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PSYCHOPATHOLOGICAL AND NEUROPSYCHOLOGICAL FEATURES OF NEGATIVE DISEASES IN LATE SCHIZOPHRENIA

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Abstract. *In connection with the clear changes in the age structure of the general population in relation to large age groups and, perhaps, with an increase in the proportion of mentally ill people in old and old age, the study of the geriatric aspects of psychiatry is becoming an increasingly important and necessary task. These global trends make it relevant to study the psychoses of schizophrenia, which debuted at the atypical (late) age due to difficulties in diagnosis, a differentiated approach to treatment and rehabilitation.*

Key words: *Schizophrenia, geriatric aspects, diagnosis, treatment, rehabilitation.*

ПСИХОПАТОЛОГИЧЕСКИЕ И НЕЙРОПСИХОЛОГИЧЕСКИЕ ОСОБЕННОСТИ НЕГАТИВНЫХ ЗАБОЛЕВАНИЙ ПРИ ПОЗДНЕЙ ШИЗОФРЕНИИ

Аннотация. *В связи с четкими изменениями возрастной структуры общей популяции по отношению к крупным возрастным группам и, возможно, с увеличением доли психически больных людей в старости и пожилом возрасте, изучение гериатрических аспектов психиатрии становится все более важной и необходимой задачей. Данные мировые тенденции делают актуальным изучение психозов шизофрении, дебютировавших в атипичном (позднем) возрасте из-за трудностей диагностики, дифференцированного подхода к лечению и реабилитации.*

Ключевые слова: *шизофрения, гериатрические аспекты, диагностика, лечение, реабилитация.*

Introduction. According to modern research on schizophrenia, the diagnosis of slow (low progressive) schizophrenia is delayed by 10-15 years from its initial stage [1]. Slow (low progressive) schizophrenia is manifested by borderline diseases, which are often not considered manifestations of the disease by the patients themselves and their relatives and are not a reason to seek medical attention [6]. Slow schizophrenia, including affective (depressive) disorders, with a high frequency of attachment with psychoactive substance dependence, has been noted [2-4]. The Narcological service does not have the practice of"double diagnosis". A number of patients with schizophrenia have been observed on the General Medical Network for a long time [5], in these cases the diagnosis is for the first time determined only by an active psychiatric examination.

Schizophrenia, which is difficult to diagnose, with a predominance of negative diseases [6]. Neuropsychological studies based on the principles of syndromic analysis and involving the consideration of higher mental functions in their close relationships allow for a more consistent picture of neurocognitive activity in schizophrenia [7].

Slow schizophrenia, which has mainly Affective Disorders. Before the onset of Affective Disorders in adolescence, psychogenism and psychosocial stresses (mother leaving the family, change of place of residence and school) appear. The debut of the disease is characterized by apathetic depression, the next type of monopolar flow or a psychopathic-like mania, a mixed affective state with a transition to hypomania. Against the background of subdepression or hypomania, drug abuse begins at the age of 15-17 years, polysubstant (chaotic intake of alcohol, opiates, cannabinoids and toxicomaniacs) in all observations. Behavior disorders with manic influence are more severe-psychomotor agitation, altered forms of alcohol with aggression; in addition to intoxication-courage, deliberate resistance, ease of sex, communication in social companies. In depression, there is an awareness of the antidepressant effect of the surfactant [8-12].

The next dynamics of the state in the bipolar course is repeated (psychogenic provocation) depressive episodes or the appearance of a schizoaffective attack, erased by a mixed effect, an attempt at literary creativity. Subsequently, heroin addiction develops, persistent personality changes are formed, such as a psychopatho-like defect (with a bipolar course) or a deficiency schizoid (with a monopolar depressive). Women with formed personality changes have children from drug addicts, there are no maternal feelings for children, grandchildren are in the care of the parents of patients [13-15]. For relatives, patients are heavy, rude, impudent addicts who lead a" parasitic " lifestyle. Patients were observed and treated by narcologists. The delay in diagnosis is due to the" Narcological " interpretation of the condition of patients (drug addiction, alcoholism) and the position of parents who psychologize the sharp contrast between the patient's premorbid (socially, artistically gifted) and the painful state with a lack of acceptance of the version of mental illness [16-18].

