

CLINICAL RESEARCH

## Unipolar Depression in Paroxysmal Schizophrenia

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### Abstract

Based on the current study, the clinical characteristics of unipolar depression in the clinical picture of schizophrenia with the paroxysmal type of disease course are presented. Given the concomitant depression with phobic symptoms, the following clinical variants are marked: depression with generalized social phobia and/or anthropophobia and depression with generalized pathological body sensations and hypochondriacal phobias. In other words, we are talking about a necessity to allocate a special type of schizophrenia with affective structure episodes and comorbid neurosis-like symptoms.

Information on the basic treatment strategy of schizophrenia with depressive structure episodes and comorbid neurosis-like symptoms in everyday psychiatric practice is also provided.

**Keywords:** *schizophrenia, depression*

### Introduction

In today's topical publications by the domestic authors on "Depression and Schizophrenia" issue, the information regarding the frequency of foreign studies on the onset of the depressive symptoms in schizophrenia, in step-wise symptomatic manifestations during the chronic course, as well as a contingent of community-acquired expressions according to epidemiological studies are included [1,2]. Foreign literature suggests that depressive symptoms, as an integrative part of the clinical form, can occur in any type of schizophrenia and at all stages of the disease. Depressive symptoms may be categorized as subsyndromal depression or fit the clinical picture of a major depressive episode. The fact of an additional antidepressant prescription to the base neuroleptic treatment in the national everyday psychiatric practice [3], including patients with a first psychotic episode, is a confirmation of the significant frequency of depressive symptoms in schizophrenia [4]. According to a survey of more than 500 Russian psychiatrists, the combination of antipsychotic and antidepressant therapy was prescribed for almost a half of all the patients with schizophrenia [5]. Most physicians consider it possible to use antidepressants in the acute period too. Among the main indications for antidepressant prescription, suicidal ideas, depressed mood,

depression and anxiety, and to a lesser extent, anhedonia and early awakening have been listed.

Relative to the theme of this topic, we need to focus on the interpretation of the role and importance of the affective symptoms of schizophrenia without persistent hallucinations and/or delusions. In the Manual of Psychiatry (1983) by academician A.V. Snezhnevski, the course of slow-progradient ("sluggish") schizophrenia in the active stage of the disease is characterized as being continuous, as an episode or as a series of episodes [6]. In the case of the paroxysmal course of slow-progradient schizophrenia<sup>1</sup>, it has the expression of attacks with polymorphic structure obsessions (attraction, contrasting thoughts) prolonged from several months to several years, acute paroxysmal phobias or chronic alarming depression with the phenomena of depersonalization (including in the form of painful mental anesthesia). The cenesthopathic option of hypochondriacal slow-progradient schizophrenia is also often observed within the erased affective phases. Autochthonous affective phases in the active period of the disease in the case of slow-progradient schizophrenia with hysterical manifestations are also discussed, and finally, the presence of adynamic depression in the case of poor symptoms of schizophrenia is ascertained. Slow-progradient schizophrenia is also possible in a one-episode form during the period of age crisis with a long duration of the episode as adynamic or hypochondriacal depression, impaired thinking, cenesthopathy and depersonalization disorders, as well as a penchant to a continual course of the disease.

A statement in the Manual of Psychiatry (1999) under the

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1. "Slow-progradient" in the sense of having obsessions, phobias or overvalued ideas.

editorship of academician A. S. Tiganov reads that the “sluggish” schizophrenia type, as well as other forms of schizophrenic psychoses, can develop continuously or episodically with a constant number of neurosis-like psychopathological disorders expressed as “axial” symptoms [7]. In other words, the current estimate of “sluggish” schizophrenia has been confirmed, as was done in the Manual of Psychiatry (1983). Subsequent publications acknowledge the possibility of the exacerbation status in the clinical obsessive-phobic type schizophrenia as an attack with a predominance of depressive disorders and anxiety increased ruminations oriented towards the past and the future; with regard to slow-progradient or “sluggish” schizophrenia [8]; the presence of depressive phases with hypochondriacal, hysterical and depersonalization symptoms have also been emphasized [9,10].

