

CLINICAL RESEARCH

Prodrome of Paranoid Schizophrenia with Episodic Type of Course and Schizoaffective Structure of Manifest Episode

Alexander S. Bobrov*, PhD, ScD; Marina Yu. Rozhkova;
Nina Yu. Rozhkova, PhD

*Irkutsk State Medical Academy of Continuing Education
Irkutsk, Russian Federation*

Abstract

Prodrome of paranoid schizophrenia with the episodic type of course (F20.1 and F20.2 according to ICD-10) and the schizoaffective structure of the episode was retrospectively studied. The pronounced and persistent affect, in particular depression in conjunction with hallucinations and/or delusions throughout the whole episode, served as the basis for an episode qualification as the schizoaffective structure. Diagnosis of schizophrenia was confirmed by the extremely low socio-demographic indicators at the time of the manifest episode, by the presence of catatonic or catatono-oneiroid symptoms in more than half of the patients, as well as an incongruence of hallucination plot and/or delusions against the dominant affect. In most cases, the affective symptoms were detected in clinical presentation of a prodrome and significantly more often in the form of depression, in comparison with bipolar and mixed affective disorders. Different clinical manifestations of negative symptoms were revealed in significantly more than half of the patients. The study showed that there is a significant frequency of negative manifestations in conjunction with depression in the prodrome.

Keywords: *prodrome; paranoid schizophrenia; schizoaffective variant; episodic type.*

Introduction

A prodrome (Latin - *prodromus*; Greek - *running forward*) is a precursor or *harbinger*, any symptom that signals the impending onset of a disease. The prodromal period generally refers to the time interval between the onset of the first prodromal symptom and onset of the characteristic signs/symptoms of the fully developed illness. For example, prodromal period in a clinic for schizophrenia, which is delayed in time from the occurrence of initial (pre-manifest, prodromal) and active manifestations of the disease, should be distinguished from episodic and constant forms of a psychopathology diathesis in the preschool and early school years [1]. In Russian literature, the clinical signs, which may cause one to suspect the possibility of schizophrenia, include a headache, dizziness (like coenesthesia), mizo-oxy-tafophobia, dyspsychophobia (body dysmorphic disorder – BDD), dyspsychophobia, panic attacks with increasing agoraphobia, bizarre asthenic and hysterical disorders in conjunction

with obsessions, pathological fantasy and propensity to form overvalued ideas, disorders of appetency, depression (often) and mania, paratimia against relatives, regressive syntonos or, on the contrary, isolation combined with a painful vulnerability, and elements of thought disorder [2]. However, none of these signs taken separately is sufficient for the diagnosis of schizophrenia; only a certain set of them suggests the possibility of this disease. A generalized description of prodromal manifestations, preceding an acute episode of schizophrenia, includes a mild cognitive impairment; motor changes; specific disorders of perception; loss of interest in work, social activities, appearance, and hygiene habits—all of which is combined with mild depression [3].

According to foreign literature of the late 1990s, a semistructured interview (IRAOS) for a retrospective analysis of the early stage of schizophrenia was used in large-scale epidemiological and neurobiological research in patients with the first episode of schizophrenia. However, the negative and affective symptoms were allocated as the initial manifestation of the disease [4]. Social decline occurred on average 2–4 years before the first hospitalization; in the case of late-onset diseases, decline in social status compared with an elevated initial state was marked. Research of prepsychotic detection

**Corresponding author:* Prof. Alexander S. Bobrov, PhD, ScD. Irkutsk State Medical Academy of Continuing Education. Irkutsk, Russian Federation Email: bobrov_irkutsk@rambler.ru

and intervention before a manifestation of psychosis has been conducted only since the beginning of this century, so there is a need to better understand what we are going to discover [5]. This is particularly true of subjective experiences in the prodromal period. Nevertheless, four major manifestations of the prodromal period are allocated in this paper. These include a cessation of classes at school (or a significant time of school nonattendance) or at university, shift of interest, social passivity and isolation, and odd behavior or appearance. Early adolescent social dysfunction with anhedonia, suspicion, and a decrease in mental health is also considered as a good candidate for inclusion in a prediction algorithm of future psychosis (hazard ratio [HR] = 1.30; $P=0.014$) [6].

