Schizophrenia traveler type

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DSM-IV-TR classifies schizophrenia in several types: disorganized, paranoid, catatonic, undifferentiated and residual. This classification is focused on the symptoms one could identify during an interview and puts less emphasis on the insight domain and discrepancies between the perception abnormalities when compared with abnormalities in thinking with and without substrate in reality. The DSM V does not include any types of schizophrenia. I suggest that it is important to take a closer look at an empirical observed phenomenon: traveler schizophrenia population. There are several ways to look at this phenomenon: i) there could be differences in insight earlier in the illness, partially leading to same discrepancies described in duration of untreated psychosis studies which in turn could lead to a worse or different prognosis; ii) the illness have a different course likely as result of excess in erroneous thinking, mainly a-posteriori and also a-priori constructs that lead to changes in behavior, such as extensive travel patterns. In a study, extensive travel history (more than two states), after the schizophrenia diagnosis, was documented in 28 of 74 patients with schizophrenia. Only nine patients from the 28 with an extensive travel history settled in this area, in the 4 year follow up, as documented in their medical records and by the repeated visits in the following years. The remaining 19 patients had an average of 1.2 visits to the hospital and for those patients that had more than one visit this occurred within 2 months of the initial contact. Six of the patients that remained in the area were offered boarding home services for an average of 11 months. In another study, we compared the clinical course of 17 patients with the first time diagnosis of schizophrenia to 50 patients admitted with a preexisting diagnosis of schizophrenia made an average of 8 years earlier. 53% of the control group moved from a different state before being treated at this facility. Only 14.2% of the study group came from other states. The frequent traveling was often secondary to persecutory, religious or grandiose delusions rather than in response to auditory hallucinations. Patients with an established diagnosis of schizophrenia demonstrated an increased travel pattern, often connected with their delusional symptoms, when compared with patients with a recent diagnosis of schizophrenia. This can introduce bias as the patients with schizophrenia with an increased traveling behavior are less likely to be included in longer term studies due to their travel pattern and exclusion criteria of the studies. However, when they are included, they are pooled with the rest of the group to which they enrolled. Also, this lead to lack of investigations to determine if they deserve a separate classification and is suggested that they have a worse prognosis. The removal of types of schizophrenia from the DSM V should not deter physicians from considering the prognostic value of individual presentation.

References