5.1 Definition and epidemiology

Schizophrenia was first recognized as a separate mental disorder in the 1890s. Often misunderstood as ‘split personality’, it is actually a serious mental illness with psychotic symptoms of delusions and hallucinations that comes on in early adult life. In most cases, it then runs a chronic, relapsing course. This is one reason why it is one of the top five most expensive disorders in all of medicine.

Schizophrenia is defined as a psychotic mental illness, meaning it is a severe disorder with delusions and hallucinations (psychotic symptoms). Sufferers usually have episodes of acute psychotic symptoms, often with more persistent social impairment.

The main facts are given in Table 10. An average GP will see about one new case per year, although, because the illness usually needs long-term treatment, he or she will be involved in the ongoing care of 20–30 schizophrenic patients at any one time.

5.2 Symptoms

The symptoms of schizophrenia can be divided into positive symptoms and negative symptoms. Positive symptoms are:

- delusions: in schizophrenia these are often bizarre
- hallucinations: these are usually auditory; about 20% of patients will have visual, olfactory or tactile hallucinations
- schizophrenic formal thought disorder.

Some positive symptoms are called first rank symptoms because they occur in schizophrenia and rarely in other disorders. They are listed in Table 11.

The symptoms of schizophrenia can be divided into positive symptoms and negative symptoms. Positive symptoms are:

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- schizophrenic formal thought disorder.

Some positive symptoms are called first rank symptoms because they occur in schizophrenia and rarely in other disorders. They are listed in Table 11.

5.3 Causes, onset and course

5.4 Management

Further reading and sources

Self-assessment: questions

Self-assessment: answers
Appearance and behaviour

Appearance and behaviour may be normal, but watch for three areas.

Abnormal movements as a result of illness. The individual may be restless and agitated. They may be doing unusual things. Mannerisms are seemingly purposeful movements done for no reason, such as saluting. Stereotypies are repetitive non-purposeful movements, such as rocking or grimacing. Rarely there may be catatonic signs, where the person is frozen like a statue, allowing their limbs to be moved to new positions like Plasticine.

Abnormal movements as a result of drug treatment. Antipsychotic drugs can themselves cause involuntary movements (Ch. 17).

Negative symptoms. These include poor personal hygiene and self-care. Is the person dishevelled or unwashed?

Speech

Speech is often normal. However, about half of patients with schizophrenia have a characteristic disorder of language called schizophrenic formal thought disorder. This is an abnormality in the way the person is speaking, which when mild is quite subtle, but when marked is striking. The person’s speech loses the usual logical flow between one idea and the next, so that segments of speech become partly disjointed from each other. This is known as loosening of associations or ‘knight’s move thinking’, after the two-squares-forward-one-sideways move in chess (Box 32).

Concrete thinking describes an aspect of thought disorder that involves the impairment of the ability to think

<table>
<thead>
<tr>
<th>Table 10 The epidemiology of schizophrenia</th>
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</thead>
<tbody>
<tr>
<td><strong>Epidemiology</strong></td>
</tr>
<tr>
<td>Incidence (rate of new cases)</td>
</tr>
<tr>
<td>Prevalence (number of existing cases)</td>
</tr>
<tr>
<td>Global rates</td>
</tr>
<tr>
<td>Social class</td>
</tr>
<tr>
<td>Sex</td>
</tr>
<tr>
<td>Peak age at onset</td>
</tr>
<tr>
<td>Family history</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 11 Asking about first rank symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Symptom</strong></td>
</tr>
<tr>
<td>Third person auditory hallucinations</td>
</tr>
<tr>
<td>Running commentary</td>
</tr>
<tr>
<td>Echo de la pensee (thought echo)</td>
</tr>
<tr>
<td>Delusions–thought insertion/withdrawal</td>
</tr>
<tr>
<td>Delusions–thought broadcasting</td>
</tr>
<tr>
<td>Delusions–passivity feelings</td>
</tr>
<tr>
<td>Primary delusion: a delusion that arises suddenly, with no other prior symptoms</td>
</tr>
</tbody>
</table>

Box 32

An example of knight’s move thinking or loosening of associations

**Interviewer** How have you been feeling today?

**Patient** Well, in myself I have been okay what with the prices in the shops being what they are and my flat is just round the corner. I keep a watch for the arbiters most of the time since it is just round the corner. There is not all that much to do otherwise.

