

## SOCIAL CHARACTERISTICS OF PATIENTS WITH SCHIZOPHRENIA FOR A LONG TIME IN COMBINATION WITH EXOGENOUS-ORGANIC DISEASES OF THE BRAIN

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**Abstract.** *For many years, great interest in psychiatry has been a matter of combined pathology. Currently, the combination of schizophrenia with exogenous-organic brain diseases remains the least understood. According to the results of previous studies, the organic process significantly changes the clinic and orientation of schizophrenia, which affects both personality changes and the quality of remission, which in turn determines the parameters of social activity and reflects the patient's adaptive capabilities. In many years of the disease, the level of social activity in patients with schizophrenia decreases in many areas at the same time.*

**Keywords:** *schizophrenia, exogenous-organic diseases, personality changes, alcohol dependence.*

**Introduction.** There is an opinion that organic brain failure softens the schizophrenia defect, makes patients more comfortable and in contact [1-3]. Mental disorders combined with alcohol addiction are increasingly becoming an object of close study, as they exist at the "crossroads" of two specialties – addiction and psychiatry, thus leading to difficulties in the medical examination, prevention and treatment of patients [4-9]. Thus, according to various authors, one-fifth (20%) of patients with alcohol addiction, drug addiction, and drug addiction detect procedural endogenous mental disorders, and 12-50% of patients with endogenous diseases abuse alcohol and drugs [10-16]. However, the special dispensary account of patients in this group is not carried out in either Narcological or psychoneurological dispensaries. With a sufficiently studied psychiatric component of combined pathology [17-23] it should be noted that the clinical features of the course of secondary alcohol dependence are not sufficiently illuminated-real and symptomatic [24-29], also, the effect on the motivation and effectiveness of alcohol treatment in people with mental pathology of the characteristics of the recorded types of alcohol dependence. Thus, the purpose of this study is (1) to study the clinical features of secondary alcohol dependence in people with non-specific mental disorders, as well as (2) the effect of these characteristics on patients seeking alcohol assistance and the effectiveness of various types of Alcohol Therapy [30-33].

Excessive alcohol consumption is directly related to the exacerbation of the main symptoms of the disease [34]. There may be no primary pathological attraction to alcohol during remission [35]. During addiction, there may be long-term, "unexpected" self-remissions [36]. There is also "secondary true alcoholism", in which the symptoms of addiction that appear in the "base "of mental illness are completely" separated " from the underlying disease, and alcohol addiction develops in the same patterns as primary true alcohol addiction [37-40]. Various forms of pathological attraction to alcohol, loss of control, increased tolerance, withdrawal symptoms

and even typical alcoholic psychoses (delirium, hallucinosis) are observed [41]. Terminology, this type of dependence belongs to the heterogeneous type of development and development of the addictive process in patients with endogenous diseases [42].

The purpose of the study: The goal is a comparative analysis of social performance in patients with schizophrenia and in patients diagnosed with organic brain disease at different stages of psychiatric observation, in addition to the diagnosis of schizophrenia.

**Materials and methods.** On the basis of the dispensary Department of a large psychiatric hospital, 105 cases of schizophrenia were examined, which were observed in a psychiatrist for at least 10 years by an unparalleled, clinical-psychopathological method. The study included individuals over the age of 18 diagnosed with schizophrenia (under ICD-10 F 20.0 - F20.9), with the duration of the disease ranging from 10 to 42 years. According to the research tasks, patients are divided into 3 groups: 1 – individuals with schizophrenia without constant organic deficiency; 2-individuals with schizophrenia and with an exogenous history of deleterious. Organic signs were identified in them. And later, in a clinopsychopathological examination, patients of this group were diagnosed with stage I or I-II psycho-organic syndrome. However, despite the information about the presence of a pathology in which they were combined, exogenous-organic pathology was not diagnosed in the second. Group 3-individuals diagnosed with exogenous-organic brain disease at different stages of the disease, in addition to the diagnosis of schizophrenia.

Such a sign is intended to distinguish between " primary "or" real " alcohol dependence, which appears on psychopathologically unloaded soil and continues according to classical law, forming mental and physical dependence – alcohol withdrawal syndrome. In symptomatic alcohol dependence, such patterns are not followed, and alcohol abuse develops as an independent symptom of a mental illness, or as a symptom that is directly related to it, despite the presence of alcohol abuse or constant abuse for a long time.

**Results and discussions.** The split left 64 people (60,9%) in 1 Group, 26 people (24,8%) in 2 groups, and 15 people (14,3%) in 3 groups. Next, an analysis of social indicators from objectified data sources (outpatient card), a clinical interview was conducted. The study was conducted through a survey-based map to assess the social functioning and quality of life of the mentally ill. To determine the level of social activity of patients, the GAF scale and the patient performance assessment scale in various social areas were used. The results obtained and their discussion. The distribution of patients in groups by gender and age did not reveal significant gender and age differences. Mixed factors predominated from exogenous-organic damage.

