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SECTION 20. Medicine.

THE STRUCTURE OF PSYCHOPATHOLOGICAL DISORDERS IN PATIENTS WITH POST-SCHIZOPHRENIC DEPRESSION

Abstract: *The psychopathological structure and clinical essence of post-schizophrenic depression in the dynamics of the main schizophrenic disease were determined. The study revealed dissociation between the minor severity of the actual depressive symptoms and subjective patients ' perception of their condition as painful, duration and resistance to ongoing drug therapy.*

Key words: *paranoid schizophrenia, post-schizophrenic depression, psychopathological disorders.*

Language: *English*

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Introduction

In recent years, there has been an increase in the number of depressive disorders both in the population as a whole and among patients undergoing treatment in psychiatric institutions [3, p.34; 4, p. 497; 5, p. 74]. The problem of post-schizophrenic depression is now becoming important [7, p. 295; 10, p. 230; 11, p. 25]. The volume and content of post-schizophrenic depression as an independent diagnostic category both psychopathologically and clinically remain unclear, and their nosological assessment is debatable [1, p. 26; 8, p. 23]. The resolution of these issues is closely connected with the clarification of clinical and psychopathological content of schizophrenia as a nosological unit and improvement of its systematics [2, p. 280; 13, p. 422]. According to different authors, the prevalence of depression among patients with schizophrenia ranges from 25-30% [12, p. 208; 14, p. 38]. It was found that they are associated with such indicators of prognosis as increased suicidal risk, a high probability of recurrence of acute psychotic state, as well as a decrease in adaptive capacity and a lower level of social functioning [6, p. 769; 9, p. 8; 15, p. 431].

The aim of the study was to investigate of psychopathological structure and clinical features of post-schizophrenic depression to determine their place in the dynamics of the main schizophrenic disease.

Material and methods:

The study examined 38 patients with episodic paranoid schizophrenia, who were diagnosed with post-schizophrenic depression during the examination. This depressive condition developed in patients with post-onset schizophrenia and met the diagnostic criteria of "post-schizophrenic depression" (F20.4 MKB-10). In the picture post-schizophrenic depression some schizophrenic symptoms persisted, but leading patients remained depressive disorders that met the description of the depressive episode (F32.) and observed for at least two weeks with post-schizophrenic depression. The average age of the examined persons was 36.1±1.0 years in the whole sample, including 37.5±1.2 years for women and 32.9±1.8 years for men. The maximum number of cases was detected among the age groups 30-39 years and 40-49 years. The study was conducted by clinical-psychopathological and clinical follow-up methods. For a standardized assessment of post-schizophrenic depression conditions, their structures were used psychometric methods of analysis-a scale for assessing Hamilton depression (HAMD) (21 signs) and a subsection of the scale of positive and negative symptoms (PANSS), containing 7 signs of negative disorders.

Results and discussion:

Revealed in the course of research psychopathological features of post-schizophrenic depression, distinguishing these States from the "classical" endogenous depression, manifested in varying degrees of depression. The specificity of the depressive symptoms of post-schizophrenic depression itself was expressed primarily in their incompleteness or, conversely, in their hypertrophy, or coloration of their properties of other disorders. For post-schizophrenic depression characteristic was the sterility of the thymic component, signs of vitality and daily rhythm, the prevalence of apathy, indifference and dysphoric mood. In the clinic of post-schizophrenic depression with the greatest constancy there were motor disorders, which were characterized by either adynamic or asthenic coloration. The manifestations of ideational disorders ranged from a decrease of intellectual productivity, reduce concentration of attention to a distinct thought disorder with elements of depersonalization. Symptoms such as anhedonia, anergia, emotional indifference, social isolation, apathy, thought disorder in some cases, by their nature, were derived depression and their legitimacy was viewed as "secondary" negative disorders (W.Ca pente, 1988), others had more of a primary (deficit) character and were caused by the underlying disease - schizophrenia. In the structure of post-schizophrenic depression, there was a combination of symptoms of depression with schizophrenic disease-related residual psychotic and varying degrees of negative (deficit) disorders. There was a slight dissociation between the severity of the actual depressive symptoms (HAMD scale indices) and subjective patients ' perception of their condition as painful, duration and resistance to ongoing drug therapy.

The average age of the manifestation of episodic paranoid schizophrenia in the sample as a whole was 30.5±1.0 years; somewhat earlier the disease was manifested in men (26.5±1.7 years) than in women (32.2±1.2 years). In this group, hallucinator-paranoid syndrome (75.7%) was detected most often in the clinic of the initial period of the disease. This syndrome was characterized by delusions of physical and mental pressure, mental automatisms, auditory and visual pseudohallucinations. In other cases, in the clinical picture of the manifest attack there were: depressive-delusional syndrome - in 16.5% of cases, delusional — in 6.8 %, polymorphic — in 1.0% of cases.

The study of the typology of depressive syndrome revealed 6 variants, among which apathetic (50,5%, $p<0,001$) prevailed reliably; further in descending order of frequency the following variants were found: alarming (19,4%), simple depression (11,7%), asthenic (8,7%), adynamic (6,8 %) and dysphoric (2,9 %). The average score on the scale of Hamilton's depression was: in women — 18,1±0,9 points, in men -17,8±2,9 points. Significantly more often (68.9 %, $p<0.001$), the symptoms were consistent with moderate depression; severe depression - in 27.2% of cases, mild depression - in 3.9 %.

The study of the clinical picture of post-schizophrenic depression showed that manifestations of "classical" depression were not typical: significantly more often (77.7%, $p<0.001$) atypical syndromes were detected. The sterility of the hypothymical component of depression (38.8%) was manifested by a weak representation of vital disorders, poverty of emotional manifestations, lack of external tension, which did not correspond to the relevance of internal experiences of depression, despair and reflected the discrepancy between the internal (cognitive) and external (behavioral) aspects of the depression syndrome.

