

A Study of Symptom Complexes/Syndromes in an Out-patient Sample of Patients with Schizophrenia

Wafaa E. Haggag, Hanaa Soliman, and Lamis A. El Raie

Recent published research on the diagnosis and phenomenology of schizophrenia and related disorders reflects a gradual shift in interest from categories to dimensions and individual symptoms. However, methodological deficiencies as the use of chronic hospitalized populations were recognized. As a result, there is a growing need to investigate these phenomena among patients who are living in the community and are being managed in out-patient facilities while receiving neuroleptic medication.

Sixty five patients with the diagnosis of schizophrenia according to DSM-IV had been assessed using BPRS and Andreasen's SANS and SAPS. Mean age was 32.8 years (19-56), 16 were females (24.6%), 49 were males (75.4%). 29 (44.6%) were first births, 38 (58.5%) were single and 45 (69.2%) of patients were on drugs at the time of assessment.

A principal components analysis of individual symptom scores of the 65 patients yielded a four-dimensional structure of negative, positive, disorganized and affective symptoms. The concepts underlying these results and their clinical implications are discussed.

(Egypt.J.Psychiat., 1998, 21 : 159- 169).

INTRODUCTION

Recently published research on the diagnosis and phenomenology of Schizophrenia and related disorders reflects a gradual shift in interest from categories to dimensions and individual symptoms (Copolov, 1996). More attention has been paid to the development of symptom complexes/syndromes as opposed to types of Schizophrenia, with the goal of obtaining a better understanding of the relationships between psychopathology, pathophysiology, course of illness and

treatment response. Inherent in a categorical approach of typologies is mutual exclusiveness of categories. Typologies classify patients belonging to either one or another category. In contrast, a dimensional approach (syndromes or symptom complexes) classifies symptoms and not patients. Therefore, a patient may present with more than one syndrome as is, in fact, the case in clinical practice (Malla, 1995).

Although negative symptoms have been considered essential to the nature of Schizophrenia since Kraepelin and Bleuler, they were de-emphasized in DSM-III and DSM-III-R because of concerns that they could not be rated as reliably as positive symptoms, and that their inclusion as diagnostic criteria would contribute to the excessive diagnoses of Schizophrenia in the USA (Davidson & McGlashan, 1995). How-

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ever, research over the past decade has shown that negative symptoms can be identified, differentiated from depressive symptoms, and rated in a reliable and objective fashion (Kibel et al., 1993). This leads to a significant change in DSM-IV in line with ICD-10 by giving greater prominence to the negative symptom group (DSM-IV, APA, 1994).

In their review of recent literature, four researchers, who have played key roles in the conceptualization and analysis of the dimensions of Schizophrenia (Liddle et al., 1994) and Andreasen (1995), concur that at least three factors are required to account for the breadth of symptoms seen in the disorder. To the factors of hallucinations and delusions - reality distortion and negative symptoms - psychomotor poverty should be added disorganization, which incorporates formal thought disorder, disorganized behavior and incongruous or inappropriate affect. In keeping with the strength of currently available data, DSM-IV has included these three dimensions as alternative description for Schizophrenia to the classical subtypes (DSM-IV appendix proposals, APA, 1994). Whereas studies that use scales for the assessment of positive symptoms and scales for assessment of negative symptoms generally favour the previous three factor solution, researchers whose data sets include a broader range of symptoms have identified a larger number of factors: four (Peralta et al., 1994), five (Kitamura et al., 1995) or even greater number (Stuart et al., 1995). The additional dimensions include depression, anxiety, mania, excitement, affective symptoms, social and relational dysfunction and catatonia.

If symptom dimensions provide clues about underlying categories and pathogeneses, then their precise characterization is important. Such characteri-

zation awaits further research and agreement about the appropriateness of considering, for example, mood related symptoms as either integral to schizophrenia or as comorbid features (Copolov, 1996).

Barequera et al., (1996) have recognized methodological deficiencies in most of the studies conducted in this area. A very important one is the use of chronic hospitalized Schizophrenia populations. As a result, Malla (1995) stressed the growing need to investigate these phenomena among patients who are living in the community and are managed in out-patient facilities while receiving neuroleptic medication.

SUBJECTS AND METHODS

The population selected were those patients attending out-patients clinics of three university hospitals with the diagnosis of Schizophrenia according to DSM-IV criteria. For inclusion in the study patients had to satisfy the following requirements :

- a. Agreement to participate in the study.
- b. Egyptian nationality.
- c. Less than 60 years of age to avoid possible effects of old age on rating of certain behaviors.

Exclusion criteria were those required for the diagnosis of schizophrenia according to DSM-IV mainly :

- a. Schizoaffective and mood disorder.
- b. Substance use/general medical condition
- c. Relationship to previous developmental disorder and for this requirement those below 18 years of age were excluded.

65 patients fulfilling the previous requirements were recruited along 1 year period :

30 patients (Suez Canal University Hospital, Ismaelia City).

20 patients (El-Menia University Hospital, El Menia City).