There were 11 people (42,3%) in 2 groups of such patients, and 7 patients (46,7%) in 3 groups. In the second group of those tested, the proportion of vascular and somatogenic factors was also higher - 7 people (26,9%), compared to the third Group - 2 people (13,3%). In the third group, the percentage observed in 4 patients (26,7%) was higher than in the second group in 2 patients (7,7%). The first group found 34 people (53,1%) to be unfit for treatment, the second group found 10 people (38,5%), and the third group found 6 patients (40,0%) to be unfit for treatment. Often the subjects received secondary special education. And if in the third group there were no persons who graduated from a higher educational institution, then in the first group the number of such patients was 12 people (18,8%), in the second Group 3 people (11,5%) received higher education. All three groups had students not anywhere during the study, 1 Group employed 11 people (17,2%), the second group employed 2 people (7,7%), and the third group employed 2 people (13,3%) (including temporary pay). There was a significant increase in the average seniority of patients in the second group.

The average seniority of patients in the second group is  $14,2 \pm 1,2$  years, in the third group  $9,7 \pm 1,4$  years, in the first group  $7,2 \pm 0,8$  years. All groups were dominated by individuals with

Group II disabilities. In the first group, the proportion of widowed, single and divorced women was 56 people (87,5%), living with their spouse only 8 people (12,5%).). In the second group, there were slightly fewer loners than in the first group, with 21 people (80,8%), and in the third group, the number of loners was 12 people (80,0%). The number of patients who never had a family turned out to be significantly higher in the third Group – 9 (60,0%), in the first group – 31 (48,4%), and in the second – 8 (30,7%). They live alone, without relatives. the first group had 25 people (39,1%), the second group had 10 people (38,5%), and the third group had 2 people (13,3%). Over the past 5 years, the first group has seen higher admissions to a psychiatric hospital (its average is 2,26 times in 5 years, and 1,38 and 1.46 in 2 and 3 groups).

In the third group, patients have been treated in a day hospital twice as often as in the other two groups over the past 5 years. On average, patients of the second group are less likely to be admitted to mental hospitals than patients of the first and third groups, and are treated in a day hospital at approximately the same frequency as patients of the first group. The sum of the average scores on the patient performance assessment scale in different social areas: in Group 1 – 13,1 points, in Group 2 – 12,8 points, in Group 3-13,4 points. In Group 1 of patients on the GAF scale, the average score is  $39,5 \pm 1,2$  points, in Group 2 –  $39,9 \pm 1,5$  points and in Group 3 –  $37,7 \pm 1,7$  points. In accordance with the goals and objectives of the study in the composition of the combined pathology, we considered true alcohol dependence or symptomatic alcohol dependence as components of a single combined (comorbid) disorder. True alcohol dependence was diagnosed by us in 67 people (60 men and 7 women) (1 gy), symptomatic – in 33 people (28 men and 5 Women) (2 gy). These groups did not differ in age. In terms of the psychiatric component of the combined disorder, Group 1 had a significant advantage over patients with organic brain damage (32,8%) and mental retardation (11,9%) ( $p < 0,02-0,05$ ) and 2 GT had a significant advantage over patients with schizophrenia (88,24%), and they had a higher prevalence than Group 2 ( $p < 0,02-0,05$ ). More than 1 g ( $p < 0,001$ ).

In Group 1 patients (with true Alcohol Dependence), alcohol-dependent relatives are reliably frequent ( $p < 0,009$ ) and the debut of mental illness has been found to be associated with prior intensive alcoholism ( $p < 0,0003$ ). Reliably, in Group 1 ( $p < 0,05$ ), patients began to abuse alcohol before the age of 25 and, accordingly, alcohol withdrawal syndrome was formed, periodic type of alcohol abuse ( $p < 0,04$ ) and frequent ( $p < 0,0008$ ) alcoholic psychoses were observed. We also evaluated therapeutic motivation, therapeutic efficacy and duration of therapeutic remission of alcohol dependence, as well as the duration of stay in patients of research groups outside the walls of a psychiatric hospital. At the same time, we tried to objectify the data as much as possible and were not limited only to the answers of patients to relevant questions. We used data from medical documents, information from close relatives, neighbors and medical personnel. In patients of Group 1, alcoholism significantly negatively affected the development of a combined mental illness in comparison with 2 gy ( $p < 0,05$ ), which was manifested in provoking an exacerbation of the underlying disease, increased aggression, including to close people, increased antisocial activity, which often served as a reason for psychiatric hospitalization. Group 1 patients showed significantly less time intervals outside the walls of a psychiatric hospital ( $29 \pm 4,7$  days and  $54,9 \pm 14,4$  days;  $p < 0,05$ ). Frequent ( $p < 0,02$ ) alcohol consumption by Group 2 patients "softens" psychiatric symptoms, such as depression, irritability ("calms"), and reduces the severity of suspicion, improves communication, etc. Apparently, due to the distinctive variety of alcohol methods, Group 2 patients were less likely to seek treatment from alcohol dependence, with nearly half (46,3%;  $P < 0,05$ ) Group 1 patients attempting to treat alcohol dependence by various methods, including secondary indirect psychotherapy methods (20,9% and 5,9% of 2 gy patients). 34,3% in Group 1 and 11,8% in Group 2 were re-treated for alcohol dependence.