Basic cognitive-perceptual manifestations of a prodrome are allocated. In order to identify them, the COPER (Cognitive-Perceptive Basic Symptoms) scale and COGDIS (Cognitive Disturbances) scale, comprising from 9 to 10 basic symptoms, were used [7,8]. The version with 9 symptoms (COGDIS) includes an inability to allocate attention, interrupting thoughts, racing thoughts, sperrung (mental block), receptive language disorder, expressive language disorder, unstable ideas of relationships, abstract thinking disorders, and diversion of attention to the details that fall within the field of view. It is noted that some of these disorders, such as interruption of thought, receptive language disorder, and visual distortion, predict schizophrenia with a probability of 91% (specificity: 0.95-0.91; false-positive probability: 1.9-7.5 %). However, psychometric variables are unable to distinguish between two groups of subjects with a prodrome as having either transient psychotic symptoms or active psychotic process with the gradual development towards a definitive diagnosis of schizophrenia [9]. Perhaps cognitive and perceptual symptoms should be identified at an earlier stage of the prodrome before the onset of attenuated psychotic symptoms and a significant deterioration in general functioning [10].

Borders of prodromal symptoms of schizophrenia are significantly expanded. So, along with the negative-affective disorders and basic cognitive-perceptual symptoms, other positive symptoms are highlighted. They include weakened (subpsychotic) symptoms, namely delusions, suspiciousness, and thought disorder [11].

According to the SOPS scale, among prodromal manifestations, positive symptoms in the form of unusual thought content/delusional ideas, suspiciousness/persecutory ideas, grandiosity, perceptual abnormalities/hallucinations, conceptual disorganization are highlighted [12]. Negative manifestations (SOPS scale) include social isolation and shut off, abulia, emotional flattening and deficit feeling of "I", the impoverishment of thinking, impaired role behavior. General symptoms include sleep disturbance, dysphoric mood, motor disturbances, and impaired tolerance to normal stress.

In the early years of this century, a number of authors writing about the allocation of "hard core vulnerability to schizophrenia," regardless of the degree of positive symptoms, emphasized the importance of cognitive deficits, social isolation, and school failure [13]. In the first decade, the concept of ultra-high risk of prodrome transformation

in the obvious psychotic state was formulated. At the same time, some authors include in this concept life in the city, receiving state benefits, and poor premorbid adjustment [14]. Others emphasize that the risk syndrome for future psychosis (psychosis risk syndrome – PRS) is derived from criteria of ultra-high risk (UHR) and presupposes the existence of subthreshold or attenuated psychotic symptoms [15]. Greater detail is as follows: Criteria for high-risk transformation in psychosis include attenuated positive symptoms, brief intermittent psychotic symptoms, and change in mental status or decrease in the intensity of social functioning for at least 1 month in the previous year [16,17]. This list is complemented by genetic risk indicators, namely, the presence of any psychotic or schizotypal disorder in first-degree relatives. Detection of patients with PRS enables early intervention to be carried out to prevent or delay the onset of a full psychotic disorder. Treatment with antidepressants and antipsychotic medication helps to improve the condition of patients in the prodrome, which is a prerequisite for a high level of recovery after the initial episode [13,18].

PRS is the most controversial diagnosis in discussions about the new version of the Diagnostic and Statistical Manual of Mental Disorders, DSM-V [18]. There is a potential danger in unforeseen consequences of classifying PRS as an official diagnosis; this danger makes the inclusion of PRS in the DSM premature [15]. Moreover, the reason, according to the discussion, is the possibility of unduly exposing people to the effects of antipsychotics. Nevertheless, identification of the prodrome symptoms is welcome, including a structured interview adapted for the extensive clinical examinations [18].

