EGATIVE SYMPTOMS IN CHRONIC SCHIZOPHRENIC INPATIENTS; ORBIDITY WITH DEPRESSIVE SYMPTOMS, LATE INVOLUNTARY MOVEMENTS, AND COGNITIVE DEFICITS

(Cross Sectional Study)

Thesis
submitted for the partial fulfillment of
M.D. Degree in
Psychological Medicine

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FACULTY OF MEDICINE
AIN SHAMS UNIVERSITY

1993

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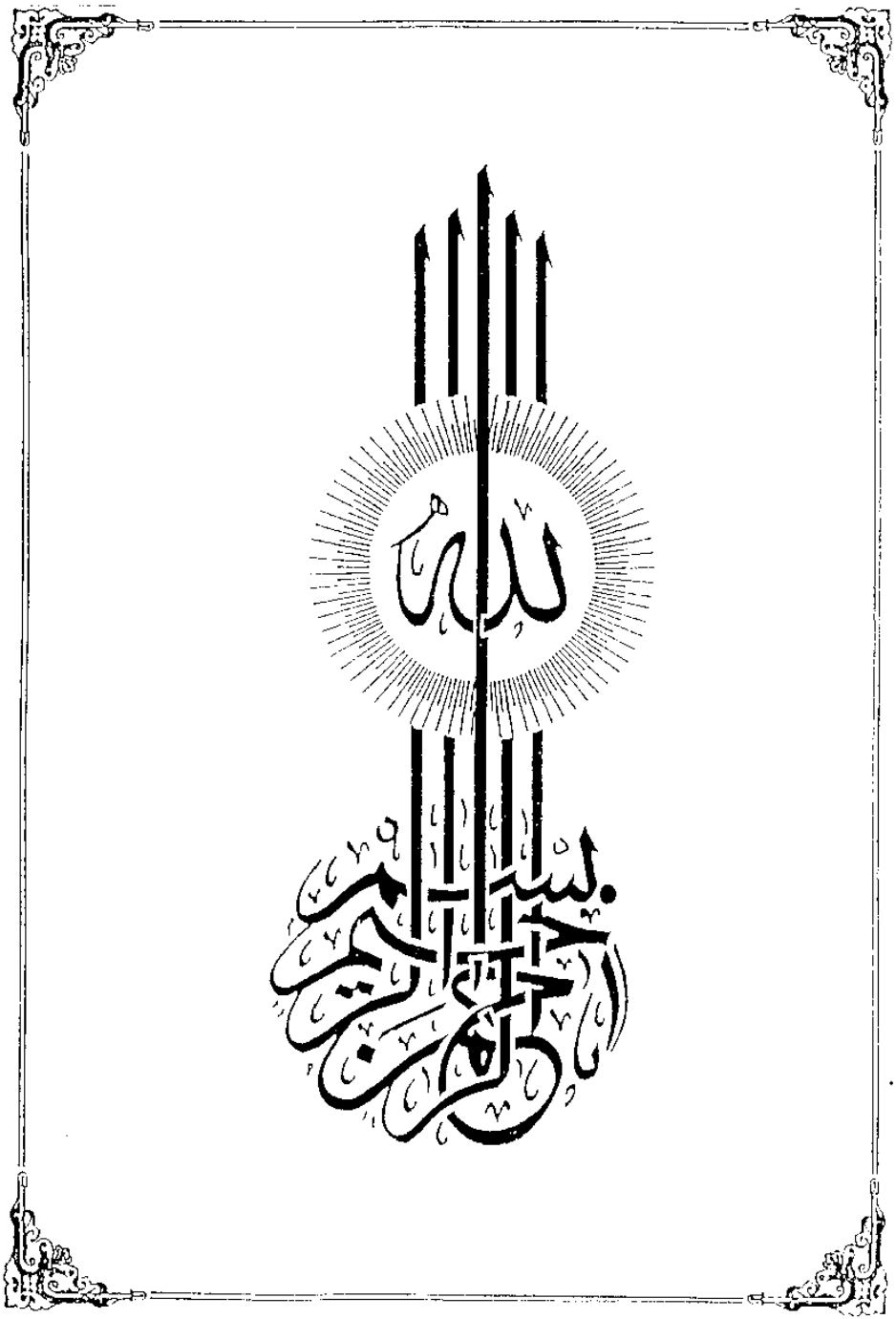
To

