Editorial Comment

RE-EVALUATION OF THE EVIDENCE ON THE PROGNOSTIC IMPORTANCE OF SCHIZOPHRENIC AND AFFECTIVE SYMPTOMS

HELEN HERRMAN

An earlier literature noted consistently that depressive symptoms appear to bode well for outcome in schizophrenia and related disorders. Although this view is psychodynamically plausible, most of the studies suggesting it have substantial shortcomings. In particular, most studies have been confounded by the effects of variations in duration and history of disorder, which have a major influence on both affective expression and outcome. A contrary view is that depressive symptoms in patients with schizophrenia and related disorders suggest an increased risk of self-harm and social dysfunction, just as these symptoms do in individuals with other disorders. The substantial risks of mortality and morbidity from self-harm, the link between suicide and depression, and the high prevalence of depressive symptoms in the acute and chronic stages of the disorder have all been documented in people diagnosed as having schizophrenia. Social influences are well known to be crucial to the course and outcome of schizophrenia. The expectations of others and patients' own attitudes to their illness are also known to influence outcome. Despite this, there is no longitudinal study of first admission patients to allow us to examine the possible intervening or other role of depression in the development of chronic disability.

Although depression is regarded as one of the classic indicators of favourable prognosis in schizophrenia (Vaillant 1964), in more recent studies cross-sectional observations have not emerged as strong predictors of outcome. The strongest predictors are longitudinal variables related to course, such as acute or insidious onset of illness and duration of previous hospitalisation (Strauss & Carpenter 1972, 1974, 1977). The best predictors of deterioration are indicators that deterioration has already occurred, such as reduction of affective range.

An unwarranted circularity in reasoning has helped maintain the view that depressive symptoms suggest a good outcome in patients with schizophrenia and related disorders. The chronically ill with blunted affect have usually been shown to remain ill. The converse, that signs or symptoms of depression or elevation of mood suggest a likelihood of recovery, has become part of accepted knowledge about the functional psychotic disorders (Torrey 1983; McGlashan 1986).

A major problem with this view is that the studies on which it is based, including the International Pilot Study of Schizophrenia (IPSS) (World Health Organisation 1979) used mixed groups of patients of recent onset and longer-standing disorder (Harrow & Grossman 1984). Vaillant (1978), for instance, reassessed...
10 years later the patients used in his 1964 publications of prognostic indicators in schizophrenia, by which time approximately 40% of the original sample of remitted schizophrenic patients showed a negative outcome. None of the prognostic variables allowed differentiation of schizophrenic patients who continued to show good outcome during the second interval from those who relapsed.

Two small prospective studies, of first admission (Gift et al. 1980) and recent onset (Carpenter et al. 1978) patients, have specifically attempted to delineate the prognostic value of affective symptoms in patients diagnosed as schizophrenic (including patients with both manic and depressive symptoms). Both reported that, contrary to the authors' expectations, affective symptoms had minimal prognostic value over two and five years respectively. Gift and colleagues (1980) noted, but did not elaborate upon, the finding that among their 35 first admission patients, those with high ratings of depression initially had lower quality of work functioning at follow-up.

The emphasis appears to have shifted in the recent studies from attempts to delineate the favourable influence of affective features in schizophrenia to the apparent unfavourable influence on outcome of mood-incongruent psychotic features, especially in a depressed patient (Maj 1985; Brockington et al. 1980).

Depression in other patients is known to be linked both to death from suicide and other unnatural causes, and to persisting social dysfunction. In patients diagnosed as schizophrenic, death and morbidity from unnatural causes are major risks (Herrman et al. 1983), and recent retrospective studies of suicide have, in fact, clearly linked suicide with depression (Roy 1986) and hopelessness (Drake & Cotton 1986), despite the apparent difficulties in predicting self-harm in these people.

Another line of study has placed emphasis on the unfavourable effects of depression on the course of schizophrenia, especially an association with poor outcome and relapse (Herz & Melville 1980; Mandel et al. 1982; Siris et al. 1984; Becker et al. 1985). Although these authors concentrate on what they see as depression complicating the course of schizophrenia, they do bring to attention the possible implications of the presence of depressive symptoms in the acutely psychotic individual.

