SIMPLE SCHIZOPHRENIA: PATIENTS IN SEARCH OF A DIAGNOSIS

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SUMMARY

Recent classification systems of schizophrenia consider the presence of psychotic features like certain forms of hallucinations and delusions as sine qua non of this disorder. Consequently, earlier categories like simple schizophrenia have been discarded from many diagnostic systems. However, there is a category of patients who present with gross deterioration in personality without ever experiencing hallucinations or delusions. Negative schizophrenia, a contemporary popular syndrome has again revived interest in this subgroup of patients. The authors present four cases diagnosed as simple schizophrenia and argue the case for retention of this subgroup of schizophrenia in the current nosological classification systems and conclude that simple schizophrenia of yesteryears has close resemblance with today's negative schizophrenia.

Rapid advance made in the understanding of syndrome of schizophrenia have lead to numerous revisions of basic concepts of this disorder as well as the criteria for its diagnosis. While a major part of research focuses on biological aspects, some workers continue to take interest in fundamental issues such as subtypes of schizophrenia (Crow, 1980; Andreasen, 1985). Following traditional Bleulerian teaching in psychiatry, schizophrenia has been divided into 4 principal subtypes: simple, hebephrenic, catatonic and paranoid. With accumulating knowledge, certain categories like schizo-affective have gained stronger foothold, while others like simple schizophrenia have been largely ignored.

Of the 2 main classification systems used in psychiatry, the 9th revision of the International Classification of Diseases- the ICD-9 of the World Health Organization (1978) and DSM-III-R of the American Psychiatric Association (1987), the former continues to retain the diagnostic entity of simple schizophrenia (coded as 295.0) and describes it as a psychosis with an insidious development of oddities of conduct, inability to meet the demands of the society and decline in total performance. However, the clinician is cautioned that since schizophrenia symptoms are not prominent, diagnosis of this form should be made sparingly, if at all. DSM-III-R (American Psychiatric Association, 1987), does not have category of simple schizophrenia, as it clearly considers features like delusions and hallucinations to be pathognomonic of schizophrenia. DSM-III-R states that a patient who was earlier diagnosed as simple schizophrenia would now be considered as schizotypal personality disorder.

In a major review tracing the origin and later criticism of the concept of simple schizophrenia, Blach and Boffeli (1989) emphasised the need to retain it as a diagnostic entity. The authors proposed operational criteria for its diagnosis, stating that deterioration in clinical status over time differentiates simple schizophrenia from schizotypal personality disorder. Another subtyping of schizophrenia, which has aroused considerable interest, is the distinction between positive and negative types of schizophrenia. Originally proposed by Reynolds (cited in Berrios, 1985) and later developed by Hughling-Jackson (1931), it has been revived by Crow (1980), Andreasen, (1982; 1985) and Andreasen and Olsen (1982).

Negative schizophrenia is typified by affective blunting, alongwith alogia (poverty of speech/poverty of content of speech), avolition-apathy, anhedonia-asociality and attentional impairment. The disorder has insidious onset, a chronic deteriorating course, impaired social functioning and poor occupational record (Andreasen, 1985). Andreasen (1985) goes on to state that "some patients may begin with predominantly

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negative symptoms and remain in that state throughout their lives". This clearly differentiates these negative schizophrenics from the "Residual Schizophrenia" category of DSM-III-R (American Psychiatric Association, 1987) in which an active phase of the illness for a period of six months with undisputed history of psychotic symptoms is required to label any individual schizophrenic.

Therefore, as the situation exists today, it would appear that the boundaries between "simple schizophrenia" of the past and "negative schizophrenia" of today are ill defined and tenuous, more so if the diagnosis of schizophrenia is to be made in the absence of tangible psychotic phenomena.

The authors present 4 cases diagnosed as simple schizophrenia in a centre where ICD-9 (World Health Organization, 1978) is used for clinical diagnosis. The authors suggest that simple schizophrenia continues to be a clinically relevant entity and is phenomenologically closely allied to the recently popularised category of negative schizophrenia.