In the course of the naturalistic studies of the effectiveness of Seroquel in the combined therapy, a group of schizophrenic patients was selected having polymorphic neurosis-like symptoms and significant representation of depressive symptoms with a phase of a chronic depressive episode or recurrent episode with depressive structure [11]. The allocation of clinical variants of schizophrenia with multiple anxiety-phobic and obsessive-compulsive disorders with periodic, sustained-intermittent and one-episodic types of courses can also be a confirmation of the possibility of schizophrenia with paroxysmal neurosis-like symptoms [12].

## Material and Methods

In all, 29 patients (21/72.4% males and 8/27.6% females) having schizophrenia with a depressive episode were studied. The ages of the disease manifestations were as follows: 44.8% (n=13) at the onset of puberty, 20.7% (n=6) in adolescence and 34.5% (n=10) in adulthood. The average age from the time of onset was  $14.3 \pm 1.7$  years for the puberty period,  $19.6 \pm 1.9$  years for the adolescents, and  $39.5 \pm 8.8$  years for the adults. The inclusion criteria were depression with persistent and pronounced desadaptive influences on all spheres including social, domestic functioning and school/work, thus, taking into account the severity of the negative symptoms and the low socio-demographic indicators, enabling the diagnoses of the presence of schizophrenia. Subpsychotic transient manifestations were not an exclusion criterion in this study. Patients were examined at the stage of a unitary chronic actual depressive episode or recurrent depression.

Methods of study included clinical-psychopathological and clinical-anamnestic examination. At the stage of the actual depressive episode, the psychometric studies using the PANSS scale [13], Calgary Depression Scale [24] and the scale of social and psychological functioning were performed [15].

To identify statistically significant differences between the clinical subgroups, we used Student's t-test (parametric test for assessing the quantitative and binary normally distributed data), Mann-Whitney test (nonparametric test for the quantitative assessment of abnormally distributed and ordinal data), chi-square test (nominal data), Fisher's exact test (or exact chi-square test when dealing with small samples); Wilcoxon criterion iconic ranks (nonparametric test

for comparing two subgroups with rank dependent features) [16,17]. For signs of the binary type (i.e. those with only two values - “yes” or “no”), a representation of the relative frequency (proportion, ratio and their confidence intervals) was used. Zero statistical hypotheses regarding the equality of the relative frequencies in the two populations and no difference between the relative frequencies in one or two groups were verified. In such a case, if the null hypothesis was rejected, the alternative option that differences of statistical significance were present was accepted. When one of the subgroups compared was dominated by a frequency, the one-tailed test was used [16].

## Results and Discussion

Information on the presence of family history of psychopathology was obtained for 15 (51.7%) patients having schizophrenia with depressive episodes and having first-degree family members (n=10; 66.7%/15). Among certain groups of mental and behavioral disorders in the relatives of the proband, the manifest and pre-psychotic variants of schizophrenia were identified (n=6; 40%/15). In rare cases, affective pathology and personality disorders (n=3; 20%/15), alcohol dependence (n=2; 13.3%/15) or mental retardation of the younger brother (n=1; 6.7%/15) of the patient were identified. The pathognomonic included a significant number of biological fathers of probands (n=8; 27.6%/29), which did not produce any information because the proband's mothers had parted from the biological fathers soon after conception or after childbirth.

Information regarding the pregnancy and childbirth was collected for 20 (68.9%) mothers of the probands. In 9 mothers, the pregnancy and childbirth were uneventful (45.0%/20). In more than half (n=11; 55.0%/20), a Complicated Obstetric History (COH) was revealed<sup>2</sup>. The COH includes toxicosis during early pregnancy (n=5), threat of abortion (n=2), pathology in childbirth as uterine inertia which could lead to the implementation of cesarean section, forceps delivery, preterm labor or signs of newborn asphyxia (n=3). Four mothers (36.4%/11) of probands revealed a combination of up to two manifestations of COH. Various manifestations of the COH were revealed only in those patients with active manifestation of the disease during puberty or in the adolescent stage.