In the cited foreign studies devoted to the schizophrenic prodromal state, there is no differentiation among the types and forms of its course. A survey of foreign literature on the schizophrenic prodrome (also without differentiating its forms) contains a number of Russian publications [19-21].

From the standpoint of the domestic taxonomy, paranoid schizophrenia with an episodic course and progressive or stable defect (F20.1 and F20.2 according to ICD-10) includes paraphrenic schizophrenia, schizophrenia with the Kandinsky-Clérambault syndrome (hallucinatory and delusional variants), as well as paranoid schizophrenia with an episodic-progradient course [22]. Paranoid schizophrenia with an episodic course and progressive or stable defect (F20.1 and F20.2) is equivalent to episodic-progradient (shift-like) schizophrenia in the Russian taxonomy [23].

It should be noted, in episodic-progradient schizophrenia, Russian guidance in psychiatry from 1983 allocates 3 clinical variants [24]: malignant (close to juvenile schizophrenia with the continuous course) variant; progradient variant with episodes of paranoid delusions, acute hallucinosis, acute paranoid delusions with Kandinsky-Clérambault syndrome, acute paraphrenic delirium; schizoaffective variant with episodes of affective-paranoid delusions, affective-hallucinatory delirium, and acute syndrome of Kandinsky-Clérambault on a background of depression or mania.

In Russian manuals of psychiatry (1999, 2012), compared with guidance from 1983, among clinical manifestations of episodic-progradient schizophrenia,

malignant and progradient variants are retained, but the schizoaffective (“polymorphic”) variant is excluded [25,26]. Clinical systematics of this schizophrenia were added with a variant that is close to sluggish schizophrenia with symptoms of neurosis registered on a background of a depressive or manic affect. Schizoaffective psychosis is highlighted in a separate diagnostic group [27,28]. Six clinical variants of schizoaffective psychosis classified in accordance with historical differentiation dividing by affect-dominant and schizo-dominant forms are marked. Visual-figurative delirium (oriented oneiroid, antagonistic delusions) and episodes with the Kandinsky-Clérambault syndrome in structure of delirium of perception with elements of interpretation were attributed to the “marginal” variants of schizoaffective psychosis. Episodes with clinical presentation of intellectual delirium of perception, and two variants of episodes with Kandinsky-Clérambault syndrome in structure of visual-figurative delirium or interpretative delirium were included in the schizoaffective variant of schizophrenia. Delirium of perception (delusional mood, delirium of dramatizations, delirium of symbolic value) is defined as the “nuclear” option of schizoaffective psychosis. It should be noted that the clinical manifestations of schizoaffective psychosis did not receive any broad discussion in modern Russian literature. However, the results of G. P. Panteleeva’s research raise the question of the inclusion of the schizoaffective variant in clinical taxonomy of types of episodic-progradient schizophrenia.

The aim of the study was the allocation of clinical features of the paranoid schizophrenia prodrome with an episodic type of course (F20.1 and F20.2 according to ICD-10) and schizoaffective structure of manifest episode.

Material and Methods

The prodrome was studied in 44 patients (females - 30/68.2% and males - 12/31.8%) with paranoid schizophrenia with an episodic type of course (episodic-progradient schizophrenia in a domestic sense). Women were significantly predominant in the study ($P=0.02$). The mean age at the prodrome onset was 25.3 ± 10.4 years. The average age at the manifestations of psychosis was 26.6 ± 9.8 years.

Inclusion criteria were the presence of paranoid schizophrenia with pronounced and persistent affective symptoms (such as depression) throughout the whole manifest episode. The presence of clear affective symptoms in the structure of the manifest episode indicates the episodic course of the disease. Socio-demographic indicators of the studied group of patients served as confirmation for the diagnosis of schizophrenia. At the time of the active manifestations of the disease, most patients were not legally married ($n=34/77.3\%$); civil marriage was registered only in a few cases ($n=2/4.5\%$). Most patients did not have children and continued to live with their parents ($n=31/70.5\%$). Diagnosis of the schizoaffective disorder is excluded based on the presence of the transient catatonic or catatonic-oneiric symptoms of the manifest episode in the clinic in more than half of the patients. Incongruence of plot of psychotic symptoms (hallucinations and/or delusions) to the depressive affect, which was dominant in this study,

also suggests the diagnosis of schizophrenia¹. Patients with paranoid schizophrenia with the presence of manic or mixed affective symptoms in the structure of the manifest episode by analogy with manic and mixed types of the schizoaffective disorders (SAD) were excluded from the study.