**Comment** The word ‘arbiters’ used here is a made-up or inappropriately used word, known as a neologism, in schizophrenic thought disorder.
in abstract ways. This is often most obvious if you ask the person to solve an abstract verbal puzzle or explain a proverb.

**Mood**

Mood in schizophrenia can be normal. Two particular abnormalities are important to look for on examination.

**Blunted affect.** This is where mood in conversation can be seen to have lost its usual variability. Instead of the normal play of facial expressions and gestures in a social situation, a person with blunted affect appears to have an unresponsive, unchanging expression. This is one of the negative symptoms of schizophrenia.

**Incongruous affect.** This is where, for no apparent reason, the person will giggle or smile secretively to themselves in a way that is inappropriate to the situation. Incongruous affect is found only in schizophrenia.

**Thoughts**

The person may be preoccupied with their abnormal beliefs and experiences.

**Abnormal beliefs**

Table 12 reminds you how to ask about abnormal beliefs. Common in schizophrenia are ideas of reference, where the person has the impression that items on the television or radio, or in the newspapers, are referring specifically to them. This can also extend to everyday occurrences in the street, such as the impression that people in the street seem to be looking at the person, or the registration plates of passing cars have a special meaning for the person. These become delusions of reference if they become fixed and unshakable. Other delusions in schizophrenia can be persecutory, grandiose, religious or hypochondriacal. They can be extremely bizarre. When a delusion becomes so extensive that it becomes a series of linked, fixed beliefs that govern much of what the person says or does, it is said to be a systematized delusion. Delusions in schizophrenia can be primary, where they arise out of the blue, often quite suddenly, or secondary to pre-existing hallucinations as an attempt to explain them, as the result of a radio receiver implanted in the brain, for instance. Some delusions are so characteristic of schizophrenia that they are first rank symptoms (Table 11).

**Abnormal experiences**

Hallucinations are usually auditory, of speech, in schizophrenia. Visual, olfactory or tactile hallucinations can occur in schizophrenia but are unusual and should alert you to the possibility of organic illness. Most sufferers can describe their auditory hallucinations in some detail, as in Table 13.

**Cognitive state**

This will be essentially normal in schizophrenia, although deficits in concentration and abstract thought may be detected, particularly if the person is acutely psychotic or has chronic negative symptoms.

**Self-appraisal**

Insight into the illness is usually lost in acute schizophrenia and sometimes is not regained fully after recovery. Insight is not a clear-cut issue. People can retain insight into the fact they have an illness but not agree they need treatment, for example. Assessing self-appraisal is essential in determining what management approaches are possible.

**Subtypes based on symptoms**

Subtypes of schizophrenia can be based on the balance of symptoms and include paranoid, with prominent delusions, and hebephrenic, with prominent negative symptoms and poor outcome. Catatonic schizophrenia is rare and involves marked mannerisms and posturing. Psychoses similar to schizophrenia are:

- schizoaffective disorder: positive symptoms including first rank symptoms are combined with prominent mood disturbance, either manic or depressed; long-term outcome tends to be better than in schizophrenia.