The average age of the patients at the time of onset of active disease during the ages of puberty or adolescence (n=19) was  $15.6 \pm 0.6$  years. Most of the patients in this group (n=12; 63.2%/19) continued schooling/lyceum or college. Without exception, all lived in the parental home or with their relatives. The average duration of the active phase of the disease was  $8.7 \pm 2.0$  years. At the time of this study, 26.3%/19 (n=5) of patients continued their education in school/high school, college/university, 10.5%/19 (n=2) of patients were working, 63.2%/19 (n=12) of patients had discontinued education or work, and disability was recognized in 26.3%/19 (n=5) of patients.

The vast majority of these patients (n=17; 89.5%/19) continued to live with relatives, and only two patients with

2. Obstetric complications according to foreign studies are an important factor associated with the subsequent development of schizophrenia [18].

active disease onset in adolescence were married with the complete submission and leadership in the home to a healthy family member. Some of the patients lived with mothers or mistresses, who were registered in the mental hospital. At the time of the active onset of the disease in adulthood, all the patients (n=10) had completed secondary or university education, while most of them continued to work. More than half had entered into a civil marriage, fewer numbers in an official marriage relationship, one patient remained alone and two patients were divorced. At the time of this study, with the mean duration of active disease up to  $8.2 \pm 3.0$  years, the same marital status was maintained. Most patients (n=7; 70.0%/10) had given up working and were recognized as disabled.

Among those patients having schizophrenia with depressive episodes, based on the information gathered from relatives, the psychopathological manifestations of diathesis were revealed in preschool and school ages<sup>3</sup>. The episodic (early and late version) and constant form of psychopathological diathesis were allocated [20]. The possibility of the similarity in manifestations of the constant form of psychopathological diathesis in some important parameters and, in some cases, the resemblance with personality characteristics is detected. Therefore, the relationship with the integrative evaluation of the disease in the form of progression is postulated [21]. In patients with schizophrenia, the frequency of the psychopathological diathesis reaches 86% (various manifestations of its combination are detected in 60.0% of the cases). The episodic form of psychopathological diathesis in the patients in our study occurred in 37.9%/29 of cases. In more than half of the patients (55.6%) having the active manifestation of the disease at the ages of puberty age or adolescence, the particular manifestations of hyperdynamic syndrome (rarely a schizoid variant), the overvalued fear of the dark, and sleep disorders such as dyssomnia were revealed among the early (preschool) manifestations of the psychopathological episodic diathesis.

The presence of the constant form of psychopathological diathesis was found significantly more frequently in patients with active manifestation of the disease during the puberty or adolescent stages (n=13; 68.4%/19 vs n=3; 30.0%/10; p=0.031). Among those patients with the active disease onset at puberty or during adolescence, the constant form of psychopathological diathesis in the vast majority of patients had presented as the communicative variant (n=12; 92.3%/13), in more than half of the patients as the energy variant (n=7; 53.8%/13), and in a single observation as an intellectual-sexual-dissociated variant. The combined variants of the constant form of the psychopathological diathesis were identified in more than half of the patients. In patients with the active manifestation of the disease in adulthood, it was marked only by solitary manifestations of the constant form of psychopathological diathesis, viz., the communicative variant in two cases, the dissociated variant in one case.

Both clinical groups at the ages of early puberty or adolescence or adulthood with active manifestations of the disease

revealed some degree of talent and interests, usually outside of their pathological variants<sup>4</sup>. To a certain extent the manifestations of their talent can be attributed, obviously, to their success in schooling, their learning ability in art, music schools, participation in competitions in the humanities and natural sciences, ease of mastering a foreign language and even the ability of self-mastery to play various musical instruments. In one case, a partial talent was manifested as mathematical ability, whereas in another case, according to their relatives, «a brilliant memory». A notable fact is the accumulation in patients with active manifestation of the disease during the age of puberty or adolescence, cases of successful schooling, partial manifestations of talent and interest in reading and collecting, while the good manual skills evident in childhood fascination with sports activities during the puberty or adolescent ages were more characteristic for patients with the active manifestation of the disease in adulthood. In general, these features, with an emphasis on the interests and lesser partial endowments were significantly more marked in the older age group (p=0.044).

