

EDITORIAL

Schizophrenia revisited

Robin G. McCreadie

It is now four years since I wrote an editorial in *APT* introducing a series of articles about schizophrenia (McCreadie, 2000). At that time subjects that we thought were topical were schizophrenia in adolescence (Hollis, 2000), the detection of early relapse (Birchwood *et al.*, 2000), cognitive impairment (O'Carroll, 2000), depression in schizophrenia (Mulholland & Cooper, 2000), the role of the community psychiatric nurse (Gournay, 2000), the person with schizophrenia in conditions of high security (Thomson, 2000), smoking habits (Kelly & McCreadie, 2000) and assessment of drug-related movement disorders (Gervin & Barnes, 2000). Many of these articles remain topical and are worth a return visit. Although little on schizophrenia has appeared in *APT* since, there have been a number of important developments. A new *APT* series 'Schizophrenia revisited', which begins in this issue with Stuart Leask's article on environmental influences, will address some of these.

Aetiological factors

The search for aetiological factors in schizophrenia continues. Both environmental and genetic factors excite much interest, but many studies are not replicated. In recent years, however, a number of environmental factors do appear to be of relevance: season of birth, geography of birth, urbanisation, immigration and substance use, as well as maternal factors such as prenatal influenza, famine and other stresses, and obstetric complications. The evidence for these putative factors is critically assessed by Stuart Leask in the current issue (Leask, 2004).

The NICE clinical guideline

The National Institute for Clinical Excellence clinical guideline for schizophrenia was

launched in December 2002 (National Institute for Clinical Excellence, 2002). Although it received a generally warm welcome, it contained little on how it should be implemented. As Paul Rowlands will point out in the next issue of *APT* (Rowlands, 2004, in press), distribution of a guideline is not implementation: more needs to be done. Successful implementation will require collaborative working between managers, clinicians and service users. The guideline is extremely ambitious and it must be recognised that in some areas resource deficiencies might present insurmountable obstacles.

Applications of neuroimaging

There has been an explosion of interest in the research community regarding neuroimaging in schizophrenia and other psychiatric disorders; indeed, there are journals totally devoted to this topic. However, much of the research remains just that: research. What, if any, are the implications of the findings for clinicians? Should we be scanning patients with first-episode schizophrenia? And if so, why? These and other issues will be explored.

Cognitive impairment

As I have already mentioned, in the 2000 series of articles cognitive impairment was discussed. We make no apology for returning to this topic. It is now recognised that cognitive impairment is a core feature of schizophrenic illness, and much of the inability of an individual with schizophrenia to cope successfully in the community is due to such deficits. Cognitive deficits can be detected early in the illness; the role of cognitive remediation in first-episode schizophrenia will be reviewed.

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Early intervention

First-episode schizophrenia is also addressed in an article on early intervention. There is still vigorous debate about the value of such intervention, but whatever its merits it is likely to be practised for some considerable time. 'Early intervention' means different things to different people, and there are at least three currently accepted definitions and three different models of care. An article on this topic will emphasise that there is more to early intervention than simply intervening early: it also requires the intervention to be effective.

Lifestyle issues

At any given time the vast majority of people with schizophrenia are not in hospital, but are living in the community. Their illness forms just one part of their lives. However, many of their lifestyle 'choices' predispose them to poor physical health and comorbid medical disease. Many people with schizophrenia die prematurely. Opportunities to modify lifestyle and risk factors such as weight gain and obesity will be described.

Finally, it is well known that sexual dysfunction is common in both men and women with schizophrenia. The illness itself and antipsychotic and other medications are contributing factors. The evidence

regarding the sexual function and behaviour of people with schizophrenia will be presented, and the implications for clinical practice described.

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