The onset of the disease in adolescence begins with bipolar affective disorders or monopolar depression. The course of Bipolar Affective Disorders is more progressive, and 5-6 years after their manifesto, neurocognitive insufficiency, the absence of complex intellectual activity (patients stop studying at the university, cannot withstand the program of full-time postgraduate studies), constant asthenia, infantilism and changes in appearance (subcatatonic manifestations,"soft catatonia") [19].

Monopolar (recurrent) depression (tosclivoapatic with dysphoria-like additions) is complicated by symptomatic alcoholism, followed by drug use. 8 years later, a defect appears on the type of schizoid defective from the debut. Parents organize an informal follow-up of a psychiatrist without issuing medical documents, without publishing a diagnosis (transparency, "stigmatization" is undesirable for the reputation of parents), willingly accept "somatoneurological" versions of the diagnosis, financially include patients, avoid formal contact with psychiatrists-until this time.it is necessary to solve the issue of working capacity or when patients show aggression [20].

Sluggish schizophrenia, which has its debut in adulthood and affective symptoms throughout the course of the disease, is characterized by a recurrent course of depression, chronic depression (somatized by apatic, senstialgic syndrome), bipolar affective disorders are less common. The disease was considered atypical MDP, or patients were observed only by a narcologist who was diagnosed with chronic alcoholism. A characteristic feature of the disease was the superiority of depressive episodes over manic ones [21]. During this period, excessive alcohol content in some patients may have occurred against the background of depressive equivalents, or secondary alcoholism began later with the development of pronounced depressive episodes. Manias were atypical in nature (similar to psychopaths, with manic equivalents, costly ideas, and obsession with pull activity), with constant variations of the paranoid type of personality being formed.

Conflict, paranoid reactions led to unstable labor adaptation; conflicts with psychiatric doctors resulted in discontinuation of follow-up and supportive treatment, with patients "lost"from the psychiatrist's eyes for many years [22].

However, they retained professional knowledge and skills, sought to find a job, remarried. The disease was assessed as psychogenic depression or cyclothymia. During repeated pseudogallusinatory episodes of AAS content or constant alcoholic remission, a chronic affective-paranoid attack may occur. The" paranoid shift" in the second half of adults, despite social losses (loss of work, family, housing)," keeps patients." Patients determine the desire to" live", find work as workers, try to engage in network marketing [23].

In most patients with slow schizophrenia with Somatoform disorders, the debut of the disease occurs in adulthood. These patients were observed for a long time in the General Medical Network, were disabled in somatoneurological pathology. The HEI General Bureau was sent to the psychiatric hospital because the initial commission diagnosis did not justify the level of incapacity for work. A inpatient examination in a specialized psychiatric institution revealed symptoms from the framework of "non-predicative hypochondria" against the background of paroxysmal conditions, senostalgia and senestopathies, depersonalization and Affective Disorders in all cases (anxiety-apatic, anxiety-adynamic depressions) [24-28].

Psychopatho-like disorders at the onset of pre-school age disease were manifested by early dysontogenesis of a dissociated type with the predominance of emotional sphere and behavioral disorders in combination with autism. We are talking about a symptom complex of schizoid, hysteroid and excitatory properties, sad mood, hysterical reactions with cataton-like negativism, motor anxiety, "uncontrollable", hyperdynamic symptomatology and disc disorders (sadistic tendencies). At the same time, patients had a good imagination, had the ability to fantasize, dreamed of romantic professions and trips. They treated their loved ones coldly or selectively contacted one of their parents [29-34].

Emotional coldness and cruelty towards relatives were combined with a careful, respectful attitude towards animals, plants and their favorite things. The level of self-esteem and claims was highly appreciated. Patients could not withstand the slightest comments on them [26]. In the case of the onset of the disease in late adolescence, psychopathic-like diseases were characterized by a combination of schizoid and hysteroid characteristics, manifested by excessive egocentrism," permissiveness" and the rapid development of alcohol dependence; pseudology, perhaps within

the framework of a delusional fantasy, is blackmail-aggression with suicidal behavior and sadism towards loved ones in the family [35-40].