Study methods included a clinical-anamnestic method with a retrospective reconstruction of the clinical features of the prodrome according to the words of patients’ parents, the patients themselves, or, if they were married, husband or wife. This type of clinical evaluation of the prodrome is fundamental to the evaluation of its predictive validity [30].

Statistical analysis was performed using the software package Statistica 6.1. A database of 32 attributes was composed. We used the Chi-square test to compare observed data. A binomial test and the one-sample χ^2 criterion were used for checking the gradation characteristics. Cramer’s correlation coefficient was used to analyze the relationship between the two signs. A value of $P<0.05$ was considered statistically significant.

Results and Discussion

Among patients with paranoid schizophrenia with an episodic type of course and schizoaffective structure of manifest episode, the presence of the prodrome, compared with its absence, was revealed with a high degree of statistical significance ($n=35/79.5\%$ vs $n=9/20.5\%$; $P<0.001$). The highest frequency of the prodrome ($n=13/29.5\%$) occurred in the fall, with almost equal frequency in summer ($n=9/20.5\%$) and winter ($n=8/18.2\%$) and a significant decrease in the spring ($n=5/11.4\%$). A stressor preceded the prodrome onset in more than half the patients ($n=18/51.4\%$), and the stressor was presented significantly more often with psychogeny compared to the exogenous affect ($n=14/77.8\%$ vs $n=4/22.2\%$; $P=0.03$). A content of psychogenic stress, preceding prodrome formation, was assessed from the perspective of its importance to the patient [31]. For different patients, this content consisted of loss of the object of affection and love (the rupture of relations with the boyfriend, the death of a loved one in the family); the loss of material well-being in connection with getting fired; threat to health in the form of serious complications in childbirth; significant threat to the health of persons (addiction of son, in another case, the arrest of son). An exogenous factor, head injuries, was presented in two cases, including a brief loss of consciousness and healthcare seeking. In one case, the stressor was surgery (tubal ligation); in another, severe childbirth with multiple ruptures of the perineum. In both these cases, we cannot exclude the value of stressful infertility in young women, and in the second case, an added health threat. An increased workload preceded the prodrome in two cases. In one of these cases, the prodrome coincided with the beginning of an internship to improve language skills abroad.

¹ Study of the schizoaffective disorders (SAD) of depressive type enabled to significantly complement the diagnostic criteria of the ICD-10 (F25.1). Along with distinct depressive symptoms in combination with one or two schizophrenic symptoms from the list of “a-g” (F20, ISD-10), SAD is characterized by the congruence of the content (plot) of hallucinatory and / or delusional symptoms against the dominant depressive affect [29].

The relative frequency of various clinical manifestations of the prodrome is presented in Table 1. As follows from the table, a significant incidence of affective disorders was found in the prodrome of paranoid schizophrenia ($n=28/80\%$). Affective disorders in the form of depression occurred significantly more often than did bipolar and mixed affective disorders ($n=17/60.7\%$ vs $n=8/28.6\%$ and $n=3/10.7\%$; $\chi^2=10.8$; $df=2$; $P=0.004$).

Table 1.