In more than half of the patients (n=16; 55.2%/29), an initial stage preceded these active disease manifestations. In most patients (n=11; 68.8%/16), the psychogenic factor preceded to the initial stage, for example, one patient listened to a lecture about the dangers of narcotics. Significantly fewer patients (n=4; 25.0%/16) had the autochthonous occurrence of the initial stage. In patients with the active manifestation of the disease during puberty or the adolescent age in the case of the psychogenic provocation, the clinical picture of the initial stage was characterized by episodes of low mood, with a sense of weakness and lethargy (in the absence of increased school and home load) combined with causeless anxiety and individual manifestations of autonomic hyperactivity with the possibility of revealing one of the options of early episodic psychopathological diathesis (“fear of sleeping in the dark”, stuttering). A marked decline in adherence to the regulations of the school load in classes 5-6 could act in conjunction with the difficulties of comprehension and understanding of the teacher’s explanations as a prologue to the future unfolded slowness of idea in an active stage of the disease.

The clinical picture with psychogenic provocation of the initial stage in the case of active disease onset in adulthood could be limited by subdiagnostic depression with the emphasis on the lack of interest (“laziness”) and persistent neurasthenia-like syndrome with a “keyed up” feeling and a tendency to alcoholism with “in order to relax and rest”. The short initial stage could be revealed by symptomatically poor panic disorders, or, conversely, the long-term initial phase after its psychogenic provocation was formed from the persistent overvalued hypochondriacal ideas of “sexual inferiority” after treatment of venereal disease. The clinical manifestations of the initial stage with psychogenic provocation could be characterized by “cross-flow” symptoms<sup>5</sup>. As in the case of psychogenic provocation and in case of autochthonous formation, the clinical expression of the initial stage in some cases was limited by ideas of a sensitive relationship tarnished

3. Psychopathological diathesis is characterized by the occurrence of subclinical neuropsychiatric disorders in childhood and adolescence. These disorders are delayed usually at the time of the occurrence of the initial and active manifestations of the disease [19].

4. Pathological interests and hobbies: "any business classes that do not have practical meaning" [22].

5. The term is borrowed from Dorozhenok IY, 1999 [23].

by a depressive affect. The affective symptomatology could be limited to the manifestations of inverted circadian rhythm [24], viz., “a good mood in the morning, then as a blast - I scream at the family and do not want to listen to anyone” or the “day could start well, but by the evening I am under attack of laziness, apathy, weakness, lethargy”.

The absence of the initial stage in the clinical picture of schizophrenia with depressive structure of episodes was detected in 13(44.8%) patients. The patient group (n=7; 53.8%/13) with an active autochthonous commencement of the disease was identified among those patients with the absence of the initial stage. The exogenous factor (Cermet on one of the top row teeth without proper therapeutic training, influenza infection without complying with the therapeutic regimen) or psychogenic factor (beginning of service in the Army and separation from a loved elder brother in one case, alcoholism of husband in another) preceded the active start of disease in less number of patients (n=4; 30.8%/13). A visit to the dental office with the development of anxiety obsessive fears (“doctor used a syringe from another patient”) with future formation of a phobia of AIDS preceded the active manifestation of the disease with the absence of the initial stage in one case. In another case, the activity of the disease coincided with a friend’s party.

Based on the load of the episodes carried at the time of this observation, schizophrenia patients with a depressive structure of episodes were as follows: one-episode type of course (79.3%), low frequency of attacks (17.2%), in a single observation – multi-attack type of course (3.5%). Low frequency attack type of disease course was represented by not more than two episodes separated usually with incomplete drug remission.

In ICD-10 to assess the depression in relation to the post-schizophrenic variant (F20.4), it was recommended that the criteria of a depressive episode be used. The criterion of the severity of the depression according to DSM-IV, including the release of a major depressive disorder is used in the English-language literature for the assessment of depression in patients with schizophrenia [25]. The severity of the current depression matched the intermediate severity (between heavy and moderate)<sup>6</sup> in more than half of the patients studied (55.2%), by taking into account the number of primary and secondary depressive symptoms from the “a-g” list (F32, ICD-10). Severe DE was diagnosed in 24.1% of the cases, moderate in 6.9% of the cases, slight in 10.3% of the cases, and subdiagnostic manifestations in 3.4% of the cases. The total score according to the Calgary scale was  $8.5 \pm 3.8$ , a total score of the subscale negative symptoms on the PANSS scale was equal to  $30.4 \pm 3.2$  points; the average values of the scale of socio-mental functioning [15] indicated the most pronounced passive-apatetic social withdrawal ( $4.8 \pm 0.5$ ), emotional fencing off, blunted affect, and communication difficulties ( $4.5 \pm 0.6$ ,  $4.5 \pm 0.5$ , and  $4.4 \pm 0.7$  respectively).