Depressive symptoms have been recognised increasingly in the early and acute stages of schizophrenia, as diagnosed according to a variety of paradigms (Shanfield et al. 1970; Donlon et al. 1976; Knights & Hirsch 1981; Johnson 1981; Moller & Zerssen 1982; Strian et al. 1982; Siris et al. 1984; Sartorius et al. 1986). Much of the morbidity in samples of patients defined as chronically ill with schizophrenia has also been designated cross-sectionally as related to depression (Cheadle et al. 1978; Roy 1986); in two studies (Serban & Gidynski 1979; Glaser et al. 1981) depression apparently contributed most to overall social dysfunction. The latter authors called for further research to determine to what extent the patterns of social dysfunction would remain similar when chronic schizophrenic outpatients were treated effectively for depression. They and other workers (Weissman et al. 1978) comment on findings that depressive symptoms observed in chronic schizophrenic outpatients and in primary depressed patients are likely to be accompanied by similar patterns of social dysfunction. To date, there are no longitudinal studies of first admission patients to allow us to examine the role of depression or hopelessness in the development of chronic disability (Pogue-Geile & Harrow 1985).

The construct of negative symptoms, generally characterised by a loss of functioning (Lewine 1985), has come to play an important role in recent theorising about schizophrenia. Yet there are few data about either the longitudinal course or the prognostic value of negative symptoms (Andreasen & Olsen 1982; Pogue-Geile & Harrow 1985; Johnstone et al. 1986). Strauss (1985) has provocatively referred to negative symptoms as possibly being a form of demoralisation, but the relationship between such symptoms and depression remains unclear. Studies have produced conflicting results about the subjective experience of depression and the behavioural features of the 'negative state' (Carr 1983; Pogue-Geile & Harrow 1984). This touches on the heart of the debate about the nature of the 'core' symptoms of schizophrenia.

Although some theorists support the idea of a developing and persisting negative or deficit state in schizophrenia, social influences are well known to be crucial to the course and outcome. Studies on family influences (Brown et al. 1972; Vaughn & Leff 1976), the effects of milieu and social stimulation (Wing & Brown 1961), social class and prognosis (Gift et al. 1986) and economic fluctuation (Warner 1985) are examples. The expectations of others and patients' own attitudes to their illness.
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Disability and of suicide. If so, this has implications also for the way functional psychotic disorders are conceptualised and classified, and hence for future research strategies.

References


SINEQUAN*  
Abridged Product Information

INDICATIONS: Psychoneurotic disorders where anxiety and/or depression are prominent symptoms.  
CONTRAINDICATIONS: Hypersensitivity to the drug, Glaucoma or tendency to urinary retention.  
WARNINGS AND PRECAUTIONS: Safe use has not been established in human pregnancy or in children under 12 years. Possibility of potentiation if used with antidepressants, alcohol or antianxiety agents.  
Caution against driving a car or operating dangerous machinery.  
ADVERSE REACTIONS: Note. Some of the adverse reactions noted below have not been specifically reported with SINEQUAN. However, note similarities between tricyclics. Anticholinergic Effects: Dry mouth, blurred vision, constipation and urinary retention. Central Nervous System Effects: Drowsiness tends to disappear as therapy is continued. Other infrequently reported CNS side-effects are confusion, disorientation, hallucinations, paresthesias, ataxia and extrapyramidal symptoms. Cardiovascular: Occasional hypotension and tachycardia. Allergic: Skin rash, facial oedema, photosensitisation, pruritus, rare reports of bone marrow depression. Gastrointestinal: Nausea, vomiting, indigestion, taste disturbances, diarrhoea and anorexia (see anticholinergic effects). Endocrine: Altered libido, testicular swelling, gynaecomastia in males, enlargement of breasts and galactorrhoea in the female, fluctuating blood sugar levels. Other: Occasional dizziness, tinnitus, weight gain, sweating, chills, fatigue, weakness, flushing, jaundice and alopecia.  
DOSAGE AND ADMINISTRATION: Initial: 50 to 75mg daily. Usual maintenance dose: 75 mg - 150 mg daily, but may be increased to 300mg daily if necessary.  
PRESENTATION AND PACK: Capsules, 10mg 50s, 25mg 50s, Tablets, 50mg 50s (all blister packs).  
NHS Availability: General - 10mg and 25mg; 50, 2 repeats. Full product information available on request from the manufacturer.  
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HELEN HERRMAN, MD, MFCM(UK), FRANZCP  
Senior Lecturer,  
Monash University Department of  
Psychological Medicine,  
Royal Park Hospital,  
Private Bag 3,  
Parkville, Vic. 3052