

# What primary care physicians need to know about people with schizophrenia

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Schizophrenia is an illness that attacks people as they first move into adolescence and adulthood, just at the time when they are starting their dreams of what they want their lives to be. It is a disorder that comes with a surprisingly high risk of mortality, from both suicide and medical illness. Even among health professionals, there are many misconceptions about schizophrenia, including the belief that there is invariably a downhill course to the illness. Actually, schizophrenia is an episodic illness, often with ups and downs, and a surprisingly large number of people affected by it are able to live independently, work at jobs they like, and have social relationships that are satisfying. Living with schizophrenia is never easy, but many people with this illness are able to live more complete and normal lives than is commonly believed.

**Overview of Schizophrenia**  
Schizophrenia has four major symptom clusters. Positive symptoms refer to hallucinations and delusions and are the most dramatic and apparent part of the illness, although they do not neces-

sarily cause the most impairment. Negative symptoms are what is lost as part of the illness, including spontaneity, motivation, and persistence. They are often more disabling than positive symptoms. People can work if they hear voices, but they cannot work if they are not motivated or cannot persevere on a task. Cognitive dysfunction, which includes verbal memory deficits—the ability to hear some piece of information and use it later—and executive function—the ability to think abstractly about what will be needed later—has been most studied and is most associated with disability. For example, grocery shopping requires that one think today about what one will want to eat tomorrow, what will go bad, what can be kept in the refrigerator, what is affordable, etc. The final symptom cluster is primary mood disturbance. Many people with schizophrenia are depressed, while some go through periods of manic-like energy. We used to think that this affective instability was a psychological reaction to life issues, but there is a growing belief that this may also be connected to the underlying biology of the illness.

While antipsychotic medication is a critical element of treatment for most people with schizophrenia, it is rarely enough. At most, 80% of people with schizophrenia respond

to medication, and even with medication, most will need some help learning and relearning skills and organizing their lives so that they do not become homeless or have other social disruptions, and will need psychological support. These psychosocial programs are as important as medication for most people trying to survive with this illness. It is even possible to actually teach people to pay less attention to their symptoms and to develop coping mechanisms to overcome symptoms that the medications do not completely eradicate. These modern psychological approaches are far different than the stereotyped psychoanalytic sessions on a couch, and have demonstrated effectiveness in research settings. The development of strategies to support families and teach them how to cope more effectively with their ill family members cannot be overemphasized. NAMI, the National Alliance for the Mentally Ill, started in Wisconsin more than 25 years ago, is an important resource for patients and their families trying to make sense of what is happening to them.

Primary care physicians will undoubtedly see people with schizophrenia as part of their practice. With a bit of common sense and a good dose of caring and respect, the care of people with schizophrenia is no different than the care of other patients.

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## Serious Medical Problems Are More Likely

People with schizophrenia are much more likely than the general population to have significant health risks including smoking, obesity, diabetes, poverty, poor medical care, and medical complications from psychotropic medication.

People with schizophrenia are MUCH more likely to smoke than the general population. There is speculation that this is related to abnormalities in the nicotinic receptors that may be connected to the illness. Obesity is rampant, in part from decreased activity and poor eating habits, but also because many of the newer and most commonly used antipsychotic medications directly cause significant weight gain. People with schizophrenia are more likely to have diabetes, in part because of the excess weight, but also potentially due to the illness itself. This was true even before the advent of newer medications that can also increase the likelihood of developing type II diabetes. These medications have also been associated with the rapid onset of keto-acidosis, even without significant weight gain.

Most people with major mental illness are poor, which also brings an array of health risks. Many people do not have any health insurance, which precludes access to any but emergency care. Other people with Medicaid find certain kinds of health care are less accessible. Even the cost of taking a bus to an appointment may be too great. For poor people who are working, taking off work for a doctor's appointment may be more difficult and could lead to decreased pay, which is generally not the case for those in more professional positions. Even when money is not an issue, people with major mental illnesses tend to seek less health care, and sometimes receive less-thorough health care.

