Early Schizophrenia: A New Clinical Entity

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Abstract: Early schizophrenia as discussed in this paper is defined as “the early phase of a first-time Schub (acute exacerbation)” based on the definition of schizophrenia as “a chronic brain disease characterized by repetition of a specific Schub developing from the early phase to the full-blown phase and then to the sequela phase”. In the past, this stage was called the prodromal phase because only nonspecific symptoms were generally observed. By referring to several prior references, the author re-discovered that symptoms specific to schizophrenia, although subtle, are latent in this stage. Considering the factors that the patient in this phase has an insight into his/her disease, typical antipsychotic agents such as chlorpromazine and haloperidol are not always effective, and patients often remain at this phase for several years, and hoping to increase early detection and early treatment of schizophrenia, the author proposed to describe this phase as early schizophrenia, a new clinical entity, in 1990. This paper re-iterates the concept of early schizophrenia and discusses the gender ratio, the age at onset, the clinical picture (diagnosis) and the treatment based on the author’s clinical experience of more than 10 years.

Key words: Early schizophrenia; Schizophrenia; Prodrome; Early diagnosis; Early treatment

Introduction

The early stage of schizophrenia is, in quite general terms, referred to as early schizophrenia, but this paper discusses “early schizophrenia” proposed as a new clinical entity by the author based on the new definition in 1990.4–10) The relation between early schizophrenia and ordinary schizophrenia may be likened to that of early cancer and advanced cancer. As the concept of early cancer prompted early discovery and early treatment of cancer, the main purpose of the author’s proposed concept of early schizophrenia is to contribute to early discovery and early treatment of schizophrenia. The concept, the gender ratio, the age at onset, the clinical picture, and the treatment are discussed below.
Concept

The definition of early schizophrenia\(^4\) is based on the definition of schizophrenia (excluding hebephrenic schizophrenia) of “a chronic brain disease characterized by repetition of a specific Schub, developing from the early phase to the full-blown phase, and then to the sequela phase” and reads as “a clinical entity meaning the early phase of a first-time schizophrenic Schub and requiring a different treatment strategy than that for ordinary schizophrenia” (Fig. 1). It is pointed out, however, that this “early phase of a first-time Schub” means the stage, which used to be referred to as “the prodromal stage” prior to the onset. Generally, this stage used to be described as presenting symptoms non-specific to schizophrenia such as unidentified mental and physical complaints and neurotic symptoms.

As the author repeated careful examinations by referring to several prior studies\(^1\)–\(^3\), it was noted that symptoms specific to, albeit subtle, schizophrenia were latent in the patient in this stage. In the beginning, there were observed four major symptoms or ten minor symptoms, which were described as “four major symptoms specific to early schizophrenia”,\(^4\)\(^,\)\(^6\) and followed by observation of 30 specific and non-specific symptoms of early schizophrenia.\(^9\) They will be discussed in further detail in the section of clinical picture.

The author has four reasons for treating early schizophrenia as a clinical entity different from ordinary schizophrenia; (1) symptoms specific to this phase are present, (2) patients in this phase have insight into or awareness of the disease unlike patients in the full-blown phase, (3) typical dopamine recep-
examination was 18.9/4.5, which was 3 to 4 years after the onset. This may be because symptoms are so subtle that both the patient and the family do not realize that they are caused by the disease.

Clinical Picture

As discussed above, there are as many as 30 symptoms observed in early schizophrenic patients if the specificity to schizophrenia is not questioned. In 102 cases examined by the author and his colleagues, prevalence of these symptoms of early schizophrenia was studied and 10 symptoms were frequently observed in more than 33% cases (33% or more), and these were classified into four higher rank groups (Table 1, Fig. 3). It is almost impossible to check the presence/absence of 30 symptoms in a clinical setting, but it becomes comparatively easy if the symptoms are limited to 10 that are most frequently observed. They are considered useful for diagnosis because of their high frequency. These 10 frequently seen symptoms of early schizophrenia are briefly discussed.

