Recurrent Schizophrenia or Schizoaffective Psychosis

Mamatkhonov Maksudbek Marifjon ugli

Andijan state medical institute
Direction of Psychiatry
Master's degree 3rd year student
E-mail: Spire94_net@mail.ru

ABSTRACT

This article discusses recurrent schizophrenia or schizoaffective psychosis. This we must know as the source of future ideas about schizoaffective psychosis and true recurrent schizophrenia. But just citing it as a source is not enough. The fact is that in the late XIX - early XX centuries. there were fierce disputes and discussions, attempts to distinguish between periodic psychoses and manic-depressive ones. These efforts have continued to this day. The names have changed, but the essence has not changed.

Keywords: Recurrent schizophrenia, schizoaffective psychosis, disease, periodic psychosis, clinical psychiatry, paroxysmal schizophrenia, hallucination-delusional psychoses, brain damage, degenerative, hereditary, exogenous diseases.

Previously, some archaically called them periodic psychoses. I am not inclined to call it that, because there is no periodicity, with the exception of isolated cases, in the so-called, there is no recurrent schizophrenia or schizoaffective psychosis and does not happen.

Two historical sources of clinical psychiatry, which determine the most recent allocation of the so-called. schizoaffective psychoses. Leaving aside all those cases of dissociated psychosis by French authors, which I spoke about last time, they are identical to paroxysmal schizophrenia. Discarding all cases of subacute and acute paranas, which pass and disappear with residual residuals; those hallucinatory-delusional psychoses that also pass paroxysmally - we are left with a large group of acute psychotic states, affectively colored, starting with affective disorders and reaching in their development (not always, but in a smaller number of cases) the degree of clouding of consciousness.

By the way, not everyone agrees that this happens. In the second half of the 19th century, these cases were classified into two groups. I speak only of the most extreme, most characteristic points of view, discarding various intermediate cases and assessments, which, of course, had something in common when the groups were singled out.

What were the groups? In the 2nd half of the 19th century, when there was still no modern psychiatric nosology, there were two points of view regarding periodic psychoses:

1) schneider's circular or cyclothymic psychosis (later - Kraepelin's manic-depressive psychosis) was already distinguished as a nosological unit;

2) periodic psychoses L.K.Kirn. There was an exceptionally large interweaving here: manic-depressive psychoses were often attributed to Kirn's periodic psychoses and in the circular psychosis there was a part of those described by Kirn. The same phenomena were described under different names.

L.K.Kirn distinguished two groups of periodic psychoses: 1) primary or central, 2) secondary or peripheral. By primary or central, L.K.Kirn understood diseases that go away with affective and affective-delusional disorders arising from damage to the brain or harm that acts directly on the brain. Some of these diseases belonged to him to degenerative, hereditary and some - to some kind of incomprehensible, exogenous.

The second group - secondary or central psychoses - was also represented by manias and melancholia, both with delirium and without it, but in which L.K.Kirn seemed to know the cause of their occurrence. And the reason was different, polyetiological: first of all, diseases of the internal organs, sometimes of endogenous origin and exogenous hazards that acted on the periphery.

This we must know as the source of future ideas about schizoaffective psychosis and true recurrent schizophrenia. But just citing it as a source is not enough. The fact is that in the late XIX - early XX centuries, there were fierce disputes and discussions, attempts to distinguish between periodic psychoses and manic-depressive ones. These efforts have continued to this day. The names have changed, but the essence has not changed.

The following sources of periodic forms of schizophrenia. Let's go back to Kraepelin'y. As I have already said, in the 6th edition of the "Textbook" in 1899, E. Kraepelin singled out, in addition to 3, what we then began to call continuous, undifferentiated acute cases. But already in the 8th edition in 1915, Kraepelin had 8 more forms of acute schizophrenia in addition to these. In addition, he described, as an independent form, paranoia and paraphrenia until the 9th edition of 1926.

I want to stop once again and retreat, so as not to return later, because paraphrenia will be discussed in passing. Until now, in our country and abroad, some understand paraphrenia as an independent disease. About two years ago, I read a doctoral dissertation at the Higher Attestation Commission, which is based on differentiating delusional schizophrenia from paraphrenia. I will not go into details, but there the whole differentiation was built on the basis of the teachings of I.P.Pavlov. When did I.P.Pavlov deal with paraphrenia? I don't know, he had no idea what paraphrenia was at all. But everything there was built on his teachings. The important thing is how sometimes our thought undergoes some jumps. Take, for example, paranoia, a delusional state with Kandinsky's syndrome and then two psychoses are differentiated in the same patient - everything that was known to V.Magnan and J.Baillarger, i.e. already receded into the past and become axiomatic. I of course, exaggerate. A paraphrenic state is taken from one and the same patient, a delusional state from another, a differential diagnosis is carried out between them and for this a doctorate degree is awarded.