In all patients with psychopatho-like symptoms in a slow schizophrenia clinic, bipolar or conditionally bipolar affective disorders were found, regardless of the age of onset of the disease: chronic hypomania with increased activity, high-value hobbies or pseudoscience (equivalents of hypomanic states), replaced by depression, repeated suicide attempts [41]. Alcohol abuse began both against the background of Affective Disorders and against the background of psychopathic-like disorders. Excessive alcohol consumption can cause repeated temporary delusional and hallucinatory-delusional (schizophrenia-like) episodes of the "cliché" type that occurred during periods of alcoholism and alcoholic remission. Patients were not busy with work in production, but kept active and social contacts in the field of extremely valuable hobbies - for example, radio engineering, collecting books and replacing them "in the ruins of a book", trading with a tray, finally fulfilling the role of "housewife" - presenting a shopping report with checks attached to his wife [42-47].

The purpose of the study: the purpose of the work is to determine the features of the violation of high mental functions in patients with schizophrenia with the debut of late life.

Materials and methods. 76 patients (48 women and 28 men) aged 46 to 68 (average age 52±5.8 years) were examined for their debut in the late life of the schizophrenic process (after age 45), which formed the core group. The duration of the schizophrenia process in the main group of patients was from 1 to 21 years (average duration 7.3±6.12 years). Patients between the ages of 32 and 59, when schizophrenia began at the age of 30-44, formed a control group, 32 people (24 women and 8 men) were examined. In patients in the control group, the duration of the disease was compared with its duration in patients in the main group – from 0.5 to 21 years (the average duration is 7.8±6.7 years).

Clinical-psychopathological, pathopsychological and neuropsychological research methods have been used.

Research results and discussion. The Apato-abulic defect type was found in 29 patients – 38.2% of the main group and 19 patients – in 59.4% of the control group. Patients with late schizophrenia differed significantly from the control group in the small value of average estimates on "expressive speech", "understanding speech and verbal phrases", "auditory speech memory", "visual memory", "praxis" and "thinking"blocks ($p<0.05$). Some patients complained of fatigue, drowsiness, weakness, asked to "postpone the conversation for another time." A decrease in the ability to control programming and mental activity in patients with Apato-abulic impairment came to the fore. In general, the apato-abulic defect in patients with schizophrenia coincided with the second variant of neuropsychological syndrome, which includes late-life debugging, prefrontal convexital parts of the frontal lobes, subcortical ganglia, violation of cortical-subcortical relationships.

The type of pseudo-organic defect was found in 22 patients of the main group (29%) and 6 patients of the control group (18,8%). In both groups of patients with this type of defect, all VPF is very grossly impaired. In the blocks" expressive speech"," understanding speech and verbal phrases"," hearing-speech memory"," visual memory"," delayed repetition of sentences and stories"," praxis","optical-spatial gnosis", significantly significant ($p<0,05$) incidence of disorders

in patients in the control group was found. "reading", "thinking". Symptomatology in patients with this type of defect was characterized by polymorphism and weight in general, the violation of higher forms of regulation was much more pronounced and stable compared to the first and second variants. This type of defect, which began late in patients with schizophrenia, coincided with the third variant of neuropsychological syndrome, which includes symptoms of damage to the prefrontal convexital formation of the frontal lobes, subcortical ganglia in combination with dysfunction of the convexital parietal-occipital and temporal parts of the brain.

21 patients with schizophrenia had a psychopatho-like personality defect, with a core group of 23,7% (18 patients) and a control group of 9,3% (3 people). As with the pseudo-organic type of disorder, VPF disorder with a psychopathic-like defect was very evident. In the control group of statistically reliable ($p<0.05$) patients, "expressive speech", "understanding speech and verbal phrases", "auditory-speech memory", "visual memory", "praxis", "optico-spatial gnosis", "acoustic non-verbal gnosis", "thinking" block disorders are more pronounced than in the main group. Patients in the control group are much more reliable than the main ($p<0.05$), when composing a short story from pictures, a clear distraction with external stimuli was recorded, but with the stimulating help of an experimenter, patients managed to convey the meaning of the story. The psychopathic-like defect involved symptoms of damage to the prefrontal convexital formation of the frontal lobes and subcortical ganglia in combination with dysfunction of the convexital parietal occipital and temporal parts of the brain.