The sterility of only the associative component of the triad was manifested in 3.9% of cases and was expressed in the absence of ideatory inhibition. Non-expression of only the motor component of the depressive triad was revealed in 3.9% of cases; it was manifested by the lack of depressive expressiveness in movements, facial expressions, posture. Non-expression of two or three components of a depressive triad simultaneously was detected in 31.1% of cases. In the structure of depressive syndrome, optional symptoms of depression were present in 74.8% of cases ($p<0.001$) in the form of residual delusional experiences (14.6%), hallucinatory symptoms (7.8%), hypochondrial and psychopathic (4.9%), obsessive-phobic and depersonalization (3.9%) and a combination of symptoms of different registers (35.0%). The symptoms recorded using the PANSS scale were presented in the sample as follows: the overall level of positive symptoms "below average"; the negative symptoms reached the level of "average", the general symptoms were "slightly above average". The cluster of depression ($p<0.01$) was at the level of "above average".

The study of negative disorders in patients of the main group showed their presence in all three areas. In the emotional sphere, they reached the level of grade I-II; the analysis of quantitative and qualitative relations showed the predominance of symptoms of "distortion", equivalent to mixed symptoms and symptoms of "loss". Only in 2 (1.9 %) patients negative disorders were equitably pronounced. In the study there was a decline of interest in various aspects of life, difficulties in relationships with others and interpersonal contacts, frequent feeling of inner emotional discomfort, emptiness and failure, irritability towards others, episodes of unreasonable anger.

Objectively revealed poverty facial expressions and gestures, formality in communication, external limitations in the depth of emotional experiences, lack of emotional resonance even when

communicating with loved ones and significant people; inadequacy and grotesque emotions sometimes replaced the mask of indifference. Sometimes emotional failure was manifested by lability, immaturity. In the strong-willed sphere of patients the predominance of symptoms of "loss" reaching I - II rank, appearing in weakness, fatigue, poor portability of former loadings, decrease in volitional activity and productivity due to the volume and quality of the performed functions, is more rare- in reduction of power potential was revealed. In connection with these features, there was a need for external stimulation. The symptoms of "distortion" in the volitional sphere of the patients were found more rarely; they are manifested in motor disorders (disorders of plastics, motor stereotypies, mannerisms), changing patterns of food consumption and sexual activity, etc. In the associative sphere in patients was dominated by changes in I-II grade, almost half of the cases (47,6 %) manifesting symptoms of "distortion" (difficulty and distortion in a personal self-assessment, assessment of the situation, the weakness of internal or external criteria in the cognitive process, the orientation only to the internal criteria).

The study of the ratio of quantitative and qualitative signs in the given spheres revealed the predominance of symptoms of "distortion" in the emotional (42.7%) and associative (47.6%) spheres; symptoms of "loss" (58.3%) prevailed in the volitional sphere.

In the dynamics of the disease, in addition to the growth of negative symptoms, there was a change in the structure of psychological defense mechanisms with a predominance of earlier protections: splitting, in which all external objects were divided into "absolutely good" and "absolutely bad", with sudden transitions from one extreme to another.

In the study of the ratio of post-schizophrenic depression stage schizophrenic process revealed the following distribution: in the anamnesis 1 psychotic attack-61.2% ($p<0.01$), 2 attacks – 14.6%, 3 attacks – 13.0%, 4 attacks – 7.8%, 5 attacks – 1.0%, 7 attacks – 1.0%, 10 attacks – 1.0%.

In the study of the ratio of prescription disease to post-schizophrenic depression, it was revealed that post-schizophrenic depression (80.6%, $p<0.001$) was reliably more often diagnosed in the first decade of episodic paranoid schizophrenia. The average duration from the moment of manifestation to the onset of symptoms of post-schizophrenic depression was 5.6±1.0 years. In 33.0% of cases, signs of post-schizophrenic depression have already taken place in the anamnesis.

The most frequent trigger mechanisms post-schizophrenic depression were mixed (46.6%) and jet-personality (42.7%). In the context of the personality-reactive hypothesis, post-schizophrenic depression was seen as a psychological response to the fact of schizophrenia disease, as its social and psychological consequences progressed, negative emotional experience accumulated, a sense of inferiority, dissatisfaction with oneself and life, self-esteem decreased, despair and hopelessness arose. If reconciliation with the changes did not occur, the depressive position gradually supplanted the ability to perceive life positively.

Consideration of the dynamic characteristics of post-schizophrenic depression showed that the average duration of all newly diagnosed post-schizophrenic depression was 9.9±1.4 weeks, significantly more often (53.4%, $p<0.05$) they developed as an independent affective attack; post-psychotic depression was recorded in 37.9% of cases. In most cases (79.6%, $p<0.01$) post-schizophrenic depression proceeded recursively; thus dynamics "by cliche type" (52.4%, $p<0.01$) was reliably observed more often. Recurrence of depressive symptoms occurred both under the influence of psychogenic and somatogenic hazards and autochthonous.

Conclusions:

Post-schizophrenic depression was significantly more common in the presence of 1-4 psychotic episodes in the anamnesis (97.1%) and the state of the disease with episodic paranoid schizophrenia up to 10 years (80.6%). Clinical manifestations of post-schizophrenic depression significantly more often (68.9%, $p<0.001$) correspond to moderate severity of the disorder; severe depression observed in 27.2 %, mild depression - in 3.9%. The average duration of the first detected depressive episode was 9.9±1.4 weeks. In 79.6% of cases ($p<0.01$) post-schizophrenic depression was recurrent.

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