So, paraphrenia was then independent, because discreteness was not visible. We must understand why paraphrenia was independent at that time.

Sluggish cases of chronic delusional psychosis - dementia paranoides - proceed unnoticed and if a delusional patient with his ridiculous actions does not go out into society, then he does not go to the hospital. He gets when crazy ideas become ridiculous and he can not be kept at home. And when the patient arrives, they say that he fell ill yesterday (actually much earlier) and paraphrenia is already considered independent. But this is a mistake in observation and inattention of doctors. And can we reproach Kraepelin'y or other researchers for not seeing anything? In no case. There were other tasks that distracted researchers and thinkers; and when there were hundreds of sick people for one person, then you can’t penetrate into the subtleties of each one and you can’t follow it. But there were other researchers who saw the mild paranoia of K.Gaupp, Friedman described mild paraphrenia and E. Kraepelin in recent years begins to understand that paranoia and paraphrenia are one. But he still did not dare to change all this and when he died, the last edition of his "Textbook" was already edited by J. Lange.

So, E.Kraepelin, highlighting and leaving for the present independent, described clinically 8 forms of schizophrenia. These were:

depressive, depressive-delusional, acute paranoid, intermittent, agitated, depressive-stuporous, acute catatonia and schizophasic. These 8 forms were described in 1915 in the 8th edition of Kraepelin's Textbook. At their core, these were the prerequisites for what we now call recurrent, recurrent or periodic schizophrenia, schizoaffective psychosis, atypical endogenous psychosis. These are synonyms.

It is known that even during the life of Kraepelin there was a FERIOUS criticism of his teachings and mainly, of his dichotomous scheme, where manic-depressive psychosis was on one pole, and schizophrenia was on the other. And it all started with the fact that A.Hoche wrote a work on symptom complexes, and in the end, in 1920, E. Kraepelin was forced to admit that he was right to a certain extent. From the very beginning, there was no satisfaction with a rigid dichotomous scheme; not all cases fit into it. It was a reality, a clinical fact. What about psychoses that did not fit? Studies have been carried out, I will mention only the main ones. The C.Wernicke-K.Kleist school, mainly Kleist, was most involved in this matter. C.Wernicke, as you know, did not recognize Kraepelin's concept at all. And the clinician C.Wernicke was God's grace, but he is less known to us than E.Kraepelin, because E.Kraepelin is the creator of the concept. But if you refer to the works of C.Wernicke, you will see that he was a more subtle and refined clinician than E.Kraepelin. It is no coincidence that C.Wernicke left so many definitions and psychiatric definitions. C.Wernicke described paraphrenic, paranoid and neurotic states with such clarity and precision that you can use these descriptions even now. He singled out three large groups of psychoses: auto-, somato- and allopsychosis. Since K.Kleist was a student of C.Wernicke and the whole teaching was built on brain pathology, in order to get out of the impasse that had created in the dichotomous system, he began to select those cases that did not fit into the rigid boundaries of manic-depressive psychosis and schizophrenia, dementia praecox. For the first time, the so-called. motor psychoses, the names of which were given by C.Wernicke. K.Kleist wrote that motor psychoses - with hyperkinesis and akinetic - differ from catatonic ones. This is not the catatonia we talked about: with negativity, muscle stiffness, etc. This catatonia is different: with expressive and expressive movements. Therefore, these motor psychoses cannot be classified as catatonias.

Even K.Kleist singled out another group of psychoses, which were accompanied by severe anxiety, fear or expansiveness. C.Wernicke said that there is an expansive psychosis, K.Kleist later called it a psychosis of inspiration, excitement. By the way, in the modern manual H.W. Grule (1960), translated into Russian by B.M. Segal and I.Kh. Dvoretsky, there is a mistake in translation. It is written "psychosis of suggestion" - Eingebungspsychose. You can translate Eingebungs as “suggestion”, but this is not a psychosis of suggestion, but of inspiration, excitement, because it was opposed to another psychosis - inhibition (in C. Wernicke and K. Kleist). This is a translator's error and indeed, you can ignore it. It was necessary to look in the context of what C.Wernicke and K.Kleist wrote - Eingebungspsychose.