### Table 12 Mental state examination: asking about abnormal beliefs

<table>
<thead>
<tr>
<th>Delusions</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abnormal beliefs in general</td>
<td>Have you had feelings that some things are not quite as they should be? (Open question)</td>
</tr>
<tr>
<td>Ideas or delusions of reference</td>
<td>Do you sometimes have the impression that things on the TV or radio are about you?</td>
</tr>
<tr>
<td>Persecutory delusions</td>
<td>Do you ever feel there might be a plot about you? Or even an experiment?</td>
</tr>
<tr>
<td>Hypochondriacal delusions</td>
<td>Has anything strange been happening to your body?</td>
</tr>
<tr>
<td>Grandiose delusions</td>
<td>Have you special powers or abilities?</td>
</tr>
</tbody>
</table>
Schizophrenia

5.3 Causes, onset and course

Learning objectives

You should:

- know the likely age of onset and presenting history
- know the possible causes
- know of the dopamine hypothesis to explain the biological basis of schizophrenia.

Auditory hallucination

<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are they voices?</td>
</tr>
<tr>
<td>How many voices are there?</td>
</tr>
<tr>
<td>How loud are they?</td>
</tr>
<tr>
<td>How often do they happen?</td>
</tr>
<tr>
<td>How do you explain the voices?</td>
</tr>
</tbody>
</table>

- delusional disorder: characterized by gradual onset of systematized persecutory delusions, without hallucinations or thought disorder
- drug-induced psychosis: has a sudden onset and resolves over a few days after the drug is withdrawn; amphetamine-like drugs, including Ecstasy, are often responsible and the usual difficulty is distinguishing this from drug-induced relapse of schizophrenia
- organic psychoses. These can mimic schizophrenia and need to be excluded.

Onset

The median age at onset is about 23 years in men and 28 years in women. Onset is very rare under 16, and uncommon over 40. Onset can be relatively acute, over the course of 2 or 3 weeks, or insidious. The typical history is for a period of several months increasingly poor functioning at home, work or school, with noticeable social withdrawal, non-specific anxiety and change in behaviour. Delusions and hallucinations then appear, sometimes after several days in which the person reports his or her surroundings to be changed in some strange way that is difficult to describe: so-called delusional mood.

Course

Most people will recover from the first episode, usually within 3 months of taking treatment and 20% will then never have a further episode and return to full functioning. However, 70% will recover but relapse in the future, with increasing levels of negative symptoms between episodes. Even with treatment, 50% of patients will relapse in the first 2 years. Approximately 10% of patients will never recover from their first episode and will need high levels of health and social services input and support for many years. Over the first 5 years of the illness, 5% of patients will die by suicide.

Causes

Predisposing factors

The causes of schizophrenia are still largely unknown. Genetic and environmental factors are important. The risk of schizophrenia is increased 15-fold if a first-degree relative has schizophrenia. The concordance rate in identical twins is 40%, strongly suggesting a genetic effect as well as showing that environmental factors must be operating too. The genetic effect is likely to be several additive genes each of small individual effect: a polygenic model. Linkage studies and genetic association studies have provisionally identified some of these vulnerability genes. Also found in the families of schizophrenic probands are increased rates of a non-psychotic disorder of personality known as schizotypal disorder, with social isolation and eccentric thinking; this is genetically related to schizophrenia.
About a third of people who develop schizophrenia have had lifelong abnormalities, with poor social skills and few friends, often with slightly delayed motor and cognitive milestones. These are sometimes called schizoid traits.

Environmental risk factors include a range of early neurological insults that slightly increase the risk of schizophrenia many years later: obstetric complications, childhood head injury and childhood encephalitis.

Schizophrenic patients often have minor non-progressive brain changes detectable by computed tomography (CT) or magnetic resonance imaging (MRI) (see below). The most common is minor enlargement of lateral cerebral ventricles, but not to a degree considered definitely abnormal by a radiologist.

Schizophrenia is more common by three- or four-fold in one ethnic subgroup in the UK: second-generation AfroCaribbean individuals. This does not appear to be misdiagnosis nor caused by any increase in a risk factor such as street drug use. It is most likely to be a combination of an increased genetic predisposition and increased social stressors and precipitants, such as racist pressures.

