and home.

Family Background and Previous Personality

A great number of schizophrenics have no such secure roots. G. W. B. James is credited with the aphorism, "For every schizophrenic patient there is one schizophrenic parent." Genetic studies support him, and show how often the home environment is filled with woolly-minded, undependable, if not overtly unstable,

persons. (This is not an argument for environment as against heredity.) When such an individual is facing the adjustments of the post-pubertal years he does so ill-equipped, for the family offers no support or the accent is all wrong. The tendencies we normal persons believe we conquer defeat the patient.

But people are endowed with bodily characteristics as well as with mental attributes. Thus the body-build is often as tell-tale as the pre-psychotic personality (the thin test-tube type of physique, with cold extremities).

We attach the name of "schizoid personality" to the man who is without emotional warmth, incapable of genuine friendship, either coldly calculating or apathetically ineffective, a man who may never make a mistake but whom we would never trust. He hides within his carapace. Such persons often, though by no means always, constitute those from whom the schizophrenics spring. Other such personalities remain cold, detached, and only narrowly effective without ever developing the psychosis.

Early Symptoms

The youthful turbulence we have described in normal adolescents arises as much from unsteadiness in aim and thought as from rapid emotional changes. These thoughts and feelings are the reason why he seeks salvation for himself and his elders in excessive athleticism, fervent political loyalties, emotional religion, or becomes over immersed in reading and study. The inadequate frequently seek a haven in the Merchant Navy, which later they leave as impulsively. These passionate enthusiasms usually become integrated in a normal way because the youth feels he belongs to a society or to a new home, and such immature attachments are outgrown. With the schizophrenic salvation from health and beauty, the red-blue party, esoteric religion, or mystical cult are activities in which his thoughts but not his feelings find outlets. It is in this way that the early signs of the disease emerge. First the genetic background and environment play their part, and then we become aware of the attempts which are being made by the patient to control thought and feeling, or we are suddenly (though less often) faced with a florid psychotic disorder.

It cannot be too strongly emphasized that before the diagnosis is made we should be clear that we appreciate the patient's background. Hence, it is wise to be wary in diagnosing the disease in a person coming from a different social culture. Even some temperate Irishmen show conduct normal for themselves which would be psychotic if demonstrated by an executive officer of the Civil Service. A dock labourer's lack of finesse and feeling may be normal, but such signs appearing in an authoress would create surprise.

The morbid thoughts and speculations express themselves first through a falling off in normal interests, and the patient tries to concentrate upon examinations or factory work, and fails. He is described as being aloof and dreamy, and his appearance bears this out. He may explain spontaneously that things look and seem different. He may admit that he feels changed and that this change affects his head or his viscera. If asked to describe how he can explain it, the schizophrenic will either be unable to, or blame others or agencies rather than himself. Derealization and depersonalization, attributed to the operation of an outside power, are described in curious, quaint ways. One mark of the

schizophrenic is that whereas with so many other patients we can sympathize and place ourselves in their position, or exclaim "There, but for the grace of God, go I," the schizophrenic's experience eludes us; we can almost get there, but never quite. Shakespeare has described these changes in an advanced condition:

" . . . her speech is nothing.
Yet the unshaped use of it doth move
The hearers to collection; they aim at it,
And botch the words up fit to their own thoughts,
Which, as her winks and nods and gestures yield them,
Indeed would make one think there might be thought,
Though nothing sure, yet much unhappily."

It is this near-to-normal quality, yet not quite normal, which is the hallmark of early schizophrenic thinking. So, too, is the patient's conduct. There is a degree of inappropriateness rather than impropriety: turning away when we should expect enthusiasm; hilarity in place of quiet sympathy; over-activity where contemplation would better suit. When it is seen, the disdain and hauteur of the patient so unlike his previous self is pathognomonic.

Similarly convincing is a patient's complaint that his thoughts have been interfered with: they have been introduced into his head or body; they have been stolen—again from the activity of outside agencies. One caveat is needed. If these questions are asked directly *the answer should "click."* Mere passive acquiescence to the question may lead us astray. Near-defective, inadequate, or other patients may appear to suffer in these ways when they are merely obligingly answering affirmatively.

There are four objective signs of this interference with ideation. "Thought blockage" is the failure of the patient to continue a conversation. Instead it is punctuated by pauses in which he appears abstracted, thinking of things irrelevant. Sometimes the only sign of the disorder is that he will not answer our questions directly, a characteristic he shares with many defectives but capable of creating irrational antagonism in us. Mapother described the "knight's move" in the patient's associations, well illustrated by what the gentleman reported of Ophelia. Lastly, there is perplexity. Many early cases appear objectively only perplexed and we cannot tell why. There are plenty of perplexed adolescents whose difficulties we can appreciate. It is this unapproachability to the patient which is so striking. This difficulty shows itself early in those who promise they are going to do something and yet never do. The procrastinator admits his fault, is slightly ashamed, and does something. The schizophrenic smiles when taxed, gives an unconvincing promise, and does nothing. He finds it difficult to go to bed, or equally stays abed in the mornings though being wide awake for hours previously. He is said to spend his time idling, looking at a magazine yet not reading. A history of much time spent looking out of the window or into mirrors is suggestive. The loss of interest goes beyond apathy towards friends and current events. There is a loss of interest in those features of appearance which connect us with others; the hair on head and face is unkempt, the clothes are untidy, shoes are unbrushed, and nails uncut. Loss of libido comes early. Amenorrhoea may be present—transitory or permanent. Hypochondriacal concern, with curious speculative colouring, may be marked as a sign, though lacking as a symptom.

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.