It is known that people with schizophrenia have an increased morbidity and mortality in virtually every area of medical illness. They are more likely to develop cancer, heart disease, liver disease, or other serious conditions. They are much more likely to die at a younger age than other people in the same populations.

## Increased Likelihood of Drug and Alcohol Abuse

Substance abuse is a huge problem throughout our patient population. Various studies suggest that approximately 60% of people with schizophrenia living in the community probably have some degree of problem with drugs or alcohol. From a medical perspective, alcohol is clearly the biggest concern. Heavy alcohol use is associated with potential damage to every organ system in the body. It is also associated with more behavioral instability. Every patient should have an alcohol and other drug abuse screen. The following CAGE questions are one fast and easy way to screen:

Have you ever felt the need to Cut down on drinking?

Have you ever felt Annoyed by criticisms of drinking?

Have you ever had Guilty feelings about drinking?

Have you ever taken a morning Eye opener?

One can also ask how much the person drinks, then ask the last time the person used any alcohol, had a beer or a glass of wine, and then ask about the time before that. If the person does not "drink much" but had two 6 packs last night and one 6 pack the night before, it gives additional information about the extent of the alcohol use.

While people with schizophrenia may use all of the most commonly abused drugs, the use of ephedrine or pseudoephedrine in

huge quantities seems more common in this population. Bottles of over-the-counter pills are sometimes consumed daily. Physicians can ask about caffeine consumption. Large amounts of caffeine—not just pots of coffee but bottles of caffeine pills—are sometimes ingested. Finally, given its prevalence, smoking should be addressed whenever possible.

## Threat of Danger

There is a perception, spread by media accounts and often-repeated stories, that people with schizophrenia are dangerous. In reality, people with schizophrenia are much more likely to be the victims of violence than the perpetrators. People who are under 25 or male are more likely to be violent than someone older or female. We also know that people who have been violent in the past are more likely to be violent in the future. This is true of all people. It is also clear that people who abuse drugs or alcohol are much more likely to be violent. People with schizophrenia who are untreated and symptomatic are slightly more likely to be violent than others the same age and gender. However, a person with schizophrenia who is untreated and symptomatic, and who also abuses drugs or alcohol is significantly more likely to be violent than the substance abuser without schizophrenia. There appears to be an interaction between the substance abuse and the schizophrenia that increases risk. There should be caution about the risk of violence whenever one is dealing with someone who is a substance abuser, and schizophrenia adds to this concern.

Specific situations should also lead to increased concern. If a patient believes that someone has caused him or her harm, or if the patient threatens to hurt someone, it must be taken seriously. It is un-

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clear if command hallucinations—voices that tell the patient to hurt someone—are associated with actual increased violence, but certainly they should be taken seriously. A patient who has a delusional belief that he or she is in a romantic or intimate relationship with someone may be at risk of perpetrating violence on that person when the relationship is denied. This is not the patient who talks about loving someone, but the patient who says they are married to a specific person or that they are the real father or mother of this person's child. There is a clinical literature that such eroticized psychotic beliefs may be associated with violence, just as anyone might be predisposed to violence if their spouse denied the reality of their relationship. However, these situations, while dramatic, are rare.

#### Suicide

Suicide is a major concern when working with people with schizophrenia. At times, it is even more difficult to assess suicide potential in someone with schizophrenia than in other high-risk people. The suicide often seems to occur fairly early in the course of the illness, frequently with the more bright and intact patients who would be likely to do well. At other times, the suicide occurs without warning. While the common concerns about depression, hopelessness, thoughts of death and suicide should be assessed, they do not always provide a good prediction of risk. Primary care physicians should be aware of this high risk, and if there are concerns should discuss the patient with other mental health staff working with this patient.