**Precipitating factors**
Although clear precipitating factors are usually absent, two important classes of factor can trigger the first onset of schizophrenia in predisposed people: stressful life events and street drug use, particularly of amphetamine-like drugs.

**Maintaining factors**

*Family environment* Stressful family environment was once thought to be a cause of schizophrenia. This is now known not to be the case. However, it can cause relapse in someone who has had schizophrenia. Ways of measuring how families interact have been developed. Families who have high levels of criticism, hostility and overinvolvement are said to have high expressed emotion (EE) and studies have shown that people in remission from schizophrenia are more likely to have a relapse in such a family environment. Since families are often the principal caregivers for younger people with schizophrenia, techniques to support families and to reduce EE if necessary have been developed and shown to reduce relapse. Family intervention involves education about the illness, then advice about dealing with problem behaviours and how to ask for help when needed. A family support worker may be available, often from the voluntary sector. Families find the negative symptoms the most stressful to deal with.

*Other factors* Other maintaining factors are poor compliance with treatment and continued street drug use.

**The biological basis: the dopamine hypothesis**
The key neurotransmitter involved in schizophrenia is dopamine. The so-called dopamine hypothesis states that the symptoms result from overactivity of dopamine, particularly in the mesocortical pathway projecting from temporal to frontal areas. First put forward in 1963, the hypothesis was based on two clinical observations: (i) amphetamines, which released dopamine, could cause schizophrenia-like positive symptoms if overused; and (ii) antipsychotics caused side effects resembling Parkinson’s disease, which was known to be caused by dopamine deficiency. Further evidence was that the clinical potency (number of milligrams to have a clinical effect) of individual drugs could be shown to be closely correlated with their in vitro affinity to dopamine D2 receptors. Problems with the hypothesis were that it did not account well for negative symptoms and there was no direct evidence showing increased dopamine receptors in the brains of never-treated patients at postmortem or by scanning (positron emission tomography). The hypothesis would not predict the effects of clozapine, the superior efficacy of which is achieved with a relatively low blockade of dopamine D2 receptors.

**Structural brain changes**
Structural brain imaging using CT and MRI consistently demonstrate mild non-progressive enlargement of cerebral spaces, such as the lateral cerebral ventricles, in patients with schizophrenia compared with normal individuals. These findings suggest that patients with schizophrenia have slightly less brain tissue, affecting, particularly, cortical grey matter and the limbic system; the latter is involved in the control of emotions and memory. Other structures, such as the thalamus, which is involved in the regulation of the flow of information to the cerebral cortex, have also been implicated.

5.4 Management

**Learning objectives**
You should:
- be aware of the need for prompt action at initial presentation
- know the management of chronic schizophrenia
- understand the roles of all those involved in community care
- understand the way to communicate the diagnosis to the patient and family.
The first episode

The longer the person has active psychotic symptoms, the worse the eventual outcome, so swift referral from primary to secondary care is important when psychotic symptoms are present. Full history and assessment will lead to the diagnosis in most cases. Physical examination and investigations are essential; these include:

- neurological examination
- full blood count
- erythrocyte sedimentation rate (ESR)
- electrolytes and urea
- thyroid function
- electroencephalograph (EEG)
- CT scan
- urine screen for street drugs.

Care needs to be taken over how the diagnosis is discussed with the patient and family; skills in breaking bad news are important. Management of the first episode will usually involve admission as an inpatient or daypatient, although over a third of patients will be able to be managed at home throughout their first episode, with frequent visits from staff of the community mental health team (CMHT). Most people in their first episode will be young adults. Almost all patients will need antipsychotic drug treatment, although low doses of a conventional drug (e.g. haloperidol 1–2 mg twice daily) or new atypical drug are usually sufficient.

Education of the patient and family about the nature and management of schizophrenia are very important. Introduction of the Care Programme Approach (CPA) is needed, with an integrated and documented care plan and a keyworker with responsibility for coordinating the care plan. Continuing involvement of a psychiatrist, community psychiatric nurse and social worker as a minimum are usually needed.