1) Autochonous thinking is thoughts that come spontaneously to mind. For instance, a
Table 1: Highly Frequently Observed Symptoms of Early Schizophrenia Useful for Diagnosis

1. Autochthonous experiences
   - Autochthonous thinking
   - Autochthonous recollection
   - Autochthonous fantasy images
   - Autochthonous music images (musical hallucinations)

2. Heightened awareness
   - Heightened auditory awareness

3. Tense and perplexed mood and its related symptoms
   - Tense and perplexed mood
   - A vague sense of being watched and/or “Leibhaftige Bewußtheit”
   - Suspicion of being observed and commented on by the people around

4. Disorders of immediate cognition
   - Disorders of immediate understanding and judgment
   - Disorders of immediate memory

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Fig. 3 Incidence of (30) symptoms of early schizophrenia (n = 102)
patient complains that “thoughts that are irrelevant to what I am consciously thinking come to me in surges”. Rambling and incoherent thoughts come to the mind in succession.

2) Autochthonous recollection is experienced when “scenes of by-gone days come to mind frequently. They are usually scenes of myself playing with friends, clear and colorful as in the actual setting, and people move and the scene changes. I do not think I hear voices, but I feel as if I am conversing with someone” according to a patient. Emotional scenes that the patient experienced in the past spontaneously come back to him without relevance to the current situation or mood, and he can “see it inside his head or hear the sound actually”.

3) Autochthonous fantasy images are explained by a patient as follows. “The name of someone I like comes to mind and I feel that the person is actually with me and I talk to that person. I am half aware that they are fantasies, but half the time I am totally immersed in that scene in the other half. When I come to myself, I find me sitting in front of the desk.” This is generally described as daydreaming, and consists of visual and auditory images of a fantasy scene unfolded like a story.

4) Autochthonous music images are explained as follows. “I feel like I am giving a concert in my mind. Commercial songs and popular songs that I half know come and go in quick succession.” The expression “autochthonous music images” is used to indicate that this is also an autochthonous experience, but it may be described as musical hallucination. Autochthonous thinking, autochthonous recollection, autochthonous fantasy images, and autochthonous music images as discussed above fall under a higher rank concept that is widely referred to as “autochthonous experiences”.

5) Heightened auditory awareness is an experience such as “I become highly agitated when I suddenly hear other people’s voices, sudden noises such as opening of the door or the sound of an electric train running nearby”. A person becomes unintentionally aware of auditory stimulus of a slight sound or a human voice that suddenly and unexpectedly comes into his surroundings, and his attention is diverted by the sound. This is often accompanied by astonishment. Although the incidence of such phenomenon did not exceed 1/3 of the total, there are symptoms such as heightened visual awareness and heightened proprioceptive awareness that fall in the same category. This symptom should therefore be classified under the higher rank concept of “heightened awareness”.

6) Tense and perplexed mood is described as “suppose I am up on stage. Before that, you get tense. I continually have that kind of feeling.” While the patient is tense because he anticipates some incident, he is perplexed because he does not know what he is anticipating. This mood consists of autochthonous tenseness and perplexion.

7) A vague sense of being watched and/or “Leibhaftige Bewuβtheit”. For instance, a patient says “I am studying at night in my room and have the feeling that I’m being watched from behind by a spirit. When I turn around, no one is there, but when I look forward, I feel again that someone is still watching me.” The sense of being watched is clear and certain, but the patient knows that there is actually nobody looking at him. As for this “watcher”, there are various types ranging from vague and unclear (vague sense of being watched) to clear perception of the presence (Leibhaftige Bewuβtheit).

8) Suspicion of being observed and commented on by the people around. A patient says that “when I see people talking around me, I feel that they are watching me or commenting about me, even though I half know that it is not so.” In a place with people around, he feels that he is being watched or being commented on with malice. Different from delusion of persecution, he thinks only half of what he believes (or to be more pre-
ciscely, believes it now and denies it the next moment).

