Psychoses:
– diagnoses/characteristics

ANHEDONIA, SCHIZOPHRENIC SYMPTOMS AND DEFICIT SYNDROME IN SCHIZOPHRENIA.

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Anhedonia may predispose to schizophrenia and could be a trait of schizophrenia. Therefore, anhedonia would be independent of deficit syndrome and other schizophrenic symptoms (negative, positive, general and depressive symptoms).

The aim of this study was to test the independence of anhedonia from deficit syndrome and other symptoms presented by schizophrenic patients.

Fifty-one schizophrenic patients were evaluated with the use of Positive And Negative Syndrome Scale (PANSS), the Montgomery and Asberg Depression Rating Scale (MADRS), and with a scale for physical and social anhedonia (Chapman) by the same investigator (FAB). Forty-eight of these patients were interviewed by two other investigators (SD and JMR) with the Schedule for the Deficit Syndrome (SDS).

We showed a positive relationship between social or physical anhedonia scores and severity of general ($r=0.35$, $p<0.01$; $r=0.32$, $p<0.05$), negative ($r=0.42$, $p<0.001$; $r=0.35$, $p<0.01$) and depressive symptoms ($r=0.34$, $p<0.01$; $r=0.36$, $p<0.01$) of schizophrenic patients. However multivariate analysis considering all the symptoms and confounding factors (age, study level, professional activity) indicated that there was no relationship between physical anhedonia score and severity of general, negative and depressive symptoms and that social anhedonia score remained linked only to the severity of negative symptoms. Moreover deficit patients did not differ from non-deficit patients on social and physical anhedonia scores.

The hypothesis that physical anhedonia is a fundamental symptom in schizophrenia and a trait of schizophrenia, independent of deficit syndrome and of other schizophrenic symptoms (negative, positive, general and depressive symptoms) is supported by the results of this study.

PSYCHOPATHOLOGY AND PERFORMANCE OF SCHIZOPHRENIC PATIENTS IN A VISUOMOTOR TASK

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Disturbances of psychomotor functions are well known in schizophrenia. They are not only due to extrapyramidal side effects of neuroleptic agents but also a central feature of schizophrenic psychopathology. Different aspects of motor movement control - such as planning or litheness - may be controlled by different dopaminergic systems.

A set of visuomotor tasks involvingthe increase of complexity requiring prefrontal involvement was carried out with schizophrenic patients in a repeated measure design over a period of six weeks. According to their clinical improvement which was measured as a reduction of BPRS and SANS scores, schizophrenic patients were divided into two groups, one group responding to therapy ($N = 10$) and another group showing only minor improvement ($N = 10$).

Groups differed mainly in the tasks of higher complexity. Schizophrenics who improved made a high number of errors in the acute state as well as in the state of remission. Schizophrenics who did not show clinical improvement made only few errors, but they were very slow. Their amount of errors did not differ form healthy controls.

Extrapyramidal movement control seems to be disturbed to a smaller extent than movements demanding integration of higher cortical functions. Clinically distinct schizophrenic syndromes are related to definite patterns of psychomotor disturbances. Since dopaminergic systems are of central importance for motor control as well as for higher integrative cognitive functions it is suggested that they are related to different dopaminergic subsystems.

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TRAITEMENT IMPLICITE DU CONTEXTE PHRASTIQUE DANS LA SCHIZOPHRENIE

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Dans le cadre de l'étude des processus implicites de traitement de l'information dans la schizophrénie, nous avons étudié la sensibilité de la mémoire implicite au facteur contextuel lors d'une épreuve de mémoire implicite associative.

Nous appelons processus implicites de traitement de l'information, des processus cognitifs mis en jeu lors de tâches au cours desquelles le sujet utilise des connaissances sans être conscient de les utiliser. Ces processus non conscients sont particulièrement intéressants à étudier dans la schizophrénie. En effet, de nombreux arguments expérimentaux nous permettent de penser que seuls les processus de traitement de l'information explicites, c'est-à-dire s'accompagnant d'une prise de conscience, seraient altérés dans la schizophrénie, alors que les processus implicites de traitement de l'information seraient intacts.
Par ailleurs, il est actuellement bien admis que les sujets schizophrènes présentent des difficultés à prendre en compte et à traiter le contexte phrastique immédiat lors d'épreuves mettant en jeu des processus plutôt explicites.

Notre hypothèse est que ces sujets sont capables de traiter le contexte comme les sujets témoins lors de processus implicites.