Case reports

Case 1
A 22 year old, single male, from upper socio-economic urban family, with good premorbid adjustment, presented with 2 year history of progressive social isolation, deterioration in academic achievement, disinterest in family, friends and social pursuits, delayed and minimal response to question, lack of motivation and subjective complaints of lack of energy. There was marked deterioration of personal care, so much so that he would often knowingly not change his clothes soiled with urine and faeces, and would be completely unconcerned. His appetite was normal but there was a reversal of sleep wake cycle, the patient getting up at around 6 PM and going to sleep at 3 AM. There were no delusions, hallucinations, first rank symptoms, catatonic, affective or organic features. His birth history, early development and childhood had been essentially normal. There was history of alcohol-dependence in the father but the rest of the family did not have any obvious psychiatric problem. His physical and systemic examination was normal. Mental state examination revealed difficulty in establishing rapport, retardation, marked blunting of affect, poverty of content of speech, impaired attention, poor abstraction and lack of insight. Routine blood tests, EEG and CAT scan for ventricular-brain ratio were all normal. No detailed psychometric assessment was possible because of lack of co-operation. Repeated thiopental interviews did not add any new information. The patient was treated vigorously with antipsychotics, antidepressants and a course of 12 electroshocks with no response. Attempts at psychotherapy also failed because of the patient's lack of interest and motivation. Over a period of one year, there was no change in his clinical condition despite regular antipsychotic medication.

Case 2
A 21-years old single male, who had been premorbidly well adjusted and was studying in a medical school, presented with a 2-year insidious onset illness with inexplicable decline in academic performance, social withdrawal and neglect of personal care. After having joined a medical school, the patient, who hitherto had been a good student, suddenly started doing badly in studies, becoming intensely involved in pseudo-philosophical ideas, staying alone and started neglecting his personal care. He had marked ambivalence towards his studies and future career and became increasingly estranged from his family members. There were occasional periods of sadness, but by and large the patient appeared aloof and cold. He complained of difficulty in concentrating on his studies and appeared slow, lethargic and sluggish. There were no features of an affective disorder and no hallucination or delusion. His family background revealed an over involved mother and a cold unemotional father, with pathological communicaton patterns between the family members. Mental state examination revealed poverty of content of speech, shallow affect, impaired attention and loss of insight. Psychometry revealed schizothymic traits with emotional instability and Rorschach ink blot test revealed poor ego strength, low group conformity and few human responses, suggestive of schizophrenia. Patient had been...
drifting aimlessly after dropping out of medical school and did not show any improvement on anti-depressants and antipsychotics in follow-up of one year period.

Case 3
An 18-year old single male from an urban background had a brilliant academic record but 3 years ago his family noticed an inexplicable decline in his school performance along with increasing social isolation. He became slow in his activities, stopped taking part in any conversation and became completely self absorbed. At times he was found muttering or smiling to self but did not admit to any hallucinatory experiences. His sleep was normal but eating and personal hygiene were neglected. There were no delusions, hallucinations, catatonic symptoms, affective disturbance or organic pathology. The patient was treated by traditional faith-healers as well as a psychiatrist, with no improvement. There was history of schizophrenia in a paternal uncle who had responded to antipsychotics and electro-convulsive therapy. Mental state examination revealed a withdrawn, retarded patient with blunted affect, poverty of content of speech, attentional impairment, poor abstraction and impaired insight. Routine physical investigations revealed no abnormality. The patient was treated with antipsychotics with no change over a six month follow up period.

Case 4
This 23 year old house wife from an urban background had been maintaining well till 3 years ago. She had been teaching in a school, had a good social circle and was very well adjusted in all spheres of life. Then she started withdrawing from social interactions and stopped taking interest in her school, at times doubting that some colleagues talked about her behind her back. This never preoccupied or bothered the patient. Gradually patient's contact with other human beings became minimal, her speech output reduced to monosyllables and she neglected her own and her family's care. She did not show any reaction to a demand of divorce by the husband. The condition progressively worsened but no positive psychotic features, catatonic features or features suggestive of organicity appeared. There was no family history of psychiatric illness. Mental state examination at the time of presentation revealed an uncooperative, retarded patient with flat affect and severe poverty of speech. Detailed physical examination, neurological examination and investigations revealed no physical abnormality. Rorschach Ink Blot Test revealed absence of human responses, very few popular responses and perseveration, suggesting schizophrenia. The patient was put on pimozide and over three months showed minimal improvement, that too in speech output.