15 patients (El-Kaser El-Eeini University Hospital, Cairo City).

Evaluation Procedures

All patients were evaluated using The Brief Psychiatric Rating Scale (BPRS, Overall, 1962) and the Schedule for the Assessment of Negative Symptoms SANS and the Schedule for the Assessment of Positive Symptoms SAPS (Andreasen, 1984) respectively. Details of psychiatric history and assessment of behaviors, activity, and contacts with friends and family were collected from patients and at least one of the patient's relatives. Spearman-Rank correlation coefficient had been used as a measure of inter-rater agreement between the three raters.

Statistical Analysis

The statistical analysis was carried out using SPSS. The dimensionality of the total item scores was examined through the use of principal components analysis (PCA) of the corresponding correlation matrix. Varimax rotation was used to aid the interpretation of the results. Using the factor pattern matrix only the variables with factor loadings (regression coefficients) of 0.4 or higher were taken to be descriptive of the factor.

RESULTS

Sociodemographic and Clinical Findings :

Of the 65 out-patients with the diag-

nosis of Schizophrenia according to DSM-IV criteria, 20 cases were paranoid, 18 undifferentiated, 15 residual and 12 disorganized subtypes respectively. 49 (75.4%) were males, 16 (24.6%) were females, 29 (44.6%) were first births, 38 (58.5%) were singles. 14 (21.5%) had positive family history of Schizophrenia. The mean duration of illness in months was 125.9 (8-360) and the mean number of hospitalizations for the total sample was 2.78 (0-12). 20 cases (30.7%) were free of medication at the time of assessment. Socio-demographic and clinical characteristics of the whole sample are shown in tables 1&2.

Inter-rater Agreements

While agreements between the 3 raters were excellent > 0.9 for all SANS and SAPS items and subscales, less agreements were noticed on SANS subscale: affective flattening, that ranged from 0.47 to 0.94 and SAPS subscale : thought disorder, that ranged from 0.77 to 0.94. The reason for this excellent agreements is related to the fact that the 3 raters revised their ratings after returning back to definitions of items as provided by the author of SANS and SAPS several times until excellent agreements had been reached. This was applied in a pilot study of 10 patients before starting the project.

Factor Analysis

Principal components Analysis (PCA) of BPRS and both SANS and SAPS variables (68 variables) yielded 19 factors with Eigen value greater than 1.0 accounting for 82.9% of the variance. However, 4 factors appeared as being the most prominent with Eigen-values : 12.09, 8.43, 4.38 and 3.90 respectively explaining 46.9% of the variance. Tables 3-a-b-c-d showed the pattern matrix of each of the 4 factors

Table 1
Sociodemographic Variables

Variable	Out-patient sample of patient with Schizophrenia (no. = 65)
Mean age in years (median; range)	32.8 (18-56)
Gender:	
Male (no.; %)	49 (75.4%)
Female (no.; %)	16 (24.6%)
First births (no; %)	29 (44.6%)
Single (no; %)	38 (58.5%)
Residence:	
Urban (no.; %)	53 (81.5%)
Rural (no.; %)	11 (16.9)
Education (frequency; %):	
Illiterate	10 (15.4%)
Primary	9 (13.8%)
Preparatory	4 (6.2%)
Secondary	21 (32.3%)
More than 12 years	12 (18.5%)
University graduate	6 (9.2%)
M.S, Ph. D	2 (3.1%)
Others	1 (1.5%)

Table 2
Clinical Findings For the Total Sample

Variable	Out-patient sample of patient with Schizophrenia (no. = 65)
Family history	
Positive (no.; %)	14 (21.5%)
Negative (no.; %)	51 (78.5%)
Duration of illness in months	125.9 (8-360)
No. of hospitalizations (mean; range)	2.78 (0-12)
Medication at the time of assessment	
on medication (no; %)	45 (69.2%)
no medication (no; %)	20 (30.7%)
Schizophrenia subtypes (no; %)	
Paranoid	20 (30.8%)
Undifferentiated	18 (27.6%)
Residual	15 (23%)
Disorganized	12 (18.5%)
Catatonic	0 (0%)

Table 3-a
Results of Principal Components Analyses
of Behaviors of Patients with Schizophrenia

Behaviors	Factor I
- Paucity of expressive gestures	0.810
- Lack of vocal inflections	0.749
- Relationship with friends	0.737
- Affective non responsivity	0.730
- Physical anergia	0.730
- Unchanging facial expression	0.727
- Blunted affect	0.725
- Grooming and hygiene	0.717
- Intimacy and closeness	0.717
- Decreased spontaneous movements	0.693
- Motor Retardation	0.654
- Impersistence at work	0.651
- Recreational interest	0.649
- Social inattentiveness	0.636
- Emotional withdrawal	0.635
- Sexual interest, activity	0.621
- Poverty of speech	0.580
- Inattentiveness during testing	0.545
- Increased response latency	0.520
- Poor eye contact	0.427
Eigen value	12.099
PCT of variance	17.8%
Cumulative variance	17.8%
Factor I = Psychomotor poverty	