However, despite such a reliable difference in turnover, the average duration of therapeutic remission did not make a reliable difference between the groups. Patients in this group were primarily (88,3%) diagnosed with true secondary alcohol dependence, and only 4 cases (11,7%) were diagnosed with symptomatic alcohol dependence. Organic brain damage in 68% of cases preceded the development of az and served as a kind of "soil", and in 32% of cases, the development of alcohol dependence preceded organic brain damage, sometimes the direct cause of brain damage (severe brain damage or dementia after alcohol delirium), sometimes absent (infectious brain diseases, epilepsy since childhood). Hereditary weight was reported in 63% of patients in this group due to alcohol dependence. Alcohol dependence in this group is a moderate component, and the median age for the formation of alcohol withdrawal syndrome is 28 years, which may be due to the presence in this group of mentally retarded patients with difficult access to alcohol. The composition of alcohol withdrawal syndrome is dominated by a neurological component, manifested by cephalgia, bulky tremors, epileptiform seizures.

The latter does not contain alcohol withdrawal syndrome in patients with schizophrenia combined with real addiction. Interestingly, in patients with schizophrenia, compared with "organic substances", alcohol withdrawal syndrome was dominated not only by the mental component, but also somatic-vegetative. In the study group, the constant type of alcohol abuse (70,4%) was significantly ( $p < 0,05$ ) superior to the periodic type (29,6%), which isolated the group of patients. Also, in 53% of cases, alcoholic psychoses were diagnosed, which is 2 times the number of alcoholic psychoses in a group of patients with schizophrenia who are addicted to real alcohol. We also studied in detail the issues related to alcohol addiction therapy. Organic patients with the true nature of addiction were found to have made confirmed treatment attempts in 53% of cases, with 43% of patients treated more than 1 time. Only 3 patients indirectly resorted to psychotherapeutic treatment with the method of emotional-stressful psychotherapy, which is much less (11 people) than patients with schizophrenia. It is important to note that 18 (60%) of organic patients have been diagnosed with varying degrees of decreased intelligence.

We also found out how much alcohol dependence affects the development of a combined disease in terms of its impact on the mental, somatic-neurological and social condition of patients. That reveal the positions of the "negative" and "positive" effects of alcohol dependence on the joint disease process. The data is represented by points. Each character of this or that register was given 1 point. It is clear that one patient can characterize the effects of alcoholism from different positions. Analyzing the data, we note that the positive aspects of intensive alcoholism have significantly affected the condition of patients in comparison with negative ones, even in relation to patients with schizophrenia. Considering that organic patients seek treatment and use it (and often repeatedly) more often than patients with schizophrenia, the more severe the effect of real alcohol dependence on the above conditions, the more patients and their relatives seek to get rid of addiction. mainly the use of inpatient pharmacological treatment, and less often-outpatient psychotherapeutic. Of course, the quality of treatment and personal involvement require a lot. Only 4 people from this group were able to achieve a remission of addiction for more than 1 month. However, there is a general trend in which intensive alcoholism is not seen as a coping or coping factor.

**Conclusions:** Exogenous-organic mental disorders in schizophrenia are not often recorded by psychiatrists as a second diagnosis, in our study only 15 people (14,2%). In the patients examined, a high percentage of exogenous-organic risks of a mixed nature were identified. Compared to a group of patients with schizophrenia who are incompetent, the diagnosis of exogenous-organic disease of the brain during the disease is less pronounced, the history of exogenous-organic damage is less indicated in incompetent patients.

In Anamnesis, patients with exogenous-organically non-harmful schizophrenia often graduate from higher education and carry out more labor activities, although not always on a permanent basis. In general, the second group (individuals with schizophrenia with a stage I or I-II psycho-organic Syndrome Clinic in exogenous deleterious Anamnesis) appears to be "safer" in terms of socio-demographics: they have greater seniority (statistically significant increase in average seniority of patients in the second group ( $p < 0,001$ )). compared to the first group of patients), they are less likely to be disabled, patients in this group are more likely to marry. In general, when assessing indicators on the social activity scale, indicators in the second group are slightly better than in the first and third. Thus, it can be assumed that patients with schizophrenia who have an exogenous deleterious history and do not have clear clinical manifestations of coarse organic pathology have a predisposition to a high level of social activity. To some extent, this is confirmation of the conclusion of a number of authors that organic brain failure softens the schizophrenia defect. In connection with the results obtained, further research in this direction is necessary.

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