Maintenance after the first episode

Maintenance management after the acute symptoms have resolved will include regular CPA meetings organized by the keyworker. Maintenance antipsychotic drug treatment will be needed. How long this should continue if the person has no symptoms depends partly on how severe the initial episode was. Drug treatment should be continued for a minimum of a year; if the first episode was severe, drugs should continue for at least 2 years. Clear discussion of the ‘pros and cons’ of continued drug treatment will help compliance.

Acute relapse needs reinstatement, change or increase of antipsychotic drug treatment. Admission to daypatient or inpatient services may be needed. Attempts to clarify reasons for relapse (Box 33) are needed.

Management of chronic schizophrenia

Prognostic factors in schizophrenia are listed in Box 34. Persistent positive symptoms, which fail to respond well to other antipsychotic drugs, will improve with clozapine in about 50% of patients. Recent evidence supports the effectiveness of a modified form of cognitive-behaviour therapy for persistent delusions and hallucinations. Persistent negative symptoms are more difficult to treat. Rehabilitation uses a set of graded techniques in order to reduce partially the negative symptoms that cause most disability. Rehabilitation includes occupational therapy, which starts with assessing the degree of functional disability in terms of doing everyday tasks. People with chronic schizophrenia are often unable to live independently, needing sheltered housing or a residential placement with specialist staffing. Work retraining is an important part of rehabilitation.

Some people with schizophrenia are difficult to engage or maintain in treatment. In the past, such patients were often lost to follow-up as they did not attend for outpatient appointments or treatment. Very intensive forms of community treatment have been recommended by the Department of Health in the UK for such patients.

Intensive community treatments

Assertive outreach involves the delivery of continuous and comprehensive community care and treatment to certain schizophrenic patients who have difficulty in engaging or remaining in treatment. Assertive outreach therefore involves intense personal contact with the patient, as well as a programme of care. The patient is offered a team member as a keyworker whose sole responsibility is to ensure that the patient receives the care and medication that is needed. Assertive outreach involves being available to the patient for a substantial part of the day, with the team being able to respond to crises immediately. The patient is encouraged to live independently with support from the team.

Box 33

Common causes of relapse

The causes are listed from most common to least common.

- non-compliance with drug treatment
- discontinuation, or reduction, of drug treatment
- street drug use
- family stress; high expressed emotion
- life event
- childbirth

Box 34

Prognostic factors in schizophrenia

Good prognosis

- acute onset
- early treatment
- good response to treatment
- male sex
- good occupational and social adjustment previously

Poor prognosis

- early age at onset
- insidious onset
- poor previous adjustment
- negative symptoms
- street drug use
patients. It usually involves a multidisciplinary team, who provide 24 hour support and cover. There is a small patient-to-staff ratio of about 10:1, so that staff can provide close follow-up and contact with patients. Usually each member of the team is familiar with each of the patients, so any member of the team can respond to each patient in an appropriate fashion. It is most suitable for those patients with severe mental illness who are at high risk of self-harm or harm to others, and who will not attend clinic appointments or who are erratic in their pattern of attendance. These people often have multiple social problems and drug abuse in addition to psychosis. Assertive outreach, in the UK, is more effective at keeping patients in contact with services and in treatment than conventional care. It does not, however, result in a better clinical outcome. In the USA, it has been shown to reduce hospital admissions, but there is no evidence that it has such an effect in the UK. This may be because of differences in service delivery in the UK or because assertive outreach is not implemented as intensively in the UK as it has been in the USA.

Case management is another form of intensive community care. It differs from assertive outreach in that one member of staff usually works with a small group of patients to provide intensive follow-up and care. The case manager will be part of a team but, usually, will work exclusively with his/her own patients. Twenty-four hour cover is not usually provided.