#### Medical Symptom vs. Somatization

Somatization symptoms with no clear organic cause are common

throughout medicine, and are no more common in people with schizophrenia. When people with schizophrenia do have a somatization delusion, it is usually clear. One of my patients believed that bugs were crawling up and down inside her skin. She refused to see me or any other psychiatrist, because this was a medical problem with bugs. She eventually went to a dermatologist who called me and agreed to prescribe an antipsychotic medication with the goal of making the bugs less uncomfortable for her. She took it and it worked, and over time we in the mental health system were able to reestablish a treatment relationship with her. Many people with anxiety disorders, especially panic attacks or depression, are more likely to have somatic symptoms that are difficult to distinguish from organic illness. This is much less common in people with schizophrenia.

It is somewhat more common for someone with schizophrenia to be convinced that they have a medical condition that would explain their psychiatric difficulty. Again, this is no different than other patients who may have similar beliefs. Working with the person's psychiatrist and therapist and/or case manager may help determine management strategies for these concerns.

#### People with Schizophrenia are People

With all serious and chronic illness, we sometimes get so focused on the illness that we stop paying attention to the person. This is particularly true of mental illness—even more so of people with schizophrenia. People with schizophrenia want the same things other people want from their physician: to make them feel better when they are sick, to stop the pain when they hurt, and to find a treatment for their medical complaints. Above all, they

want their physician to really listen to them and to get the sense that their complaints are being taken seriously. This is true regardless of current psychotic symptoms or lack thereof. The issue for the primary care physician is to be a respectful and empathetic listener providing medical care, which is easier when the patient presents with a well-organized complaint that lends itself to focused medical investigation or treatment. It is more difficult when the request appears based on beliefs that seem delusional. The reality is that physicians often see patients with health concerns that have no identifiable biological cause. Since the beginning, physicians have listened, tried to determine what part of the complaint fits within their area of expertise, examined the patient both to collect data and to demonstrate that they take the patient seriously, and provided large doses of reassurance when indicated. People with schizophrenia are much the same as all of the other patients whose complaints do not seem to be connected to biological pathology.

There are times when someone with schizophrenia will have a complaint directly related to his or her psychiatric illness. An example is the patient who wanted a neurosurgeon to operate to take out the computer chip that was controlling him. However, it is actually quite rare that people with schizophrenia come to see a physician based on a purely delusional concern. It is extremely important to continue to be respectful of both the patient and his or her complaint. This should be obvious for all patients, but people continue to stigmatize patients with schizophrenia, roll their eyes about bizarre behavior, make jokes that support stereotypes, and behave disrespectfully. The attitude of the receptionist or nurse who refers to people with

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schizophrenia despairingly, or who comments to another staff “look at how that one is dressed” or “this one is a real nut” will be communicated to the rest of the staff and to the patient. We are sensitive about these kinds of attitude issues concerning race and religion, but we tend to be less sensitive to these same issues when they are directed at people with mental illness.

### Agree With What One Can Agree With Honestly

It is often confusing to know how to get into a respectful and positive relationship with someone who believes things that are clearly erroneous. When a patient says that the police have put a chip into his head to control his activities, should one pretend to agree with the delusion or point out the absurdity of it? The answer is neither. It will work best if the physician agrees with things that he or she can honestly agree with, and tries to just let go of the other things. For example, this patient might continue and say how terrible it feels to be controlled all the time, how much he would like to be able to work but feels unable to do so, and feels that his lack of money and car really interfere with living a normal life. These are all statements that any of us could empathize and agree with. Rarely will a patient push us to confrontation, and even then one can respond respectfully and honestly. “I see no evidence that such a chip was implanted, and I have never heard of such a chip in any of the medical literature. I realize that you feel controlled by something in your head and it must feel terrible. What have you tried to do to be back in control of yourself?”

### Dealing with Medical Appointments

There are a few things to think about in communicating with peo-

ple who might appear odd or disorganized, whether they have a diagnosis of mental illness or not. Some people take longer to respond to questions than others. This can occur for cultural reasons or because the person is distracted. Some people get confused by rapidly fired, multi-part questions. If the patient appears to be having trouble, slow down, simplify questions, and make sure your questions only require single-part answers. At times, patients may wander off on tangents or appear disorganized. It is appropriate to keep a patient focused on the primary complaint or reason for the visit.