48 sujets ont participé à notre étude :
24 schizophrènes remplissant les critères du D.S.M. III R et 24 témoins.
L'épreuve utilisée est une épreuve de mémoire implicite associative par complétion de mots. Le paradigme expérimental permet d'étudier les capacités à utiliser le contexte pour améliorer les performances mnésiques.

Les résultats montrent que les sujet schizophrènes traitent le contexte phrastique immédiat comme les sujets témoins lors de cette tâche mettant en jeu des processus implicites de traitement de l'information.
Ces résultats sont donc en accord avec l'hypothèse avancée.

PREVALENCE DES ETATS AUTISTIQUES (EA) DANS UNE COHORTE DE TRES JEUNES ENFANTS SUIVIS EN HOSPITALISATION A DOMICILE (HAD)

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OBJECTIFS Il s'agit de préciser certains points laissés en suspense par les classifications actuelles des troubles mentaux (ICD-10, DSM-III-R, Classification Française...) en ce qui concerne les troubles autistiques de la première enfance.

METHODOLOGIE Une étude prospective sur 6 mois est réalisée sur une cohorte d'enfants âgés de moins de trois ans, suivis en HAD pour des troubles mentaux très divers. Certains de ces enfants présentent à leur entrée dans le protocole un diagnostic d'autisme (groupe A) d'autres non (groupe B).

Par ailleurs, un petit échantillon d'enfants normaux de même âge développemental est étudié (groupc C).

L'étude menée en "double aveugle" par des psychiatres extérieurs à l'équipe soignante, et n'ayant pas accès au dossier clinique, consiste en entretiens avec exploitation par l'enregistrement vidéoscopique ; un recueil de données standardisées permet de définir comme variable statistiquement significative, la présence ou non chez les enfants étudiés, d'états autistiques (EA) (définis en référence notament aux échelles standardisées type ERC-N. Cette variable est rapportée quantitativement à la durée de l'EA par rapport á la durée totale des entretiens.

RESULTATS
1) Présence d'EA aussi bien dans le groupe B que dans le groupe A (mais non dans le groupe C d'enfants normaux).
2) Différances quantitatives entre groupes A et B.
3) Evolutivité des EA, dans les groupes A et B, entre le début et la fin de l'étude.

CONCLUSION L'autisme est un état observable au cours de la première enfance ne répondant pas à une situation univoque, mais correspondant à un ensemble défensif dont les manifestations cliniques sont susceptibles de varier, notamment en fonction de l'environnement.

SPECIFIC IgE ANTIBODIES IN MAJOR PSYCHOSES

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In our previous paper, a high frequency of immediate skin reactions to common allergens was found in patients with schizophrenia and affective illness (Biol. Psychiatry 1992, 31, 1181-2). In this study, an occurrence of the specific IgE antibodies against inhaled allergens was investigated in patients with major psychoses. There were 25 patients with schizophrenia, 11 male, 14 female, aged 21-55 (mean 32$\pm$7 years) and 33 patients with affective illness, 8 male, 25 female, aged 20-55 (mean 42$\pm$10 years). Control group consisted of 30 healthy students (10 male, 20 female), aged 18-22 (mean 20$\pm$2 years). The assay was done by means of immunoenzymatic Phadiatop method (Kabi Pharmacia Diagnostic AB, Uppsala). Positive results of the test were found in 10/25 (40%) of schizophrenic patients, in 15/33 (45%) of affective patients and in 7/30 (23%) of control subjects what made a trend for higher frequency of positive results in patients with major psychoses compared with controls (χ^2=3.34, p=0.068). *No difference was* observed between diagnostic subtypes either in schizophrenia (paranoid vs. nonparanoid) or in affective illness (bipolar vs unipolar). A gender effect was found in affective illness with male patients having higher frequency of positive tests then female ones (75% vs. 36%, p<0.05). The results obtained suggest a higher propensity to allergic changes in major psychoses, possibly as a part of their common biological make-up.