Many years have passed with this group, called by Kleist "edge psychoses" - Randpsychosen. And all his students - E.Funfgeld, P.Schroder - developed this group. Subsequently, they were combined into autochthonous degenerative psychoses. Again the question arose of degenerative psychoses, bearing in mind (as, indeed, now) heredity. Various sub-forms have been delineated and identified. Their line was further continued by K.Leonhard, having singled out the 3rd nosological endogenous unit - the so-called. cycloid psychoses. He essentially borrowed everything from his teachers - psychosis of fear, happiness, inhibited and uninhibited depressions, affectively saturated paraphrenia - and differentiated them with similar schizophrenic groups. K.Leonhard stated directly that he was trying to overcome the collapse of the dichotomous system and, as he called it, "the impoverishment of psychiatry." But he emphasized that he stands on the firm positions of Kraepelin’a, i.e. on nosological. In our literature, Leonhard was criticized a lot, I

also expressed my disagreement. But there is a rational grain that there is a group of diseases, also endogenous, which do not fit into the rigid framework of the dichotomous system, of course.

I told you about the direction that was more inherent in German psychiatry. But there are two psychiatric schools in the world: French and German. How did the French work in this direction? Independently, independently and fruitfully.

Of course, they did not deal with the problem of Kraepelin's dichotomy. However, in France there were students of Kraepelin who carried his ideas. Later in France, schizophrenia was adopted with some amendments and today the question arose there too: what to do with affective-delusional psychoses? To which group do they belong? But keeping in mind the syndromological direction of French psychiatry, in contrast to German, I will allow myself one more digression in order to explain what the syndromological direction means.

Back in 1903, the remarkable clinician and pathobiological theorist Ballet wrote in a manual on psychiatry (and French psychiatrists remember this now): all countless attempts at clinical differentiation of nosography were unsuccessful and were erroneous. Of course, nosology is the most essential task, but it is a matter for the future. Why did all these attempts fail? Because real nosology (and this is the delimitation of diseases) is based on knowledge of etiology, pathophysiology, pathomorphology and the clinical picture. And with our illnesses, we do not know this. Therefore, the purpose and task of our time (Ballet wrote this 70 years ago) is to painstakingly study the syndromes in their dynamic development and explore what happens. He was absolutely right.

Just do not understand me in such a way that I deny nosology, because the groups were nevertheless singled out and at least fundamentally correct: schizophrenia and manic-depressive psychosis, these two poles. Therefore, it is necessary to work correctly in the future and investigate the syndromes and symptom complexes, the symptoms of their development, but taking into account what is already an achievement of psychiatric thought.

So, in recent years, French psychiatry has also dealt with the problem of periodic and acute psychoses. And the most acute - delirium acutum - is a combined concept that is often found more in French psychiatry and in German - T. Meinert's amentia. In general, everything that was not included in the acute cases of manic-depressive psychosis and Kirn's periodic psychoses was dumped into an even larger pot than hebephrenia - into Meinert's amentia. And we are surprised: the real concept of amentia is completely different than what it used to be. It really was a group. T.Meinert himself singled out depressive amentia, depressive confusion, amentia due to an increase in manic excitement, hallucinatory amentia (this is only biologically) and the list could be continued. And if we talk about the cause, then amentia included rabies, alcoholic and postpartum psychoses, etc. The French considered Delirium acutum not as a disease, but the Germans had a tendency to isolate the disease (they approached scientifically). The syndromic direction, which is negative when it is extreme, was at the same time positive: the French never claimed that delirium acutum was an independent disease, but considered it as a combined syndrome. P.Guiraud, however, singled out idiopathic forms.

So, you and I have the most acute forms such as amentia and not so acute that they lead to death - affective-delusional, up to oneiric catatonia. In France, all this was combined under the name "acute delusional outbursts" of Magnan. We know Magnan for the continuous forms, for the associated intermittent-progressive psychoses, but Magnan also dealt with acute delusional outbursts. "Outbursts" is a relative concept and means an attack. But that's why they were called outbreaks, in comparison with psychoses in degenerates, because they really seem to flare up, i.e. develop rapidly, which is one of the characteristic features of schizoaffective psychosis. In France, these outbreaks - acute psychoses - were divided into the following 4 groups:

1) acute fantastic psychoses of E.Dupre and J.B.Logre, which most often proceeded with delusions of grandeur or humiliation, self-accusation and sometimes took on the character of enormity;

2) acute interpretive psychoses P.Serieux and M.J.Capgras, similar to acute paranoid states;

3) acute hallucinatory-delusional psychoses with a large component of pseudo-hallucinations and ideas of influence, i.e. acute Kandinsky syndrome;

4) atypical manic-depressive psychoses; however, they were called not so, but as equivalents to MDP: catatonic, senestopathic, acute delusional, pseudomelancholic schizophrenia, schizoform melancholia, schizophrenic psychoses of a catatonic structure.