Clinical characteristics of prodrome

Prodrome presentation	Paranoid schizophrenia ($n=35$)	
	Abs.	%
Affective disorders, including	28	80.0
Depression	17	60.7/28
Single episode	15	88.2/17
Recurrent course	2	11.8/17
Bipolar affective disorders	8	28.6/28
Single hypomania	-	
Mixed affective disorders	3	10.7/28
Negative symptoms of the prodrome	20	57.1/35
Subpsychotic symptoms	13	37.1/35
Other variants	3	8.6/35

The negative symptoms of the prodrome, in accordance with the foreign systematics, were retrospectively diagnosed in significantly more than half of the patients ($n=20/57.1\%$). Subpsychotic symptoms were detected in 37.1% ($n=13$). In a few cases, the prodrome included a long-term symptomatic panic disorder, active pursuit of weight loss in overweight women, symptoms of neurasthenia on a background of increase in work volume and short deadlines.

Dreary affect of hypothyria in prodrome presentation ("sorrow", "sad", "sadness"), as well as its vitalization, was identified in sporadic cases. A few patients reported thoughts about the unwillingness to live; in 2 cases, depression was provoked by a personally meaningful psychogenic factor in the form of "loss" of the object of affection and love. A gloomy and pessimistic vision of the future was not typical for patients with depression in the prodrome structure. Ideas of guilt and humiliation were detected in sporadic cases ("disappointed in myself, did not meet the expectations of parents"). Reduced self-esteem and self-confidence were also rare, but when they occurred they applied mainly to matters of study ("Cannot get a good grade, the teacher will be betrayed") or to self-doubt in one's own abilities, fear of failing the exam, or having to write a term paper. The asthenic component of depression ranged from increasing weakness during the day with the need to rest in the evening to a variant of the grotesque—"Went to the store and already tired" or "collapse after work"—without increasing its volume and duration. In some cases, asthenia was of an autochthonous character, especially in the morning ("There is no way to get out of bed") and was maintained for the rest of the day ("All the day I'm just lying").

Sleep disorders included difficulty falling asleep in the evening (including ultra-long early insomnia), and mixed variants in the form of difficulty in falling asleep in the

evening, nightmares, frequent awakenings during the night, and significant reduction in the number of hours of night sleep. Neither disorder was registered as late insomnia. Among patients with reduced appetite, the absence of hunger or eating only a small amount of food at the urging of relatives was noted only in few cases. Obviously, the phenomenon of daytime sleepiness (without indication of nighttime sleep disorder) and increased appetite should be attributed to the atypical symptoms. Signs of motor or psychomotor slowness, as well as autonomic hyperactivity (palpitations) in the structure of depression, were identified in isolated cases. Isolated manifestations of restlessness and fussiness ("I start one work which fails and start another one") should be attributed to the individual manifestations of anxiety. Irritability, which was not typical formerly, should be attributed to additional symptoms in patients with depression in the prodrome. Irritability was targeted and focused on one of the parents or on a younger brother or sister, accompanied by a louder voice or using profanity or accusations against the family, and occurred "on any occasion."

Bipolar affective disorder (BAD) is the second most frequent clinical manifestations of affective disorders in the prodromal period of paranoid schizophrenia. Overall, 8 patients with affective disorders according to BAD type at the time of active disease manifestations underwent 12 depressive and 9 hypomanic phases. Depression was the manifest phase in 6 cases (including 2 cases provoked by psychogenic factors and 2 cases provoked by head injury). In retrospect, two major clinical manifestations of the developed hypomanic phase can be identified. Most often, this phase manifests as a sharp change in behavior, which was not typical in the premorbid period. For example, according to the teacher's words: "She used to be a gray mouse, and now she is dancing to the music of mobile phone in front of everyone," as well as a significant change in the pattern of premorbid behavior, such as actively visiting nightclubs, being absent from home for a few days or returning home after midnight, categorically refusing to communicate with her parents, starting to smoke, stealing parents' money, and casual dating with young people (including via the Internet). In adulthood, during hypomania, she broke off long-term civil relations based on "I do not want marriage" and travelled across the country to the man whom she met via the Internet. Patients in hypomania become an object of ridicule and pranks or become arrogant and separated from the group. They also exhibit categorical and rude behavior against relatives in defending their "right to privacy." In cases of repeated hypomanic phases in the framework of a continuous or recurrent course of BAD, hypomania was presented by cliché-like variants.