my wife

and

my children



AKNOWLEDGEMENT

I wish to take this opportunity to express my sincere appreciation to Prof. Ahmed Okasha, chairman of Neuropsychiatric department, Ain shams University, for his honouring me by supervising this work, and for his continuous guidance and encouragement. I am deeply appreciating his kind assistance and support since I first started in the psychiatric field. I feel great honour for being one of his students.

I like to express my eternal indebtedness to Prof. Farouk Lotaif. Prof. of psychiatry, Ain Shams University, for his unfailing support close supervision, and continuous advise throughout this work. I am most appreciative for his helpful guidance and precious encouragement.

My profound gratitude and indebtedness are due to Dr. Mohamed Refaat El-fiky, Assist. Prof. of psychiatry, Ain Shams University, for his guidance, constructive criticism, and careful supervision. He gave me much of his time, his effort and his personal enthusiasm.

My sincere appreciation and deepest gratitude go to Dr. Mohamed Aly Aref, senior consultant and head of the psychological medicine hospital in kuwait for his encouragement and support.

I am most appreciative and grateful to Dr. Safia Effat, Lecturer of psychiatry, Ain Shams University, for her helpful guidance and kind support.

I would like to thank Dr. Manal Fuad for her cooperation and assistance.

My thanks also go to all the staff of the psychological medicine hospital in Kuwait for their help and sincere cooperation.

Salah Abd El Reheem

1993

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INTRODUCTION

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The heterogeneity of schizophrenic syndromes has long puzzled investigators, who have attempted to identify components with different etiologies, prognosis and treatment responses. One of the oldest dichotomies is that of positive versus negative symptoms. Kraepelin noted this distinction one hundred years ago when he described a chronic deficit state more devastating than the acute psychotic episode. Since that time, interest in negative symptoms has waned, with attention focused on the more florid first rank symptoms. It has only been in the past decade that researchers have once again looked to negative symptoms to understand the processes underlying the schizophrenic syndrome.

With a few exception (Mathai and Gopinath 1986 ; Kulhara et al, 1986, Gureje 1989), most of the studies relating to the negative and positive subtyping of schizophrenia have been conducted among populations of patients in industrialized countries. No study, has dealt with this issue among Arab patients. Yet there is evidence that schizophrenia may follow a different course in industrialized countries, even when an identical method of case selection has been used (World Health Organization, 1979). The possible roles of social and biological factors in bringing about this differential pattern of outcome have been speculated upon (Cooper and Sartorius, 1977). It has yet to be determined whether chronic patients from

non-industrialized countries share identical clinical features with those from industrialized countries or not.

REVIEW OF LITERATURE

ORIGIN OF THE CONCEPT

The distinction between positive and negative schizophrenia is ubiquitous historically.

Reynolds (1858) was the first who introduced the positive and negative symptoms terminology into the neurological literature. He applied them to the classification of symptoms in epilepsy. He considered positive and negative symptoms as independent of one another.

Jackson (1889) used the terms negative and positive symptoms to describe insanity and speculated that the former came from disease-induced loss of higher mental functioning and the latter from release phenomena secondary to this loss of higher control. Whether Reynolds (1858) and Jackson's (1889) views are truly the basis for positive and negative symptoms in schizophrenia or merely served as metaphors for the current use of this concept is debatable (Zubin 1985).