The 20th etude, the 2nd paragraph was specially devoted to acute psychoses. Just like all French psychiatrists (and German ones as well as ours), H.Ey asks the question: where to attribute acute paranoia, acute delusional and acute catatonic disorders? They have nothing to do with schizophrenia. Maybe they should be included in the TIR framework as an independent unit? H.Ey perfectly remembers Ballet's testament that the task of psychiatrists is to identify nosological units. Compare: the French say that the time has not come (they have not yet come to this, consider that they have not come up and they are right), and we say that we have already stepped over the nosology. Where are they to be taken? To TIR? - Not. Maybe to exogenous acute obscurations of consciousness? - Doesn't fit either. And H.Ey - the subtlest psychopathologist, theoretician of psychiatry (although, perhaps, standing on some erroneous positions) - leaves this question open. But he knows the facts of the matter impeccably. Then he tries to resolve the issue in a different way, examining all acute psychoses from the point of view of the destructuring of consciousness. He singles out 3 degrees of destructuring of consciousness (taking into account only acute periodic, recurrent psychoses): 1st degree corresponds to manic-depressive (manic-melancholic) insanity; 2nd degree - affective-delusional and hallucinatory-delusional psychoses. The first two degrees H.Ey refers to endogenous groups, but the 3rd degree, which has oneiric confusion (like twilight and delirium) with clouding of consciousness, is not related to the endogenous group. These are all exogenous reactions.

This is how French psychiatry dealt with acute outbreaks, and the ideologue H.Ey sharply set the boundaries between endogenous and exogenous. And the 3rd degree, i.e. what we can evaluate and consider within the framework of amentia, delirium, deep oneiroid stupefaction, febrile schizophrenia - he delimited from the endogenous process. We also have such tendencies, after all, we absorb them from German and French psychiatry (although we took more from German).

Thus, gradually, in the world psychiatric field, the prerequisites were created for research (there is still no teaching as such here) of the so-called. endogenous psychoses. They were called atypical or marginal (according to Kleist'y) because they did not fit into the circle of schizophrenic and manic-depressive psychoses.

I will not dwell on the points of view of other psychiatrists who in one way or another reflected German or French psychiatric thought. These are the views of H.Rumke and G.Langfeldt, who singled out true and pseudo-schizophrenia. The point of view of H. Rumke, who said that the search for symptoms specific to schizophrenia is scientific folly, is peculiar and original (I would even say extravagant), and one should look for symptoms that are primary for true schizophrenia and be guided by the so-called. the intuitive feeling of the researcher: if the researcher sees, feels that it is schizophrenia, then the diagnosis is correct. Moreover, H.Rumke proclaimed his position not just in a conversation, but at an international congress in Zurich and proposed the term Praecox-Gefuhl. This does not mean that H. Rumke did not understand anything in psychiatry. He was the finest clinician and singled out the following forms: true endogenous schizophrenia, pseudoschizophrenia (among which there was

still an endogenous group) and an unknown group.

In general, all these attempts at separation, of course, did not lead to anything. The problem of acute atypical psychoses seemed insoluble. Various genetic studies were involved, which also yielded nothing. It is permissible to ask: what was the attitude towards this in our country? We had two lines: acute atypical endogenous psychoses (which are discussed here) were considered as 1) atypical TIR; 2) as periodic schizophrenia. The last point of view is the school of A.V.Snezhnevsky and the first one (attributing atypical endogenous psychoses to atypical MDP) was dealt with by all other researchers who were not united in a single clinical direction. These periodic psychoses were distinguished by: R.Y.Golant in Leningrad (as diencephalic psychoses), G.Y.Sukhareva, T.Y.Khvilivitsky. The latter, describing atypical MDP in 1957, said that it had little in common with MDP, because its genesis was organic (traumatic, infectious, etc.). I am more impressed by the point of view of I.I.Lukomsky. He considered atypical MDP within the framework of MDP, emphasizing its atypicality in the structure of phases, pointing to a large proportion of confusion (which was noted earlier by Kraepelin), a large proportion of somatic sensations, their prolongation and different coloring. This point of view about atypicality can be accepted.

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