**Further reading and sources**


**Sources**

National Schizophrenia Fellowship. Includes access to varied resources for coping with schizophrenia, covering news, support services, literature, conferences and courses. www.nsf.org.uk

Doctor’s Guide to the Internet – Schizophrenia. Access the latest medical news and information on schizophrenia. Includes patient information, discussion groups and clinical studies www.pslgroup.com
Multiple choice questions
1. Concerning the symptoms of schizophrenia:
   a. Delusions are often of a persecutory type
   b. Tactile hallucinations are common
   c. Ideas of reference are common
   d. Insight is usually impaired
   e. Negative symptoms are strong predictors of outcome

2. Schizophrenia:
   a. Is more common in women
   b. Is mainly a disorder of Western culture
   c. Has a peak age at onset of 23–28 years
   d. Is linked to increased rates of suicide
   e. Is mainly caused by stress

3. Factors that make recovery from schizophrenia more difficult include:
   a. A stable and supportive family background
   b. Continued abuse of illicit drugs
   c. Failure to comply with medication
   d. A strong family history of schizophrenia
   e. Continued abuse of alcohol

4. Good prognostic factors in schizophrenia include:
   a. An insidious onset of symptoms
   b. Being female
   c. An early age at onset (e.g. 14 years of age)
   d. Marked negative symptoms
   e. Early treatment

5. Assertive outreach:
   a. Involves a multidisciplinary team
   b. Monitors patients with the most mild disorders in case they become worse
   c. Provides close supervision and treatment for patients with dual diagnosis and challenging behaviour
   d. Involves a large patient-to-staff ratio
   e. Is of proven efficacy in the UK

Self-assessment: questions

History 1
1. What positive symptoms did Jane have?
2. What is the differential diagnosis?
3. What good prognostic factors are present?

History 2
1. What types of delusion did Jason develop?
2. On what grounds was he detained under the Mental Health Act?
History 3

Steven had slightly slower milestones at walking and talking than his elder siblings. At primary school he was a timid child with few friends. At secondary school, he was bullied and for periods refused to attend. At 13, years of age, he was referred to child mental health services because of persistent nightmares. He told the assessment team that he knew his room was haunted and he could hear murmurings from under his bed. He did not reattend the clinic. His schoolteacher noticed that he seemed distracted and was whispering to himself.

At age 15 he was reassessed and admitted to an adolescent mental health unit. He was noticed to be grimacing and smiling incongruously. His computed tomographic scan showed slight enlargement of his lateral ventricles, which was within normal limits. He complained that his movements were being controlled by ghosts. A diagnosis of schizophrenia was made. He commenced low-dose haloperidol, which was changed to risperidone after he suffered a dystonic reaction. His delusions improved but he was still withdrawn and spoke little. He returned to the family home with visiting support but was frightened to return to his bedroom. He left home unannounced the next week. Three months later he was found sleeping rough in a nearby town, dishevelled, emaciated and muttering to himself. He was re-admitted to a psychiatric unit for further treatment.

James Kerry is 49 years old. He was brought to hospital by the police on a Section 136 4 weeks ago. He had been found by the police walking along a busy road. He was dishevelled and kept shouting at cars as they passed him. At times he shouted out ‘bastards’ and ‘leave me alone’. In hospital, he appeared to be ‘hearing voices’. He told staff that ‘the bastards are always talking about me’, ‘they keep telling each other that I’m rubbish and no good’, ‘it’s driving me mad’. ‘I’ve never touched any children. They keep whispering to each other that I molest children. It’s all a pack of lies’.

He believed that he was being followed by Mormons who were planning to kill him. He knew that all people who drove black-and blue-coloured cars were Mormons and were following him wherever he went.

Mr Kerry had a long history of mental illness. He first presented to services when he was 22 years of age and, at that time, suffered from delusions that the IRA were following him. Over the years he had had 10 admissions to psychiatric hospitals following similar presentations. He had no insight into his illness and always defaulted from follow-up and treatment after discharge.