DISCUSSION
The cases presented here demonstrate that a category of patients who best fit into the classical description of simple schizophrenia does exist.

One aspect that stands out prominently is that each case there is definite, albeit insidious onset of clinical disorder which is a clear departure from the premorbid state. Stone et al. (1968), while trying to demolish this category, stated that simple schizophrenia could be an unveiling of earlier cognitive maladaptations which become apparent in adolescence, or indicate outcome of an existing mild form of infantile autism. In these 4 cases there is no suggestion of an earlier cognitive maladaptations or of any other form of organic impairment. Although the onset in our cases is insidious, none of these can be considered a "no-onset" condition, a description often used for a personality disorder. This appears to be a definite variable on the basis of which a distinction between schizotypal personality and simple schizophrenia can be made as in the latter a definite onset can be documented.

The cases presented here mirror image the classical description of simple schizophrenia with a gradual loss of drive, interest and initiative along with apathy, alogia and anhedonia (Kant, 1948). Case 1 also presented with features of getting up very late in the day but staying awake the whole night, as has been described by Lehman & Cancro (1985). The phenomenology in these cases does not seem
to make the distinction between Bleuler's essential and accessory symptoms schizophrenia evident, the latter being conspicuous by their absence. Loosening of association was not forthcoming, presumably because of lack of co-operation and severe poverty of speech.

Lack of response to any treatment modality in these patients is another feature which has been described in simple schizophrenia and foretells a chronic progressive course.

There are striking similarities between the manifest psychopathology in these cases and that described for negative schizophrenia. All 4 cases had alogia, affective flattening, avolition-apathy, anhedonia-asociality and attentional impairment which are known to be the 5 major symptom complexes of negative schizophrenia (Andreasen, 1981). The subsequent course of the disorder in our cases was also not very different from that of negative schizophrenics. Andreasen (1985) categorically states that certain schizophrenics may have only negative symptoms through the course of their disorder. Keeping these considerations in mind, it is difficult to ascertain how negative and simple schizophrenia differ from each other. Furthermore, modern trends in diagnostic practices give pre-eminence to hallucinations, delusions and thought disorders for the diagnosis of schizophrenia. This raises the question whether one can justifiably make a case for an entity called simple schizophrenia in the broad group of schizophrenic psychosis when the so-called characteristic psychotic symptoms are missing. If one goes by Bleulerian views, then such a case exists and diagnosis of simple schizophrenia can be made.

Black & Boffeli (1989) have stressed the importance of oddities in affect, speech or thought, along with impairment in social and occupational functioning as characteristic of simple schizophrenia, if the condition is an obvious departure from an earlier level of functioning. Our cases fulfill the criteria of social dysfunctioning. However, none of the cases presented here had magical thinking, ideas of reference, odd speech, unusual perceptual experiences, suspicions or undue social anxiety, symptoms described to be characteristic of schizotypal personality disorder, which are also included in the operational criteria proposed by Black & Boffeli for simple schizophrenia. DSM-III-R (American Psychiatric Association, 1987) also states that in many cases of schizotypal personality disorder, a concurrent diagnosis of borderline personality disorder can be made. This is apparently not true for negative schizophrenia which has practically no discernible overlap with borderline personality disorder. Simple schizophrenia is, therefore, more akin to negative schizophrenia and not simply schizotypal personality disorder that appears in adulthood. If on the basis of preceding discussion one concludes that what Bleuler termed "simple schizophrenia" is now being called "negative schizophrenia", then, besides reviving the category of simple schizophrenia, we now have reliable scales for the measurement of its psychopathology and also an interesting hypothesis for its putative pathophysiology and psychopharmacology.

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