6. For intermediate degree of DE severity (between severe and moderate), observations with all three typical symptoms of depression and two to three additional symptoms from “a-g list” (F32.0 ICD-10) are attributed. An intermediate degree of DE severity has been allocated by E. A. Grigoreva [26].

The prevalence of the vast majority of patients (96.6%) with complaints of depressed mood (including more than one-third with a touch of melancholy) was significantly inferior to the frequency of feelings of low self-esteem and a sense of self-confidence (10.3%), ideas of guilt and humiliation (24.1%), gloomy and pessimistic vision of the future (17.2%), as well as suicidal thoughts (31.0%), without appropriate attempts. In the group with the active manifestation of the disease during puberty or the adolescent ages, the suicidal thoughts were associated with “meaninglessness”, “worthlessness of his life”, “loss of meaning of life” or have been colored with a dreary shade of hypothymia combined with anhedonia and ideas of self-deprecation (“one bore, black around, vapid life, who I am in it - no one”). The suicidal thoughts could arise in an “influx” with the character “Death wish, I want to do something...”. In patients with a later age of active manifestation of the disease, the suicidal thoughts were more towards the desirability of death (“All is over, and it would be better”) and were motivated by a sense of being “so tired of living”.

Significant differences were found in relation to the greater frequency of dysphoric shades of hypothymia in patients with active manifestation of the disease during the puberty or adolescence ages ( $p=0.036$ ). On the contrary, the vitalization of the verbalized / non-verbalized dreary affect (protopathic metaphorical and atypical variants, for example, a feeling of “burning behind the sternum”) was recorded significantly more often in patients of the older age groups ( $p=0.026$ ). The loss of interest had a generalized character and applied to all spheres of the patient’s life (“do not want to even move”). However, no serious attempts were made to overcome the passive-apatetic lifestyle. Asthenia as a feeling of “weakness”, “lethargy”, and “constant fatigue” is permanent and autochthonous in nature and characterized by a particularly painful physical shade (“emptiness as if died”, “weariness as the gap”), which is largely connected with vital depersonalization or grotesqueness [27]. So, for example, a patient in his own words literally falls down, falls into bed after a no-long walk accompanied by relatives; and in another case, an attempt to execute the previously usual and prolonged physical exercise lasts less than half a minute. In some patients with active manifestation of the disease during puberty or adolescence, the violation of concentration in the patient’s own words or from the standpoint of patient’s relatives appears in connection with mental slowness (“hardly understands the meaning of the question; takes a long time to answer” or “thoughts flow slowly, barely think straight”); otherwise, obviously, there is a violation in the thinking (“head as empty - no thoughts, no words, nothing”). In case of the active manifestations of the disease in adulthood, “distraction” acts against the background of the relentless of a single idea (“think about my health permanently”).

The somatic manifestations of depression in most patients in the form of anorexia have an absolute character without any recovery in the evening; these manifestations are generally accompanied by a significant decrease in the body weight. Sleep disorders are varied and occur as an early (including extra prolonged) insomnia and a combination of

early and late insomnia. The last option of combined sleep disorders is found significantly more frequently among those patients with active disease manifestation in adulthood ( $p=0.05$ ), whereas the patients from the younger group significantly revealed a higher special variant of sleep disorders in the form of partial or complete insomnia at night with a long morning or afternoon nap ( $p=0.031$ ). In one-quarter of the depressed patients, with a clinical picture of paroxysmal schizophrenia, the atypical symptoms in the form of mood reactivity, increased appetite, in individual observations "leaden paralysis" and hypersomnia were marked. Absence of daily fluctuations in the mental status was noted in 75.9% of cases, the deterioration in the evening was much fewer in 17.2% of cases, and saddle and introverted types of circadian rhythm were identified in isolated cases (3.5%).