The above discussed three symptoms, i.e., tense and perplexed mood, a vague sense of being watched and/or “Leibhaftige Bewuβheit” and suspicion of being observed and commented on by people around may be summarized as a higher rank concept of “the tense and perplexed mood and its related symptoms”.

9) Disorder of immediate understanding or judgment. For instance, a patient feels that “it is hard to understand what others are talking or what is being said on television, and it is not possible to reconstruct the content in mind”, “I am impatient because I lack judgment. For instance, chopsticks are standing in a chopstick stand, . . . . and I cannot immediately tell the differences”. He is no longer able to understand the daily conversation of other people, which he used to understand instantly, or he cannot see the differences in shape or color as in the case of chopsticks discussed above.

10) Disorder of immediate memory. A patient working as a temporary help in a souvenir shop in an amusement park said, “I forget what I was going to do. Because I forget all the time so that when I am asked to go to the warehouse to fetch something, I always take a piece of the thing that I am supposed to fetch with me.” The patient experiences that he cannot remember what he was going to do or what he was told immediately before. This disorder of immediate memory is not continuous as in the case of dementia, and is characterized by its random appearances.

These two types of disorders, i.e., disorders of immediate understanding and judgment and disorders of immediate memory may be summarized as a higher rank concept of “disorders of immediate cognition”.

As discussed above, the 10 symptoms are frequently observed in more than 1/3 of early schizophrenia patients. According to the author’s study of 102 cases, the mean of symptoms was 4.7. In other words, all patients experienced approximately half of these symptoms (Fig. 4), demonstrating the author’s theory that confirming the presence of these symptoms is useful for diagnosis.

**Treatment**

Lastly, treatment of early schizophrenia is discussed briefly. The first concerns the attitude of the treating physician. In order to respond to the patient’s tense and perplexed mood, the physician should be serious and grave above anything else.

The second concerns the techniques of interview. It is important to conduct a detailed question and answer session in order to describe the symptoms in an objective and linguistic manner. In ordinary type schizophrenia, questioning the details of hallucination and delusion is nearly always forbidden. But this is contrary in the case of early schizophrenia. Since the patient does not understand the experience he is undergoing and is extremely uneasy and tense, asking detailed questions will cause the patient to view these experi-
ences in an objective way and to recognize the same as something different from his original character. In other words, putting distance between him and the symptoms is effective for treatment.

Thirdly, the author usually administers 100–300 mg/day of sulpride as a drug of the first choice. This drug alone improves about 1/2 to 2/3 of the patients. If this is not effective enough, the dose may be increased to 600 mg/day, or a small amount of fluphenazine (about 0.75–1.5 mg/day) may be administered additionally. (Anti-parkinsonism agent should always be dosed concurrently in order to prevent extrapyramidal side effects.) It is, however, true that there are a considerable number of cases which utterly fail to respond to this treatment regimen.

Fourthly, it is essential to determine and tell the patient that he is suffering from a disease of the brain, for which he is not responsible. Almost all the patients are relieved to hear this. A patient related later “I wouldn’t have known what to do if I was told that I was not ill”. As for the name of the disease, telling the patient that he is suffering from early schizophrenia may even in this day drive him to suicide. Therefore, the author usually tells that the patient is suffering from “oversensitive disorder”, a name that may be false. However, this naming seems to be adequate to describe the experiences or symptoms of the patient and appears to be acceptable. At any rate, the important thing is the physician’s recognition that the patient is suffering from a disease, irrespective of the name.

Conclusion

The clinical picture of “early schizophrenia”, a clinical entity proposed by the author, was discussed. The author would like to conclude that only a limited number of patients can positively describe the details of their abnormal experiences (they appear to be truly inexplicable), and therefore many of such patients are misdiagnosed as “school refusal”, “adolescence crisis”, “depressive state”, or “too nervous”. The author hopes that this paper would be of some use for daily clinical scene.

REFERENCES