CHAPTER 8: APPENDIX.

ADDENDUM A

DSM-IV diagnostic criteria for schizophrenia

A. Characteristic symptoms: Two or more of the following, each present for a significant portion of time during a one-month period:

- delusions
- hallucinations
- disorganised speech (eg, frequent derailment or incoherence)
- grossly disorganised or catatonic behaviour
- negative symptoms (i.e., affective flattening, alogia, or avolition).

Note: Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behaviour or thoughts, or two or more voices conversing with each other.

B. Social/occupational dysfunction: Since the onset of the disturbance, one or more major areas of functioning, such as work, interpersonal relations, or self-care, are markedly below the level previously achieved.

C. Duration: Continuous signs of the disturbance persist for at least six months. This six-month period must include at least one month of symptoms (or less if successfully treated) that meet Criterion A.

D. Exclusion of schizoaffective disorder and mood disorder with psychotic features.

E. Substance/general medical condition exclusion: the disturbance is not due to the direct physiological effects of a substance (eg, a drug of abuse, a medication) or a general medical condition.

F. Relationship to a pervasive developmental disorder: If there is a history of autistic disorder or another pervasive development disorder, the diagnosis of schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated).

(American Psychiatric Association. DSM-IV. Diagnostic and statistical manual of mental disorders. 4th ed. Washington: American Psychiatric Association, 1994: 273-315).

ADDENDUM B:

ICD 10 Criteria for Schizophrenia

Definition

The schizophrenic disorders are characterized in general by fundamental and characteristic distortions of thinking and perception, and by inappropriate or blunted affect. Clear consciousness and intellectual capacity are usually maintained, although certain cognitive deficits may evolve in the course of time. The disturbance involves the most basic functions that give the normal person a feeling of individuality, uniqueness, and self-direction. The most intimate thoughts, feelings, and acts are often felt to be known to or shared by others, and explanatory delusions may develop, to the effect that natural or supernatural forces are at work to influence the afflicted individual's thoughts and actions in ways that are often bizarre. The individual may see himself or herself as the pivot of all that happens. Hallucinations, especially auditory, are common and may comment on the individual's behaviour or thoughts. Perception is frequently disturbed in other ways: colours or sounds may seem unduly vivid or altered in quality, and irrelevant features of ordinary things may appear more important than the whole object or situation. Perplexity is also common early on and frequently leads to a belief that everyday situations possess a special, usually sinister, meaning intended uniquely for the individual. In the characteristic schizophrenic disturbance of thinking, peripheral and irrelevant features of a total concept, which are inhibited in normal directed mental activity, are brought to the fore and utilized in place of those that are relevant and appropriate to the situation. Thus thinking becomes vague, elliptical, and obscure, and its expression in speech sometimes incomprehensible. Breaks and interpolations in the train of thought are frequent, and thoughts may seem to be withdrawn by some outside agency. Mood is characteristically shallow, capricious, or incongruous. Ambivalence and disturbance of volition may appear as inertia, negativism, or stupor. Catatonia may be present. The onset may be acute, with seriously disturbed behaviour, or insidious, with a gradual development of odd ideas and conduct. The course of the disorder shows equally great variation and is by no means inevitably chronic or deteriorating (the course is specified by five-character categories). In a proportion of cases, which may vary in different cultures and populations, the outcome is complete, or nearly

complete, recovery. The sexes are approximately equally affected by the onset tends to be later in women.

Although no strictly pathognomonic symptoms can be identified, for practical purposes it is useful to divide the above symptoms into groups that have special importance for the diagnosis and often occur together, such as:

(a) thought echo, thought insertion or withdrawal, and thought broadcasting;

(b) Delusions of control, influence, or passivity, clearly referred to body or limb movements or specific thoughts, actions, or sensations; delusional perception;

(c) Hallucinatory voices giving a running commentary on the patient's behaviour, or discussing the patient among themselves, or other types of hallucinatory voices coming from some part of the body;

(d) persistent delusions of other kinds that are culturally inappropriate and completely impossible, such as religious or political identity, or superhuman powers and abilities (e.g. being able to control the weather, or being in communication with aliens from another world);