Depression in patients with paroxysmal schizophrenia in more than one-fifth of the cases was complicated by alcoholism. The motive of alcoholism was a bad mood with a dysphoric shade and a feeling of being keyed up ("I am on the verge of collapse") with a short improvement of a feeling of drunkenness or alcohol was taken to alleviate the condition of unfable anxiety combined with a sense of tension in the body.

Among the comorbid disorders in the clinical picture of depression in paroxysmal schizophrenia, unfable anxiety in some cases (37.9%) combined with a feeling of inner tension of the body, permanent autonomic anxiety (31.0%) (in individual observations as "somatoform autonomic dysfunction" of the digestive tract or respiratory tract organs), multiple phobic disorders (86.2%)<sup>7</sup>, obsessive-compulsive manifestations (37.9%) in the form of contrasting obsessions (rarely), unanxious protective rituals in obsessive fears regarding relatives [28], the compulsions of symmetry and order in clothing, involuntary visualization of tragic memories, and the circumstances for possible suicidal behavior, "insanity doubt"<sup>8</sup>, the doubts in completeness of domestic actions with rechecking, and other indifferent obsessions were highlighted.

The comparative frequency of the various phobic disorders in the structure of actual depression in patients with schizophrenia according to the age of the active disease manifestations is presented in Table 1.

Statistically significant differences in greater frequency of sensitive ideas of reference, generalized social phobia and anthropophobia ( $p=0.036$ ,  $p=0.035$ , and  $p=0.01$  respectively) in patients with active manifestation of the disease during the puberty or adolescence ages were marked. By contrast, hypochondriacal phobia ( $p=0.004$ ), agoraphobia with cenesthesia<sup>9</sup> occurred more often in the patients of the older group ( $p=0.013$ ).

The number of depressive tainted relationship sensitive ideas varies from "feel sidelong glances from them" to "it seems that people behind me, whispering behind my back" or

"it seems that I did not pay attention, whispering behind my back", "frustrating when people look at me and interfere in my personal space". In a single observation, relationship sensitive ideas were approaching towards elements of the imagination and perception delirium: "I notice some strange attitude of the people". The ICD-10 diagnostic category F4 releases two variants of social phobia: specific (isolated social phobia) and diffuse social phobia, which include almost all social situations outside the family circle (F40.1). Isolated social phobia affects the narrow area of social life, for example, in the form of a fear of public speaking, fear of eating in public, fear of failure of habitual actions in the presence of others. The professional activity of these individuals is not affected much or changed significantly. The foreign literature highlights isolated and generalized subtypes of social phobia [30]. The generalized subtypes of social phobia are expressed with distinguishing social exclusion; social exclusion is increasingly becoming the subject of a clinical study [31]. This variant of social phobia has become a subject of study, including in terms of therapy, for several domestic authors [32,33]. In the case of generalized social phobia, anxiety extends to almost all areas of life, coupled with the necessity of contact with strangers. The context of painful shyness includes the fear to attract attention, to reveal to people their "ugly sides", mostly moral, not physical. In most cases, generalized social phobia is combined with suspicion and the formation of sensitive ideas of relationships. Phobic avoidance in generalized social phobia extends to any social situation and affects virtually all spheres of life.

**Table 1.**

*Comparative frequency of the various phobic disorders in the structure of actual depression in patients with schizophrenia*

Characteristic	Age of the active			
	12-22 years		23 years and older	
	n=19	%	n=10	%
Number of patients with phobias	17	89.5	8	80.0
Generalized social phobia	9	52.9*	1	12.5
Sensitive ideas of reference	7	36.8**	-	-
Anthropophobia	10	58.8 <sup>^</sup>	-	-
Specific isolated phobia	1	5.9	-	-
Dysmorphophobia	1	5.9	-	-
Hypochondriacal phobia	2	11.8	6	75.0 <sup>^^</sup>
Mysophobia	2	11.8	-	-
Agoraphobia based on cenesthesia	-	-	3	37.5 <sup>o</sup>
Other phobias	3	17.6	2	25.0