Frequency in content of the various negative symptoms in the structure of the prodrome was represented in descending order. Thus, social isolation and withdrawal were detected with a frequency close to half (48.3%). In particular, there was a breakdown of communication with friends, nonattendance at previously attractive entertainment and recreational activities, and a lack of communication with close relatives in the family and neighbors (the phenomenon of "sitting at home"). Several features in the shift of interest, as a variant of negative

symptoms, were detected in 27.6 % of cases. This shift was a continuity of the exciting interests in the state of hypomania alternating with depression. For example, an adherence to the principles of “healthy food” expanded significantly to absurdity in depression (requirement for parents to organize the apartment in a special way, insistence on following cooking instructions exactly and purchasing products without supplements). In a state of hypomania, there is an interest in biographies of writers with an unhealthy mind and suicidal tendencies, and the absence of any interests when in depression during the 1st and 3rd episodes.

Exciting interests can be split according to two stages of the prodrome. Interest in religious literature, in an attempt to understand oneself and place in life, arise in the 1st stage of the prodrome. In the 2nd stage, after psychogenic provocation, depression with expansion of the interest content, namely, the interest in religious literature coupled with reasoning about life and death, is formed. Passion for computer games could act against the background of social isolation, alienation from loved ones, lowering of performance at the university, refusal to continue the work, and the presence of elements of a delusional mood (fear for one's own life and the life of loved ones).

Irresponsibility (refusal to study or take part in professional activities) (20.7%) is manifested by dismissing responsibilities on one's own initiative, obtaining vacation without pay, followed by dismissal based on such beliefs as “there is no need for me in my work, they will cope without me,” as well as skipping lessons at school with a reduction in performance and the unusual unsatisfactory ratings, or refusal to study at the university. At the same time, irresponsibility (skipping) was combined with social isolation, alienation, and a violation of role behavior, and, only in one case, with the emergence of unusual interests. Violation of role behavior, including grubbiness or odd behavior, occurred in 17.2%. For example, a young woman stopped using cosmetics, although earlier, according to relatives, she did not leave home without makeup. She rarely used hygienic procedures, despite the fact that previously she took a bath several times a day; she did not change her underwear and outerwear for a long time. Another example is a teenager who lost interest in his appearance, while earlier, he used to ask for advice from parents on the best clothes, and he stopped brushing his teeth and bathing. In the case of urgent requests, the teenager closed the bathroom and pretended to be taking a bath.

About cognitive impairment (10.3%), we can mark it with certainty only in the structure of the next prodrome. For example, a few months before the onset of depression on the background of interest in a religious order (“Lent”), cognitive impairments were manifested in the form of statements: “It has become difficult to think, I cannot carry out routine tasks, it takes a long time to memorize, and the concentration of attention has decreased.” Such complaints as “It has become difficult to learn; the brain thinks for a long time; the information does not enter into the brain; I do not remember what I read” should be attributed to actual cognitive impairment as a manifestation of the negative symptoms without concomitant depression, but, in one case, with the presence of an exciting interest in palmistry. In the case of the prodrome with hypothyria, the sleep disorders and a sense of insecurity, and impaired concentration with a decrease in performance, obviously, should not be attributed to the actual negative manifestations. Reduced tolerance to everyday stress factors (6.9%), in one case, was manifested as subpsychotic symptoms in the debut of the prodrome. It was the fear of entering the porch of her own house. The patient did it only with help of the father or husband. The emotion of fear arose after hearing a rapid clatter upstairs (as it turned out, it was the housemate coming down). In another case, the prodrome was provoked by an increase in the patient's usual work.

We studied the correlation between the negative symptoms of prodrome and the affective symptoms. Representation of negative manifestations in prodrome depending on the type of the affective disorders is presented in Table 2. The Pearson criterion ($\chi^2=57.3$; $df=12$; $p<0.001$) and the Cramer criterion ($V=0.74$) were determined. Affective disorders were more often presented with depression (Yates corrected $\chi^2=6.41$; $P=0.01$) in patients with paranoid schizophrenia with negative symptoms in the structure of the prodrome, or negative symptoms took place in the prodrome of patients without affective disorders (Fisher's exact test, $P=0.005$).