(e) Persistent hallucinations in any modality, when accompanied either by fleeting or half-formed delusions without clear affective content, or by persistent over-valued ideas, or when occurring every day for weeks or months on end;

(f) Breaks or interpolations in the train of thought, resulting in incoherence or irrelevant speech, or neologisms;

(g) Catatonic behaviour, such as excitement, posturing, or waxy flexibility, negativism, mutism, and stupor;

(h) "negative" symptoms such as marked apathy, paucity of speech, and blunting or incongruity of emotional responses, usually resulting in social withdrawal and

lowering of social performance; it must be clear that these are not due to depression or to neuroleptic medication;

(i) a significant and consistent change in the overall quality of some aspects of personal behaviour, manifest as loss of interest, aimlessness, idleness, a self-absorbed attitude, and social withdrawal.

Diagnostic Guidelines

The normal requirement for a diagnosis of schizophrenia is that a minimum of one very clear symptom (and usually two or more if less clear-cut) belonging to any one of the groups listed as (a) to (d) above, or symptoms from at least two of the groups referred to as (e) to (h), should have been clearly present for most of the time during a period of 1 month or more. Conditions meeting such symptomatic requirements but of duration less than 1 month (whether treated or not) should be diagnosed in the first instance as acute schizophrenia-like psychotic disorder and are classified as schizophrenia if the symptoms persist for longer periods.

Viewed retrospectively, it may be clear that a prodromal phase in which symptoms and behaviour, such as loss of interest in work, social activities, and personal appearance and hygiene, together with generalized anxiety and mild degrees of depression and preoccupation, preceded the onset of psychotic symptoms by weeks or even months. Because of the difficulty in timing onset, the 1-month duration criterion applies only to the specific symptoms listed above and not to any prodromal nonpsychotic phase.

The diagnosis of schizophrenia should not be made in the presence of extensive depressive or manic symptoms unless it is clear that schizophrenic symptoms antedated the affective disturbance. If both schizophrenic and affective symptoms develop together and are evenly balanced, the diagnosis of schizoaffective disorder should be made, even if the schizophrenic symptoms by themselves would have justified the diagnosis of schizophrenia. Schizophrenia should not be diagnosed in the presence of overt brain disease or during states of drug intoxication or withdrawal.

ADDENDUM C

HREC CLEARANCE

ADDENDUM D

POSTGRADUATE COMMITTEE LETTER OF APPROVAL

ADDENDUM E

DATA COLLECTION SHEET: SCHIZOPHRENIA RELAPSE IN A COMMUNITY MENTAL HEALTH SETTING.

Subject enrolment number_____

Age in years

_____

Gender

Male	1	
Female	2	

Marital status

Single	1	
Married	2	
Divorced / separated	3	
Widowed	4	
Unknown	5	

Important relationship/support system

Parents	1	
Siblings	2	
Other family	3	
Friends	4	
Unknown	5	

Highest level of education

None	1	
Grade 1-5	2	
Grade 6-9	3	
Grade 10–12	4	
Tertiary	5	
Unknown	6	

Source of income

Nil	1	
Employed	2	
State grant	3	
Family support	4	

Numbers of relapse

Nil	1	
1-2 Relapses	2	
3-4 Relapses	3	
> 4 Relapses	4	

Presence of a co-morbid psychiatric condition

Yes	1	
No	2	

Co-morbid psychiatric disorder

Personality disorder	1	
Mood features	2	
Suicidal ideation/attempt	3	
Unknown	4	

Presence of a co-morbid medical disorder

Yes Specify:	1	
No	2	
Unknown	3	

Presence of substance abuse

Yes	1	
No	2	
Unknown	3	

Substance Abuse

Cannabis	1	
Alcohol	2	
Other substances Specify:	3	
Unknown	4	

Poor Compliance

Yes	1	
No	2	
Unknown	3	

Reasons for non-compliance

Poor relation with staff	1	
Distance from clinic	2	
Side-effects	3	
Poor insight	4	
Unknown	5	

Life stressors less than six months prior to relapse

Death of spouse/close family/friend	1	
R/ship breakdown / conflict	2	
Major personal injury/illness	3	
Major financial change	4	
Other	5	
Unknown	6	