Even so, the medical appointment may take more time. Communication may be odd, with tangents to topics that may have little to do with medical concerns. At other times, the medical concerns may be difficult to understand. The statement “I’m not allowed to eat” may be an expression of a delusion of control, or it may also be an odd expression of pain on eating, nausea, or loss of appetite. Patients may be concerned about how information will be used, or whether you really believe the condition is medical. One patient with a long psychiatric history has well-documented liver disease with many complications, but continues to fret that all of her doctors just think it is psychosomatic or that she is making up her obvious pitting edema.

The person’s own anxiety may get in the way. Some years ago, a man with schizophrenia died after he presented to a local ER with stomach pain. He did not appear to be in significant distress, his complaints were not overwhelming, and after what appeared to be adequate triage he was asked to wait. He became anxious in the waiting room and left, to die that night of a ruptured bowel. On review, it did not appear that any obvious mis-

takes were made, but one wonders if a different level of sensitivity could have led to a different outcome.

### Obtaining Symptom Descriptions and Medical History

Involving collateral contacts—inviting family or friends in with the patient’s permission to help provide the history and to ensure that your comments are understood—can be extremely useful. Similarly, involving the mental health clinicians who may be working with the patient is often critical in obtaining both a good history and good follow-through. While physicians often think of contacting the patient’s psychiatrist, a mental health case manager, if available, is likely to know the patient much better and have more frequent contact than the psychiatrist. But often, the case manager is intimidated about calling into a medical office to provide information or make suggestions about what medical treatment is possible, and what simply will not be able to be followed. At the same time, primary care physicians often do not think of case managers as an ally in ensuring that patients follow through with needed medical treatments.

### Importance of Coordinating Physical and Psychiatric Treatment

People with schizophrenia often have disabilities that touch many areas of their lives. There is no clear demarcation between the medical and the non-medical. Treatment of the patient’s diabetes, high blood pressure, or arthritis will be more effective if coordinated with mental health services. At the same time, an exacerbation of a chronic condition will be more easily understood if the physician is aware that the

patient just started a new job or is dealing with the illness of a parent who has been an important caregiver. Again, this is true for most patients, but people with schizophrenia may have more difficulty articulating these connections and may respond more idiosyncratically to the stress that comes with change. It is also important to note that the non-medical mental health staff may be uncomfortable calling the physician, just as a physician may find it easier to call another physician than a social worker.

We are socialized in very different ways depending on our training. When physicians talk to each other, patient information is typically condensed down to only the most relevant information relating to the decision at hand. Social workers are trained to consider the complexity and richness of a person's life. As a result, when a physician and social worker talk, the physician may feel that the social worker is a disorganized fuzzy thinker who cannot get to the point, while the social worker often feels that the physician is cold and

unfeeling and does not know the patient well. We need to understand these cultural differences and work to integrate both approaches in the treatment of people with schizophrenia.

#### The Role of Wellness and Prevention

Because of the risks already discussed, people with schizophrenia are at significantly increased risk of increased morbidity and mortality. It is crucial to stress issues of wellness. Encouraging people to exercise regularly, attempting to engage them in smoking cessation programs, and referring them to a dietician are all activities that too often we do not think of with patients who have schizophrenia. Like other patients, the suggestion may not be taken the first or second or third time. But when made supportively and respectfully, such suggestions can engender hope that "my doctor thinks I can do something more." Allowing for the hope and possibility that this person's life can get better, and supporting the idea that the patient can take a

more active role in their own wellness can help both their physical and mental health. Physicians are important people in the lives of patients, and even a few minutes spent reinforcing these kinds of wellness activities can significantly change the lives of some patients.

#### Conclusion

Patients with schizophrenia are just like other patients, except they are more likely to be medically ill, poor, and have a greater struggle seeing the doctor and explaining what they feel is wrong. They often come with a support system, such as family, friends, or someone from the mental health system. These people will be a critical element in allowing physicians to be effective in medical interventions. Physicians should remember that people with schizophrenia are people whose lives can be whole and complete, despite the added struggle of dealing with a terrible and often disabling illness.



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