WHAT RELATIVES OBSERVE AND WHAT THEY OVERLOOK IN BEGINNING SCHIZOPHRENIA

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Studies on beginning schizophrenia heavily rely on reports by patients and families about early symptomatology. Little is known, however, about the limitations and biases of these personal accounts. Within the ABC-Schizophrenia-Study, a large-scale investigation of the influences of age and gender on onset and course of schizophrenia, we compared the retrospective reports about emerging psychopathology during the early course of schizophrenia given by 171 patients and their significant others in a representative first admission sample. The comprehensive IRAOS-interview assessing early signs and symptoms revealed that patients as well as informants perceive negative, depressive, and unspecific symptoms as earliest signs of the disorder in most cases. Pairwise agreement about the presence of certain symptoms is good in a limited number of signs, e.g., substance abuse, suicidal behavior, parental and marital role deficits, and paranoid delusions. These items mainly regard abnormal behaviors which can be well observed. Reports about perceptual and formal thought disorders, i. e. subjective internal phenomena, in contrast, are not congruent. Positive symptoms tend to be better observed by partners than by the patients' mothers. The results support a continuity model of observability of symptoms in schizophrenia.

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PATTERNS OF VISUAL HALLUCINATIONS IN MAJOR PSYCHOSES

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While it is commonly received wisdom that visual hallucinations are important clinical pointers to an organic aetiology, more detailed analyses of the subject suggest that visual hallucinations may occur just as commonly in the so-called 'functional' psychoses. The present study examines this notion and extends it to analyse the nature and typology of visual hallucinations that happen in major psychoses.

We analysed the detailed phenomenology of a series of 750 patients. The series contained roughly equal numbers of depressed, manic, acutely schizophrenic and chronic schizophrenic patients, all meeting the relevant Research Diagnostic Criteria. Our typology of visual hallucinations depended on whether the hallucinations were of whole, fragmented or geometrical objects, human or non-human, recognised or unrecognised, or perceived as self or not-self. We then related the typological frequency of visual hallucinations to the diagnostic category into which the patient fell.

We show that, among major psychoses, visual hallucinations are least common in depressive psychosis, and present in just over one in four of each of the other diagnostic categories. Visual hallucinations are perceived as whole objects much more commonly in all disorders except acute schizophrenia, where part-objects and geometrical shapes are most commonly recorded. We believe that these findings may provide useful diagnostic clues, and we discuss their possible neuropsychological significance in relation to a planned follow-up study using Positron Emission Tomography.

EVALUATION AND INTERPRETATION OF SYMPTOM STRUCTURES IN PATIENTS WITH SCHIZOPHRENIA

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It is generally accepted that schizophrenia is a complex and heterogeneous entity. Current investigations have been made using the concept of positive-negative symptoms in an attempt to define a putative disease process. There is, however, little consensus about what kinds of symptoms exactly constitute positive or negative symptoms, and whether more than two dimensions are required to account for structures of the schizophrenic symptoms. Seventy DSM-III-R schizophrenic patients (male, n=53; female, n=17) were assessed for 30 clinical symptoms using the Positive and Negative Syndrome Scale (Kay et al, 1987). The mean age of the subjects was 26.2, SD 5.5 years, and their mean duration of illness was 61.1, SD 55.7 months. The total matrix sampling adequacy derived from Kaiser's equations was 0.761. Principal component analysis was applied to the full item set of this scale and disclosed five orthogonal independent symptom groups: negative, hostile-excited, thought disordered, delusional-hallucinatory, and depressive components. These five components accounted for 24.1, 20.8, 11.7, 6.7, and 5.4 percent of the variance respectively. These results were partly consistent with five of the seven components described by Kay and Sevy (1990). Moreover, our negative, thought disordered, and delusional-hallucinatory components represented the three major symptom structures proposed by Liddle (1987). Our negative component consisted of five of seven PANSS negative items with high loadings, except for the difficulty in abstract thinking and stereotyped thinking items. From this finding it could be assumed that the framework of negative symptoms to represent coherent structure is precisely restricted, and that the conceptual clarification is essential for the future study of symptom structure. Our thought disordered component consisted of items that were regarded as measurements of positive and negative features of thought disorder. The poor attention item was also loaded on this component. However, some difficulties were remained to elucidate particular components of attentional processes (i.e. poor concentration, distractibility, difficulty in shifting focus and so on) using this poor attention item. Our findings of the hostile-excited and delusional-hallucinatory components provided heuristic assumptions in the interpretation of the positive symptom. Even if these two clinical manifestations occurred simultaneously, hostile-excited phenomena might not necessarily be concomitant with delusion-hallucination and vice versa. A bipolar relationship between positive (i.e. delusion-hallucination) and negative symptoms could not be supported in this study. More broadly, the grandiosity item and three items of the excited-hostile component tended to reveal a bipolar relationship with the negative component. The depressive component disclosed here confirmed a finding that depression in schizophrenia is distinct from negative symptoms. This result only indicated that depressive symptoms measured by the guilt feeling and depression items of the PANSS could not be associated with negative symptoms. Other depressive features which are not contained in the PANSS items should be made more intricate to precisely evaluate depressive symptoms.