The group of patients with asthenic impairment of the individual turned out to be the least: 7 patients in the main group (9,2%) and 4 patients in the control group (12,5%). In all blocks of this study, there were disorders in patients in both groups, but they were found to be higher in patients in the control group ($p<0.05$). Expressive speech, auditory-speech and visual memory, praxis, gnosis, impaired thinking have been found to be less pronounced in patients with asthenic defective late schizophrenia than in other defective disorders.

The asthenic defect involved symptoms of dysfunction of the mediobasal and prefrontal convexital parts of the frontal lobes with discoordination of the cortical-subcortical connections.

In 15 patients (38,46%), actual hospitalization in a psychiatric hospital was the first. In the multi-year stage of the disease, without adequate diagnosis, 24 people (61,54%) were stasionized into the psychiatric and Narcological departments.

The larger half of them (66,7%) are two or more times. In order to reduce frequency, patients are diagnosed: personality disorders, organic brain disease, affective disorders, alcohol and drug addiction.

As a result of this study, 4 types of leading psychopathological syndromes were identified in a slow schizophrenia clinic, which was diagnosed late after the onset of the disease: affective - 20 observations, (51,3%); somatoform - 8, (20,5%); psychopatho - like - 6 (15,4%), neurocognitive deficiency-5 observations (12,8%). It is noted that the leading psychopathological syndrome is associated with the onset of the disease.

A clear manifestation of neurocognitive deficiency in a slow schizophrenia clinic was found if the disease began in preschool age (1 to 3 years old) and was one of the components of early dysontogenesis, mainly by the type of mental development delayed by autism and smoothness of emotional reactions. In domestic psychiatry, such conditions are classified as

schizotypal diathesis. During this examination, the mental warehouse of patients did not undergo significant changes and was identified by the "pseudo-oligophrenic" type of defect. The diagnosis was made during a military examination of military age. Comorbid diseases are characterized by sub-depressive episodes that appear in adolescence, protective obsessive movements, phenomena of social phobia. Patients did not have a profession, unmarried, low-skilled work was not available to them. They lived symbiotically with parents who considered the condition of their patients to be the consequences of pregnancy and childbirth pathology and did not consider them mentally ill. In one observation, despite the fact that the patient was not able to fulfill the curriculum, parents even tried to pay for studying at the University. In the event that the disease began in adolescence and adulthood, neurocognitive deficit developed within the "simplex"syndrome, manifested by gradually increasing intellectual incompetence. The delay in the diagnosis of schizophrenia can be associated with a low level of adaptation of patients, the ability to perform low-skilled labor, to live independently, orderly behavior in everyday life in general, as well as the position of relatives (indifference to the fate of patients or interpreting their condition as consequences of perinatal pathology) or traumatic brain injury).

Conclusions. The study showed that the types of defects presented in patients with late schizophrenia are pathogenetically related and are the opposite of a single pathological process of varying degrees of severity, with a deepening of disorders of higher mental function from asthenic to pseudo-organic personality defect type. The information obtained on the features of neurocognitive deficiency of each type of deficiency makes it possible to conduct local diagnostics of these diseases, and also provides invaluable assistance in conducting psycho-rehabilitation activities (including teaching cognitive and social skills).

Analysis of the syndromic characteristics of late-diagnosed sluggish schizophrenia determines the relationship between the type of leading psychopathological syndrome and the age of onset of the disease. In the event that the disease began before puberty (childhood, adolescence or adolescence), affective and psychopathic-like disorders (15.3%, respectively) dominated the active phase of the course of sluggish schizophrenia at an equal frequency. Neurocognitive deficits and somatoform disorders were reported 2 and 3 times less (7.7% and 5.1%), respectively. The onset of the disease in adulthood is often characterized by affective disorders (35.9%), the second place is occupied by somatoform diseases (15.3%).

In the event that the disease begins before reaching puberty (70.6%), there is a significant frequency of combining low — grade schizophrenia with alcohol and drug addiction, with the onset of the disease in adulthood-57.1% (in all cases we are talking about comorbidity with affective disorders). Until the adequate diagnosis of endogenous disease, patients were mainly observed by drug addicts and general medical services with a diagnosis of surfactant, personality disorder, organic disease of the central nervous system or somatoneurological pathology.

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