\* -  $p=0.035$ ; \*\* -  $p=0.036$ ; <sup>^</sup> -  $p=0.01$ ; <sup>^^</sup> -  $p=0.004$ ; <sup>o</sup> -  $p=0.013$

In our study, the manifestations of generalized social phobia as a comorbid disorder in actual depression was characterized by a sense of "Trapped in the body", "the tension" when communicating or being in a circle of strangers, or "I cannot be around people, it seems to emphasize me" or "I'm afraid to be in the spotlight". Patients respond to questions surrounding people as if they were squeezing the words through an obstacle, accompanied by excessive sweating and heart palpitations. In a situation, for example, attendance, and

7. The term is borrowed [12].

8. The patient is unable to start or complete any action, doubting constantly about the correctness of the planned or executed action. The term was proposed by Legrand du Saulte (1875).

9. Cenesthesia is included in one of the manifestations of unpleasant body sensations in the clinical picture of "cenesthopathic" schizophrenia and are characterized by kinesthetic (muscle) and vestibular sensations [29].

a classmate attempts to talk to him; this is accompanied by the perception that others are “hostile, with disgust” and there is a desire to escape, to respond quickly or just pull the plug.

In our study, anthropophobia<sup>10</sup> differed from the generalized social phobia with fabula fear with varying degrees of severity. This was the fear of communicating with strangers and even former friends - «I'm afraid all would tell me nasty things». Otherwise, it is fear - «may offend» or «sense of danger, can be rude, to strike». For example, during the survey period in the hospital, one patient was fidgety, rubbed his eyes, ruffled his hair, looked around, and looked at the faces of others: «I must be vigilant - do not miss a threat». One of the patients bought a gas canister and a gun, and carried them with him, even if he was away from home for a very brief time because of the fear of people («There are detractors around, wait a trick») or preferred to leave the house with any of the relatives.

Special cases are a combination of generalized social phobia with anthropophobia and rarely with depressive-tinted ideas of a sensitive relationship. As a result, patients take the position - «I cannot be around people, eschew all contact», or «I want to be alone, I feel calmer». In one patient, the need to leave the house amplifies the anxiety, provokes heart palpitations and a sense of tension in the body. One patient, beyond the yard of his house, makes sure that no one walks down the street and stops using public transport independently. As a result, a special attitude is formed. As in the case of generalized social phobia in conjunction with sensitive attitudes and ideas the «sense of the difficulties of communicating with people», and, in particular, anthropophobia in the form of communication fear with the fabula of moral and physical threat, there is an escape from society and, in fact, a preference to follow a «monastic life» [34]. As a result, the patient so sums up his state - «I am avoiding contacts. I am weary of people. I do not belong there. I am like a hermit».

With regard to the representation of the comorbid phobic symptoms, the monomorphic and polymorphic patterns of the episode are highlighted in patients with actual depression in paroxysmal schizophrenia. Thus, in the case of the manifestations of the active disease during puberty or adolescent age, the options with comorbid symptoms in the form of structurally related or complementary generalized social phobia, anthropophobia, and sensitive ideas of relations are classified as monomorphic structure of depression. The polymorphic structure of depressive episode includes the same options as the phobias, however, in combination with the other content of phobic disorders (filth-dread, dysmorphophobia, fear of insanity, fear of falling sleep and not awaking, hypochondriacal phobia, specific phobia or isolated), as well as individual manifestations of obsessive-compulsive disorder. In patients with active manifestation of the disease in adulthood, both the monomorphic and polymorphic structures of the depressive episode were also marked. The monomorphic structure of actual depression was represented by two cases, corresponding to the clinical picture of «limited hypochondria» with monolocal cenesthesias and

persistent requests for the removal of the «sick part of the body». Polymorphic structure of depression was diagnosed in the case of generalized pathological sensations and multilocal cenesthoalgic-cenesthopathic syndrome [35] in combination with hypochondriacal phobias expanded with a few observations of compulsive disorders.

