

PHYSICAL HARBINGERS OF RELAPSE IN SCHIZOPHRENIA

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This is a case report of a patient with schizophrenic disorder, followed up prospectively over a period of six years through four episodes of illness. Her experience of a focal physical symptom as a consistent prodromal feature of each relapse forms the focus of the report as such a clinical phenomenon has not been recorded before. The possible reason for such presentation and the value of identifying the prodromal symptoms in the control of relapse are discussed.

INTRODUCTION

Ever since the classical clinical observations of Chapman (1966) on early symptoms of schizophrenia, much interest has developed, both in research and clinical practice, on the study of the heralding symptoms of a psychotic relapse. It has become evident that the major psychiatric disorders do not arise 'de novo' and that there almost always seems to be a prodromal history - a period of progressive psychological and biological dysfunction (Docherty et al, 1978). Studies on this issue had been often carried out in patients with schizophrenia, emphasizing the recognition of prodromal symptoms in the early intervention of relapse (Thurm & Hafner, 1987; Birchwood et al, 1989).

Non-specific physical symptoms such as body aches and pains, tiredness and insomnia are well known manifestations of non-psychotic illness (Shepherd et al, 1966). Such symptoms have been shown to be useful in detecting non-psychotic morbidity in primary care (Srinivasan & Suresh, 1991). Their clinical and diagnostic significance in psychotic disorders is, however, not clear though they have been commonly observed in patients with major depressive disorders (Cadoret et al, 1980). As prodromes of psychotic episodes, somatic symptoms like sleep disturbance, appetite changes and exhaustion have been reported (Docherty et al, 1978; Thurm & Hafner, 1987). However, these symptoms are diffuse and non-specific in nature as they do not suggest any physical illness.

The clinical phenomenon of focal and specific physical complaints in the prodromal phase of psychoses have not been recorded in the literature. We had observed twelve cases in the past six years who presented with a physical complaint preceding every psychotic episode. This paper is a report on one of the cases. In this report, the possible reasons for such a clinical presentation are speculated, and the relevance of identifying harbingers of relapse in major psychiatric disorders are presented.

CASE SUMMARY

A 40 year old married woman presented with a relapse of schizophrenia, paranoid sub-type (DSM III-R, APA, 1980). She had been ill for about seven years and the course of the illness was punctuated with relapses often due to irregular medication. A detailed clinical interview elicited that she had experienced a vague pain, discomfort and sensitivity to cold and hot objects in her teeth, especially the molars, for the first 3-4 days before the onset of the episode. During this period, she also began to experience sleeplessness, restlessness and irritability. She reported that she had a similar initial symptom even during the previous relapses. This report was further clarified with the spouse who concurred with the patient. They had sought a dental consultation with negative findings on at least three earlier occasions, including the present one. The experience of the physical symptom was confirmed by interview after the patient remitted from the presenting episode.

The patient and the spouse were instructed to be alert to any recurrence of the dental symptom as it could be the beginning of a relapse, so that they could seek early treatment. However, despite advice not to discontinue medication, she developed a severe relapse of illness after a year, requiring hospitalization. The emergence of clinical phenomena were of the same nature as during the previous episode. Following recovery, the patient had her husband were instructed to adjust or restart the medication as soon as she experienced similar physical symptoms and not to wait for a consultation or for severe symptoms to emerge. The next two relapses in four years were mild and easily controlled with a hike in the dosage of oral medication before seeking consultation. Severe disruption and hospitalization was avoided. During the second relapse, her 16 year old son could himself titrate the dosage as he had been instructed by his father who was transferred on his job to another town.

DISCUSSION

In identifying a physical symptom to be a prodrome of a psychotic episode, only those symptoms which the patient and / or the family clearly and strongly experienced as the initial change of an episode were recorded as the harbingers of the relapse. It was ascertained that these symptoms always occurred before a relapse and were not experienced at other times, and the same symptom occurred prior to each episode. In the reported case, the remission of the physical symptoms was temporally associated with that of psychotic symptoms, though in some of the other cases, the symptom disappeared earlier than the psychotic phenomena. Any organic origin for the physical complaint was excluded by clinical evaluation and investigation often involving the relevant specialty consultant. Somatic hallucinations or delusion were excluded.

Several, though not fully satisfactory or comprehensive, explanations involving physiological, clinical, socio-economic, cultural and linguistic variables have been offered for the somatic presentation in non-psychotic illnesses (Shepherd et al, 1966; Leff, 1981; Sen, 1978). The origin of somatic harbingers of psychotic illness observed here is similarly open to speculation. It is possible that the evolution of the pathological process underlying the relapse takes on a somatic outlet before involving psychic functioning. The regression of the physical complaint along with other symptoms of the episode suggests that it is a part of the illness. There appears to be similarity in the occurrence of the physical prodromes for psychic phenomena and the well known experience of psychic prodromes for physical phenomena such as epilepsy and migraine. It is possible that at the onset of the illness, several changes are being perceived in both the physical and mental spheres. The physical component of these changes is more easily perceived and reported by the patient, perhaps for the same reasons that facilitates somatic presentation in non-psychotic illness. On the other hand, the psychic changes were yet to crystallize for clear expression. The amorphous state of psychic distribution could also be the reason for the patient experiencing vague discomfort rather than focal pain.

The value of recognizing prodromal symptoms to enable early intervention and avoid relapse and rehospitalisation in psychotic disorders is clearly demonstrated. In our case, after the first one or two

episodes and after making sure that the somatic symptom was strongly perceived to have preceded the episode, patients and their families were advised to be alert to such recurrences in the future and to initiate immediate remedial measures. Patients and their families also can take an important role in their own management, if they are properly sensitized to the early warning signals. The interesting aspect of the harbingers here is their specific and focal somatic nature which had often lead the patient, the family and the physician to think of a physical disorder, as the psychopathology had not yet fully developed. Given a history of past psychotic illness, the physician should be alert to the pre-psychotic significance of a focal physical complaint and initiate psychiatric treatment, especially if the patient reports the premonition of a major breakdown.

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