COGNITIVE ASPECTS OF THE SCHIZOPHRENIC THINKING AND LANGUAGE

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Psychic dissociation, considered by Bleuler to be pathogenetic key of schizophrenia, represents the first cognitive explicative model of schizophrenic thinking. The clinical signs of this thinking disturbance are specially reflected in the field of language.
Of the explicative cognitive models in the analysis of our patients we preferred the psycholinguistic model. The study of the language of schizophrenic patients was centred on the observation of abnormalities in word selection, of the syntactic abnormalities, of the disturbances of the inferential processes, of the pragmatic anomalies, of the disturbances in speech planning.
Analysis of the speech allowed the differentiation in this plane between schizophrenic, maniacal and normal control patients. Due to language destructuration schizophrenia can be regarded as a "logopathia".
In a particular case of schizophrenia, based on the aspects of the language, the theory of "intermittent aphasia" (Chomsky) is discussed.
The information obtained by the semantic analysis were compared with anamnestic and clinical data. The dynamics of the disturbances (at the level of the word, sentence), their evolution under the influence of the chemotherapy and electroconvulsive treatment were studied in the perspective of the social or at least familial reintegration.

GENDER DIFFERENCES IN HOMOTYPICAL MORBIDITY IN A BULGARIAN FAMILY STUDY OF SCHIZOPHRENIA AND AFFECTIVE DISORDER

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In the context of a collaborative family study we have explored the clinical characteristics of patients with diagnoses of schizophrenia and mood disorder as function of the ascertained psychiatric morbidity of their first-degree relatives. The characteristics examined included: age at onset, premorbid personality traits and adjustment level, symptom pattern, ICD-10 and DSM-III-R subtype diagnosis, and pattern of course (rated for severity). In addition, selected psychosocial factors operating in these families were assessed to estimate possible environmental effects on above variables. Correlation patterns between these variables were determined in 15 multiplex and sib-pair families identified through proband diagnosis of schizophrenia and 15 multiplex and sib-pair families identified through proband diagnosis of major mood disorder to derive an index of homotypia. The hypothesis tested was that homotypia is gender-dependent.
The instruments used in the study were the Family Interview for Genetic Studies (FIGS), the Sofia Neuropsychiatric Interview (incorporating sections of PSE-10 and SADS-L), the WHO Personality Disorder Examination, the Social Support Network Inventory, the Circumplex Assessment Package (CAP), and the WHO Disability Assessment Schedule.

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DECISION LEXICALE ET SCHIZOPHRENIE : DEFICIT DE L'AMORCAGE SEMANTIQUE ET CORRELATIONS CLINIQUES

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Partant de l'hypothèse cognitive d'un déficit spécifique, chez les patients schizophrènes, du traitement des informations contextuelles nécessaires à l'ajustement de la réponse, nous avons mené une série d'expériences portant sur le traitement d'un contexte verbal élémentaire par des patients schizophrènes. Nous avons utilisé le paradigme de la décision lexicale avec amorçage sémantique.
Dans un premier temps et en utilisant un délai bref de présentation du mot amorce de 240 millisecondes, nous avons montré que le groupe des schizophrènes était hétérogène en terme de fonctionnement cognitif : alors que les patients hébéphrènes se comportaient comme des sujets normaux, le sous-groupe des schizophrènes paranoides ne semblait pas influencé par la qualité de la relation sémantique existant entre le mot amorce contexte et le mot cible. Ce résultat a été interprété en terme de déficit de processus controlés prenant place immédiatement aprés l'accés au lexique.
Dans une étude de réplication et en utilisant un délai de présentation plus prolongé du mot amorce (500 ms) permettant la mise en place de processus controlés plus élaborés d'anticipation du mot cible à partir du mot amorce, nous avons retrouvé une corrélation entre l'absence de traitement du contexte et la présence, à un niveau clinique, d'un trouble formel de la pensée.
L'obtention, avec ce dernier paradigme expérimental, d'effets d'amorçage semblables à ceux des sujets normaux controles chèz un groupe de patients déprimés, délirants ou non, va dans le sens d'une spécificité du déficit cognitif retrouvé chez certains schizophrènes.