An analysis of pharmacotherapy in schizophrenia patients with depressive episodes in the domestic everyday psychiatric practice confirms the existing basic strategy of therapy for patients with schizophrenia and depression, which involves adding antidepressants to antipsychotics [5]. It is important to note that schizophrenia patients observed with depressive episodes were prescribed, in most cases, atypical antipsychotics in combination with antidepressants, as a group of tricyclics and representatives of SSRI. As an additional therapy, patients were prescribed tranquilizers, cerebroprotectors to the vast majority, and mood stabilizers in 20% of cases. The results of this therapy were negligible, which could be explained by the incomplete insight of the patients [36], including unconsciousness of the social impact of the disease in the case of active disease manifestations during puberty or adolescent age. Consequently, recommendations for maintenance therapy were performed «on occasion» as well due to the lack of significant additions to medical therapy in the form of intensive psychoeducational effects. In patients with active disease onset in adulthood and the presence of comorbid generalized pathological sensations combined with hypochondriacal phobias, the result of the therapy also was unsatisfactory, even with the recommendations during the interhospital period.

On discussing the results obtained, it should be noted that the ICD-10 (class V), adopted for use in domestic psychiatry Order of the MoH RF (1997), in relation to depressive disorders in schizophrenia, has only one diagnostic category “past psychotic depression” allocated (F20.4). Meanwhile, according to the foreign epidemiological studies, the presence of depressive symptoms in schizophrenia is lesser in frequency than only the hallucinatory-paranoid and apathetic (negative) changes [37] and the addition of neuroleptic treatment with antidepressants has become almost the main strategy for the treatment of schizophrenia in the daily practice of domestic psychiatry [2]. Hence, there is the problem of determining not only the stage of schizophrenia (initial, manifest, and chronic courser) with the presence of depressive symptoms; but it is also possible to allocate the clinical forms/types of schizophrenia with the predominantly affective disorders, and, for example, comorbid non-psychotic (neurosis) symptoms<sup>11</sup>. Undoubtedly, this finding opens the way to view the possibility of the paroxysmal course of slow-progradient<sup>12</sup> schizophrenia in the Manual of Psychiatry

11. In accordance with the version of the ICD-10, Class V, adapted for use in the Russian Federation [38] pseudoneurotic schizophrenia has been included in the diagnostic categories “Schizotypal Disorder» (F21), hypochondriac schizophrenia (including its cenesthopathic option) – under the heading “Other type of schizophrenia» (F20.8).

12. “Slow-progradient” schizophrenia in our understanding considering the registration of neurosis symptoms. Relatively the more favorable course of “slow-progradient” forms with a tendency towards stabilization and regression of the process constitute one-third of the entire “slow-progradient” schizophrenia [39].

10. Anthropophobia (from the Greek, *Anthropos* and *phobos* - fear) - fear of being in society, to be among people.

(1983) [6], confirmed in the reprint of the Manual of Psychiatry (1999) [7] and (2012) [40], as well as in separate publications on this topic [9,10].

How should we approach the assessment of the above observations in this study? Undoubtedly, they are heterogeneous. On the one hand, they noticeably widen the scope of knowledge about pubertal and youth depressive episodes with the comorbid phobic disorders in the form of generalized social phobia, anthropophobia, often supplemented with depressive sensitive ideas of reference, which are relatively little-known in domestic psychiatry. Among the patients studied with the active manifestation of the disease in adulthood, we selected a small group, which revealed similarities to the “circumscribed hypochondria” (limited hypochondria) by the interpretation of the domestic authors [41], but with a significant difference between the main matrix, being the presence of the sustained depression with the comorbid pathological monolocal body sensations beyond the algic circle and the patient behavior, devoid of auto-aggression, to eliminate the pathological bodily sensations. The clinical picture of the second variant of depression in paroxysmal schizophrenia with active disease onset in adulthood highlighted in this paper combines the hypochondriac and anxious-hypochondriac types of slow-progradient schizophrenia described recently [42] but with a significant addition to our observations as outlined diagnostically as depression. The integrity of the clinical picture is seen in the unity of depression (with extreme severity and quality asthenia) with multilocal cenesthoalgic-cenesthopathic syndrome, permanent vegetative disorders, and hypochondriac phobias.

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