He had worked as a road labourer in his twenties but had not worked for the last 20 years. He often slept on the streets as he had little money and rarely had the social stability or drive to organize benefits for himself.
Multiple choice answers

1. a. True. They are often bizarre.
   b. False. They occur only in around 20% of patients; auditory hallucinations are common.
   c. True. If they become fixed and unshakable, they become delusions.
   d. True. Some insight may be retained and this needs to be assessed for management.
   e. True. They predict a poor outcome.

2. a. False. There is an equal gender distribution.
   b. False. It is seen all over the world.
   c. True.
   d. True. Patients have high rates of suicide.
   e. False. Schizophrenia is predominantly a brain disorder.

3. a. False. The family is often the principal source of caregivers.
   b. True. Street drug use is an important precipitating factor and continued use impairs recovery.
   c. True. This is common in those who are erratic in clinic attendance, have no fixed home or refuse regular treatment.
   d. True. Risks are increased 15-fold in first-degree relatives.
   e. True.

4. a. False. This indicates a poor prognosis.
   b. True.
   c. False. Early onset indicates a poor prognosis.
   d. False. These have poor prognosis and are difficult to treat.
   e. True. The eventual outcome worsens with the length of time for which active psychotic symptoms are untreated.

5. a. True. Usually all members of the team are familiar with the patient.
   b. False. It is only for the most severely ill who are difficult to keep engaged in services.
   c. True. Dual diagnosis usually implies patients with schizophrenia and illicit drug misuse.
   d. False. There is a small number of patients per staff (usually 10:1) as the treatment is intensive.
   e. False. Although evidence from the USA has indicated benefit, the results of UK studies are equivocal.

Case history answers

History 1
1. Jane is describing classical passivity experiences in that she has delusional ideas about being controlled by an external agency. She also is experiencing third person auditory hallucinations and a running commentary.
2. The most likely diagnosis is schizophrenia because of the presence of first rank symptoms and the absence of any symptoms indicating a manic episode. In a young person, it is always important to exclude a drug-induced psychosis, which could mimic schizophrenia. Other possible diagnoses include other organic factors that could produce a schizophreniform psychosis.
3. Good prognostic factors include the rapid onset of the condition, precipitated by a life event; the rather florid symptoms; the evidence for a normal childhood without evidence of a schizoid premorbid personality; and the return to normal following the illness without any negative symptoms (e.g. blunting of affect, lack of motivation, etc.).

History 2
1. Jason developed persecutory delusions.
2. He was admitted under the Mental Health Act because he had a mental disorder, he was at risk to himself, he refused to be admitted on a voluntary basis and there was no other reasonable alternative to treatment (Ch. 15).

History 3
1. He showed evidence of lack of self-care, poor motivation and little spontaneous speech.
2. He shows evidence of soft neurological signs during childhood, an insidious onset of the disease, a very early onset of the disease (age 13), negative symptoms, poor compliance with treatment and little insight into his illness.

OSCE answer
The criteria for marking this type of station would involve a global mark based upon the candidate’s overall performance. The criteria listed below are features that should have been covered in the answers. An examiner
does not necessarily have to award one mark per point made.

1. Hallucinations and delusions. Second person auditory hallucinations (the candidate could also infer the patient may have secondary delusions).

2. Hallucination is an abnormal perception; its quality is that of a real perception; it arises in clear consciousness; it does not arise from material objects (i.e. is not a misperception like an illusion). (A student should be able to provide a clear definition of an hallucination and be able to distinguish an hallucination from an illusion. You should be able to identify that the patient is describing third person auditory hallucinations, possibly also second person auditory hallucinations.)

3. A delusion is a false belief that is held with conviction by the patient and which is out of keeping with his social and familial background. The patient is describing persecutory delusions.

4. The symptoms are suggestive of schizophrenia. Third person auditory hallucinations are first rank symptoms of schizophrenia and persecutory delusions are common in this type of disorder, although they are not specific to it.

5. The most likely diagnosis is schizophrenia.

6. Assertive outreach or case management.