THE MÜNSTER PROGNOSIS SCALE IN THE LONG-TIME PREDICTION OF SCHIZOPHRENIC ILLNESS: A COMPARISON WITH THE STRAUSS CARPENTER AND THE PHILLIPS SCALE

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The Münster Prognosis Scale (MPS) is a small and handy prognostic scale for schizophrenic outpatients. It consists of only 4 items (number of previous episodes, stability of course of illness, level of premorbid adjustment and stability of social environment) each of which can be rated favourable or not. If rated unfavourable in two or more of the items the patient is graded as poor prognosis. The MPS was used for the first time in the years 1985 - 1986. In a first follow-up of 99 schizophrenic outpatients who lived with their relatives (72m, 27w, mean age 27, mean duration of illness 5,5 years) it had a slightly better prognostic value for rehospitalisations within 9 months than the Strauss Carpenter Scale (SCS).

8 years later 65 of 99 patients participated in a follow-up investigation. The predictive validity of the MPS was compared with the SCS and the Phillips scale. Outcome criteria were number of hospitalisations, symptoms-score (AMDP) and psychosocial adjustment (GAS).

The MPS had a good prediction in the number of hospitalisations since 1984 ($p<0.001$), the psychosocial adjustment (GAS-score, $p<0.01$), the symptom-score ($p<0.01$), but was worse in predicting the number of hospitalisations since 1988 ($p=0.063$). The SCS did best in predicting a better psychosocial adjustment ($p<0.001$) and a lower number of hospitalisations since 1984 ($p<0.01$) and 1988 ($p<0.05$). No significant prediction was possible for the symptom-score. The Phillips Scale correlated with a better GAS-score ($p<0.05$) but failed to predict level of symptomatology or rehospitalisation rates. In conclusion the MPS has proven to be a reliable prognostic instrument for different outcome-criteria and is comparable to the SCS.

ANALYSIS OF EPIDEMIOLOGIC PARAMETERS FROM A REGULARLY TREATED POPULATION OF 300 SCHIZOPHRENIC PATIENTS

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Among our population of 3000 out and inpatients, 350 schizophrenic patients have been studied and classified in 1992 by their physician according to the ICD 9. Some well known data (subtype distribution by age, poor status of hebephrenic form) and some new data (good social insertion for half of schizophrenic patients, sex difference in subtype distribution) were described.
A new study concerning the population of schizophrenic patients is reconducted in 1993 according to the ICD 10. The analysis of the same parameters like in 1992 concerns : categorization of schizophrenia, age, sex, marital status, employment, housing situation, social support, type of follow up during this year...
Some new parameters are investigated : duration of illness, length of illness before treatment and type of drug treatment. These data are compared between 1992 and 1993 on the whole schizophrenic population, and on ICD 9 subgroups.

FACTORIAL STRUCTURE OF SCHIZOPHRENIC SYNDROMES DEFINIED BY SIX VARIOUS DIAGNOSTIC CRITERIA SETS.

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The aim of the study was to compare factorial structure of schizophrenic syndromes definied by various diagnostic criteria. Hospital records of 167 first-hospitalized patients with syndromological diagnosis of delusional /paranoid/ psychosis were examined. The clinical diagnosis of schizophrenia was established in 67% of the cases. Operationalized criteria sets allowed to diagnose schizophrenic disorders with various frequencies: 83% /Schneider's first-rank symptoms/, 65% /ICD-10/, 46% /Bleuler's axial symptoms/, 37% /DSM-III-R/, and 26% /Berner's Vienna Research Criteria/. Symptomatology of observed syndromes was rated using six four-point scales describing important groups of schizophrenic symptoms /delusions, hallucinations, formal thought disorders, catatonic, negative, and affective symptoms/. Factor analysis /principal components analysis with Varimax rotation and eigenvalue=1 as extraction criterion/ of these symptoms was performed in separate groups of schizophrenia patients definied by compared criteria sets. In all the cases three-factor solutions were obtained, but variance loadings and composition of particulary factors varied between groups compared. The clearest and simplest factorial structure was found in the group definied by the clinical diagnosis. The results suggest that various diagnostic criteria have marked influence not only on frequency of diagnosing schizophrenia but also on the inner structure of schizophrenic syndromes diagnosed according to a given criterion.

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