

Schizophrenia with Depression: Causal or Coexistent?

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Summary: Fifty-one schizophrenic patients diagnosed using the New Haven Schizophrenic Index and 29 other patients who did not score enough on this index for a diagnosis of schizophrenia were studied for depressive symptoms using the Present State Examination. There was no significant difference in the frequency of depressive symptoms in the two groups.

The association of schizophrenia with depression has long been known (Bleuler, 1924; Hirsch, 1982). Several hypotheses have been advanced to explain this association. They can be conveniently divided into two main groups—the post-psychotic depression (PPD) (Mayer-Gross, 1920) and the schizo-affective disorder (Kasanin, 1933). The concept of PPD has been advanced to explain the sometimes observed high prevalence of depression in about 50 per cent of schizophrenic patients whose psychotic illness has abated and who are perhaps on maintenance therapy as well (Falloon *et al.*, 1978; Knights *et al.*, 1979; Johnson, 1981). Several possible reasons have been suggested to account for PPD—that it is a mode of reacting to a psychotic episode (Mayer-Gross, 1920); that it is related to high dose depot maintenance drugs (Johnson, 1981) and that it is related to extra-pyramidal side-effects (Ayd, 1975; Johnson, 1981). More recently, Johnson (1981) has found that 50 per cent of all first schizophrenic illnesses with no previous history of drugs had depression. His patients were assessed for depression within 48 hours of admission.

The concept of schizo-affective psychosis was advanced to explain the concurrent co-existence of schizophrenia and depression (Kasanin, 1933). So far four hypotheses have been advanced to explain its nosological status (Procci, 1976)—that it is a variant of schizophrenia; that it is a variant of affective disorder; that it is a third psychosis distinct from both schizophrenia and affective disorder, and lastly, that it is a group of psychoses that at first cannot be diagnosed and that eventually at follow-up are recognizable by the clinical picture, course and family studies as schizophrenia or affective disorder.

To date there is no research report that has specifically looked into schizophrenia co-existing with depression in the African setting. This study is an attempt to do so.

Method

A list was drawn up of all consecutive first ever admissions to the professorial unit of Mathari Hospital (the national psychiatric referral hospital admitting mainly psychotic patients—Ndeti, 1980). Out of this was picked those aged 15–65 and admitted for not less than seven days and not more than four weeks, and whose psychiatric illness was not complicated with a physical illness. Eighty patients were selected in this way. Informed consent to participate in the exercise was obtained.

Each patient was interviewed for New Haven Schizophrenic Index (NHSI) diagnostic criteria (Astrachan *et al.*, 1972). Without deciding which patients had scored adequate points for a diagnosis of schizophrenia, each patient was further interviewed for Present State Examination (PSE) (Wing *et al.*, 1974) to detect depressive symptoms occurring within the previous four weeks of the interview. Using the diagnostic rules laid down by the NHSI, the patients were divided into two groups—NHSI positive and NHSI negative. They were further analysed for the various depressive symptoms.

Results

The results are summarized in Fig 1. There is no difference in the overall frequency of depressive symptoms in either group. The symptoms were found in about 30 per cent of each group of patients.

Discussion

This study did not rely on clinical diagnosis of schizophrenia or affective illness but rather on research diagnostic criteria to pick the schizophrenic illness from consecutive admissions into acute psychiatric wards, based on active symptoms at the time of admission. The PSE was then used to pick depressive symptoms from both schizophrenic and

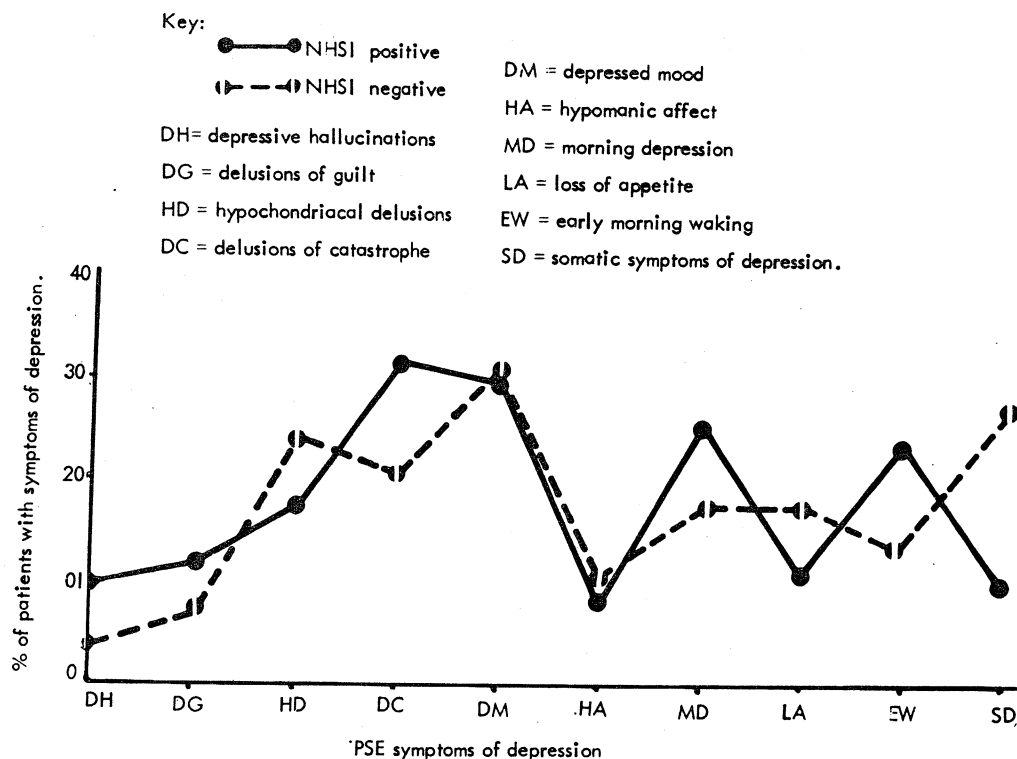


FIG 1.—Pattern of depressive symptoms in schizophrenic (NHSI positive) and non-schizophrenic (NHSI negative) patients.

non-schizophrenic patients included in the study considering their state in a period up to four weeks prior to the index interview. None of these patients was on depot phenothiazines and none had been on psychotropic chemotherapy for more than four weeks. It is unlikely, therefore, that the symptoms of depression were pharmacologically induced. Further, the type of depressive symptoms studied do not resemble the akinetic depression described by Van Putten and May (1948) as a symptom of drug-induced parkinsonism and characterized by mild akinesia with anergia and emotional withdrawal, usually associated with drowsiness.

There are two possible explanations for the co-existence of schizophrenia and depressive symptoms observed in this study. Firstly, depression occurred as a reaction to the occurrence of schizophrenic illness with returning whole or partial insight—this is not a very strong possibility as all the patients were still actively schizophrenic at the time of the PSE. Further, the NHSI negative patients had presumably more

insight into their illness than the NHSI positive patients, but did not necessarily have more depressive symptoms. More recently, Knights and Hirsch (1981) have shown in their study of symptoms of depression in schizophrenic patients that the depressive symptoms were more prevalent during the acute phase of schizophrenia, and that the symptoms decreased rather than increased with effective treatment of the schizophrenic illness.

The second and more likely possibility to account for the occurrence of depressive symptoms in the schizophrenic patients in this study is coincidence without connection, neither psychiatric state leading to the other. However, the exact nature of this co-existence is not clear.

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