Representation of negative manifestations in prodrome depending on the course type of depression is presented in Table 3. There was a moderate relationship between the parameters (Pearson criterion: $\chi^2=62.4$; $df=15$; $P<0.001$ and the Cramer criterion: $V=0.77$). In patients with paranoid schizophrenia with the negative symptoms, the depression in prodrome was presented with a single depressive episode (Yates corrected $\chi^2=10.13$; $P=0.0015$).

Table 2.

Relationship between signs of the presence / absence of negative symptoms in the prodrome and the type of affective disorders

Clinical presentation of prodrome (n=35)								
Clinical variant of prodrome	Absence of negative symptoms		Negative symptoms in structure of depression		Negative symptoms in structure of hypomania (BAD)		Negative symptoms in absence of depression	
	Abs.	%	Abs.	%	Abs.	%	Abs.	%
Depressive episode	5	14.3	12	34.3*	-	-	-	-
Hypomania in structure of BAD	-	-	-	-	1	2.9	-	-
BAD (depression in structure of BAD)	3	8.6	4	11.4	-	-	-	-
Mixed affective disorders	3	8.6	-	-	-	-	-	-
Absence of affective disorders	4	11.4	-	-	-	-	3	8.6**

*- $P=0.01$; **- $P=0.005$

Table 3.*Relationship between signs of the presence / absence of negative symptoms in the prodrome and the course type of depression*

Clinical variant of prodrome	Clinical presentation of prodrome (n=35)							
	Absence of negative symptoms		Negative symptoms in structure of depression		Negative symptoms in structure of hypomania (BAD)		Negative symptoms at absence of affective symptoms	
	Abs.	%	Abs.	%	Abs.	%	Abs.	%
Single depressive episode	3	8.6	12	34.3*	-	-	-	-
Recurrent course of depressive episode	2	5.7	-	-	-	-	-	-
Hypomania in structure of BAD	-	-	-	-	1	2.9	-	-
BAD (depression in structure of BAD)	3	8.6	4	11.4	-	-	-	-
Mixed affective disorders	3	8.6	-	-	-	-	-	-
Absence of affective disorders	4	11.4	-	-	-	-	3	8.6**

* $P=0.0015$; ** $P=0.005$

Frequency of subpsychotic symptoms was 37.1% (n=13). These symptoms included delusional mood with the plot of fear for life, life of loved ones, and even of neighbors in the dorm. Paranoid symptoms were presented by complaints, such as, allegedly, discussion of the patient by colleagues “behind the back,” ascertaining of a “duplicitous team,” detection of the changed attitude of his wife (“ceased to love”), as well as a clinically delineated plot of adultery with active control by the husband during the day, using a mobile phone, browsing the text message with the search of messages from women. Delusional fantasies such as accusations that the elderly mother brings a boyfriend at night, the elements of the delirium of imagination in the form of “I feel myself like in another world,” nightmares (“terrible beasts, end of the world”), the manifestations of the ideational variant of the Kandinsky-Clérambault syndrome by type of “influx” of thoughts (“a bundle of thoughts”) have been identified in individual cases.

Thus, this study indicates the possibility of allocation, among the clinical variants of paranoid schizophrenia with an episodic type of course (F20.1 and F20.2 according to ICD-10), of the clinical variant with the manifest episode of the schizoaffective structure based on the expressed affective symptoms (depression in the present study) combined with hallucinations and/or delusions throughout the manifest episode. Negative symptoms in the prodrome presentation were marked in half of the cases. They were presented with social isolation, shifting of interests, skimping (refusal of study or professional activity), and violation of role behavior. Cognitive impairment and reduced tolerance to everyday stressors were noted much more rarely. It was marked that there is a significant correlation between the negative symptoms in the prodrome and depression, significantly more often with a form of single depressive episode.

Competing interests

The authors declare that they have no competing interests.

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