The distinction was present in the thinking of our nosologic forefathers of the 20th century. Kraepelin (1919) described "two principle disorders that characterise dementia Praecox "... a weakening of those emotional activities which permanently form the mainspring of volition, and ... the loss of inner unity of activities of intellect, emotion and volition.

Bleuler (1950) had a similar negative-positive dichotomy in mind with his fundamental vs. accessory symptoms. The former involved loss of function (e.g. of attention, volition, affective responsiveness, and association), and was always present. The latter involved an aberration of function (e.g. hallucinations, delusions, and catatonia), and was present only during severe relapse. All of these characteristics fall well into the net of positive and negative symptoms today.

De Clerambult in (1942) reintroduced positive and negative symptoms but was away from the Jacksonian view by making positive symptoms independent of negative symptoms (Ey 1963).

Fish (1962) discussed the issue in relation to the formal thought disorder. In the negative kind, the patient has lost his previous ability to think, but does not produce any unusual concept. In positive formal thought disorder the patient produces false concepts by blending together incongruous elements.

In the Russian literature the adjective "positive" and "negative" had been adopted in relation to symptoms of schizophrenia. Snezhnevsky (1968) wrote that symptoms that contribute to the different schizophrenic syndromes may be pathologically productive, or so called positive, alternatively they may be negative symptoms expressive of "flaws", defects and disintegration.

On the other hand, the terminology has been used quite widely in the United Kingdom, for example by Wing (1978) who contrasted florid or positive or productive symptoms seen particularly in acute episodes with the negative components of the clinical poverty syndromes, which he identified as emotional apathy, slowness of thought and movement, underactivity, lack of drive, poverty of speech and social withdrawal. He considered that there are three basic groupings (tripartite scheme), the positive syndrome of acute schizophrenia, the negative (or clinical poverty) syndrome of chronic schizophrenia and combinations of the two. He drew the attention to the frequency of thought disorder as a component of the chronic syndrome.

Another line of thought regarding positive and negative symptoms and their interrelationships was followed by Strauss et al,. (1974) who traced their use of the positive - negative terminology back to Jackson (1889), but they did not adopt his inference of a causal sequence between them. They included as positive symptoms, disorders of content of thought and perception, certain types of form of thought (e.g. distractibility), and certain behaviours (e.g. catatonic motor disorders), and as negative symptoms, blunting of affect, apathy and certain kinds of formal thought disorder, such as blocking.

Since Carpenter, Snezhnevsky, Strauss and Wing all contributed to the World Health Organization International Pilot

Study of schizophrenia, one may suppose that this project played a role in disseminating the concept (Crow 1989).

Crow (1980) proposed that schizophrenia could be divided into two major syndromes which he referred to as type I and type II. Type I schizophrenia had mainly positive symptoms, good premorbid functioning , acute onset, neuroleptic responsive symptoms, and better long-term course and outcome without intellectual deterioration. Type II schizophrenia had mainly negative symptoms, poor premorbid functioning, insidious onset, drug resistant symptoms, and poorer long-term course and outcome with intellectual deterioration.

DEFINITION OF NEGATIVE SYMPTOMS

The definition of negative symptoms is clearly crucial to this concept.

Crow (1980) and Angrist et al., (1980) adopted a narrow definition of negative symptoms (NS). They described two criteria: affective flattening and poverty of speech.

Sommers (1985) included emotional as well as social withdrawal and stated that the term negative and positive imply nothing regarding either pathophysiology or the necessary relationship between positive and negative symptoms; both of which are seen as remaining open to empirical investigation. She then went on to assert that the term "residual symptoms" or defect/deficit state " should not be equated with negative symptoms.

Goldberg (1985), in his defense of the concept that negative symptoms respond to neuroleptic drugs, included as negative symptoms indifference to the environment, apathy, hebephrenic symptoms, inappropriate affect, poor social participation, poor self care and confusion.

Carpenter et al., (1985) insisted on their distinction between primary and secondary negative symptoms. According to this view, several of the above symptoms, and particularly poor social