

BRIEF COMMUNICATION

LACK OF COMPLAINTS IN SCHIZOPHRENICS WITH TARDIVE DYSKINESIA

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Eighteen of a population of 518 outpatients were found to fulfill diagnostic criteria for tardive dyskinesia. None of these patients complained to their therapists of their symptoms, and eight of them were not even aware of them. Five of the unaware patients were actively delusional or hallucinating. Since all eighteen were chronic schizophrenics on neuroleptics, these findings suggest that this group may not report their symptoms. The findings are important because early diagnosis of tardive dyskinesia allows more chance for intervention with satisfactory results.

The diagnosis of tardive dyskinesia is based on history and clinical observation. Despite the relative ease of making the diagnosis, a large variation exists in the reported prevalence of the syndrome, ranging from 5 to 50 per cent of the psychiatric population. This variation may be a result of differences in the criteria for the diagnosis of the syndrome (7), in the sampling procedure, or in the methods used (2, 4).

In our outpatient population, we noticed that tardive dyskinesia occasionally escaped diagnosis. We observed that our patients did not complain of their motor disorders and many were not even aware of them. The lack of complaints could possibly be one of the reasons for delaying the diagnosis and might account in part for the variation in the prevalence of tardive dyskinesia.

In this paper we shall seek to establish what proportions of patients with tardive dyskinesia do not complain about their symptoms and to understand the reasons for this.

Methods

Our patient sample was comprised of all 518 patients seen in a Community Mental Health Center (CMHC) in Newark, New Jersey over a predetermined 6-month period. This area is populated mainly by working-class blacks. Any patient who had the slightest nonpurposeful movements of the mouth, face, trunk, or extremities was referred for a diagnostic examination for tardive dyskinesia. These patients were evaluated according to a predetermined protocol by two psychiatrists. Each patient was interviewed by one of the

psychiatrists while the other listened and observed from a remote corner of the room. Neither psychiatrist was visible to the other.

The diagnosis of tardive dyskinesia was made on the basis of two criteria: that the patient had been on neuroleptics for longer than 1 year; and that the clinical picture consisted of the "bucco-linguo-masticatory triad" (BLM) which is characterized by persistent involuntary sucking and smacking movements of the lips, lateral jaw movements and tongue movements described as thrust, roll, or fly-catching. The BLM triad may or may not be accompanied by purposeless involuntary quick movements of the extremities (1). We excluded patients with Huntington's chorea, Sydenham's chorea, congenital torsion dystonias, hysteria, stereotypes, and mannerisms. This differential was made on the basis of history, family history, and the clinical appearance of the syndrome. One patient was not included because the family history was suggestive of Huntington's chorea.

The intensity of the syndrome was rated exclusively on the basis of motor disorders of the orofacial area according to a 4-point scale: 1, mild; 2, moderate; 3, moderately severe; 4, very severe.

The patients diagnosed as having tardive dyskinesia were interviewed a second time under the same conditions according to another predetermined protocol. The interviewer was allowed to ask certain questions or rephrase the questions of the protocol so as to establish that the patients understood him. This interview included information on whether patients were aware of their disorder or had complained of it to their therapists. Finally, a mental status examination was performed with particular attention to the presence or absence of active delusions or hallucinations.

The statistic used to assess inter-rater reliability

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TABLE I
Demographic and Clinical Characteristics of Tardive Dyskinesia Patients

Case	Sex	Age	Duration of Psychiatric Illness years	Duration of Neuroleptic Treatment years	No. of Psychiatric Hospitalizations	Duration of Tardive Dyskinesia years
1	F	37	25	14	5	3
2	F	69	12	9	0	0.5
3	F	60	17	17	1	4
4	M	58	21	20	3	0.5
5	F	43	23	16	3	3
6	F	56	36	20	6	6
7	F	39	20	19	4	4.5
8	F	33	8	8	3	1
9	F	54	21	19	5	2
10	F	71	30	11	5	4
11	M	35	19	19	10	4
12	F	44	18	16	3	3.5
13	M	58	18	18	2	0.5
14	F	41	23	18	5	0.5
15	F	50	4	4	2	3
16	M	24	4	4	1	0.5
17	F	54	9	7	2	1
18	F	35	18	17	5	0.9
		Mean: 47.8 Range: 24-71	Mean: 18.1 Range: 4-36	Mean: 14.2 Range: 4-24	Mean: 3.5 Range: 0-10	Mean: 2.4 Range: 0.5-6

was Cohen's kappa (3). This method has the advantage of taking into account the occurrence of agreement by chance (8, 9).

Results

Of the 518 patients seen in the CMHC, 96 were noted to have some nonpurposeful movements and were referred for diagnostic interview. Eighteen were identified as having tardive dyskinesia (Table 1). The prevalence of the disorder in our sample was 3.5 per cent, the age of onset 45.5 years, and the male to female ratio was 1:3.5. Four of the 18 patients had mild choreiform movements of the fingers, but these patients had by far more severe hyperkinesias in the tongue and mouth; so our decision to consider only movements of the orofacial area did not influence our rating of the intensity of the syndrome.

None of the 18 patients with tardive dyskinesia had complained to their therapists as evidenced by the therapists' reports and the review of charts. Eight of the 18 patients had discussed their symptoms with their family or friends but had not reported them to their therapists. Eight patients were unaware of their symptoms. Lack of complaints and awareness did not correlate with the intensity of symptoms. The majority of unaware patients (five out of eight) were actively delusional or hallucinating. Only one out of the 10 aware patients was actively delusional. All aware patients had explanations concerning their hyperkinesias

which seemed to obviate the need for medical attention. For the above observations: lack of complaint ($\kappa = 1$), lack of awareness of hyperkinesias ($\kappa = 1$), active hallucinations or delusions ($\kappa = 1$), rates of intensity of syndrome ($\kappa = .77$), the inter-rater agreement was very high.

Discussion

The prevalence of tardive dyskinesia in our sample population, as well as the age and sex distribution were similar to those reported by others (6, 10). Our findings suggest that outpatient schizophrenics on chronic phenothiazine treatment who develop tardive dyskinesia frequently do not report their symptoms. Clinicians should be aware of this observation and look specifically for the syndrome in this population since early diagnosis allows therapeutic intervention with rather satisfactory results (5, 10). Eight of the patients were not even aware of their symptoms. Five of these unaware patients were actively delusional or hallucinating. Actively psychotic schizophrenics seemed less likely to complain and one should be especially alert to look for tardive dyskinesia symptoms in this group.

Our use of a diagnostic criterion which required that each patient should have been on neuroleptics for a year may have skewed our sample toward chronic schizophrenics. A question for further research is to determine whether the same responses are obtain-

patients from other socioeconomic classes and different psychiatric diagnoses.

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