Table 3-b
Results of Principal Components Analyses of Behaviors
of Patients with Schizophrenia

Behaviors	Factor II
- Auditory hallucinations	0.719
- Voices commenting	0.657
- Hallucinatory behavior	0.656
- Suspiciousness	0.636
- Persecutory delusions	0.627
- Excitement	0.620
- Voices conversing	0.616
- Delusions of mind reading	0.577
- Unusual thought content	0.500
- Thought broadcasting	0.498
- Thought insertion	0.498
- Grandiose delusions	0.477
- Aggressive behavior	0.455
- Hostility	0.453
- Delusions of reference	0.446
Eigen value	8.437
PCT of variance	12.4%
Commutative variance	30.2%
Factor II = Reality distortion	

Table 3-c
Results of Principal Components Analyses of Behaviors
of Patients with Schizophrenia

Behaviors	Factor III
- Incoherence	0.794
- Derailment	0.793
- Tangentiality	0.753
- Conceptual disorganization	0.744
- Illigocality	0.604
- Unusual thought content	0.582
- Clothing and appearance	0.463
- Social and sexual behavior	0.460
- Mannerisms and posturing	0.460
- Poverty of content of speech	0.412
Eigen value	4.382
PCT of variance	6.4%
Cumulative variance	36.6%
Factor III = Disorganization	

Table 3-d
Results of Principal Components Analyses of
Behaviors of Patients with Schizophrenia

Behaviors	Factor IV
- Anxiety	0.741
- Depressive mood	0.632
- Tension	0.569
- Somatic concern	0.558
- Distractible speech	0.542
- Guilt feelings	0.532
- Guilt and sin	0.523
- Disorientation	0.478
- Hostility	0.432
Eigen value	3.909
PCT variance	5.7%
Cumulative variance	42.4%
Factor IV = Affective	

Table 4
Factor Correlation Matrix

Factors	I	II	III	IV
Psychomotor poverty I	1.00			
Reality distortion II	0.40	1.00		
Disorganization III	-0.06	0.13	1.00	
Affective IV	0.11	-0.089	-0.15	1.00

extracted. Reflecting the item loadings, these 4 factors were named : psychomotor poverty, reality distortion, disorganization and affective. The factor correlation matrix : table 4 showed that factor I "psychomotor poverty" correlated positively with factor IV the "affective factor" while it showed no correlation (around of) with factor II "reality distortion" and it was negatively correlated with factor III "disorganization". Table 4 showed also negative correlation between factor IV the "affective factor" and both factor II "reality distortion" and factor III "disorganization".

DISCUSSION

While the results of our study confirmed the three-syndrome model defined by Liddle (1987), yet our study showed a fourth syndrome/factor, affective symptom complex/syndrome (table 3-d, and table 4). This fourth factor showed high loadings on the following symptoms: Anxiety, depressive mood, tension, somatic concern, distractible speech, guilt feelings and hostility. The affective syndrome that emerged in this study showed negative correlation with reality distortion (factor II-tables 3-b and 4) and disorganization (factor III-tables 3-c and 4), while it showed some but very little correlation (0.11) with psychomotor poverty (factor I, tables 3 and 4), suggesting that it is a discrete entity. This difference between Liddle's study and ours is related to the difference in sample selection and size. While Liddle's study was on a relatively smaller sample of chronically hospitalized patients with Schizophrenia (40), our study had been conducted on a relatively larger number (65) of out-patients with Schizophrenia. The high factor scores on affective behavior syndrome (factor IV) in this study of patients with Schizophrenia

living in the community suggests an alternative explanation as Soni et al., (1992) have proposed that despite the obvious benefits, living in the community may have its price in terms of the distressing effects of affective symptoms which are, in turn, known to be associated with an increased risk of suicide (Roy, 1982). This would suggest that clinicians need to be aware that patients with Schizophrenia living in the community may be at particular risk for depression (Harvey et al., 1996).

The extracted factor I (negative syndrome or psychomotor poverty, table 3-a) showed high loadings on all SANS items except poverty of content of speech and inappropriate affect. This is in common with the disagreements cited in other studies about including those two items in the dimension of negative syndrome (Malla, 1995). While poverty of content speech loads on the disorganization factor (factor III, table 3, c) in support of the findings of other authors (Malla et al, 1993; Miller et al, 1993), inappropriate affect did not in contradiction with other studies as that by (Barquero et al, 1996). At the same time attentional impairment loads mainly on negative factor in support of the findings by Arndt et al (1991) and Shtasel et al., (1992).

Factor analytic studies in schizophrenia consistently generate a discrete negative syndrome (Arndt et al., 1995) Its relationship with other symptom dimensions and other clinical variables has been explored both in cross-section and longitudinally. Investigators suggest that persistent negative symptoms may be more reliable predictors of functioning than those elicited during an acute episode or on a single occasion. Conceptual models are now being developed that allow for testable hypotheses on the neuropsychological basis of individual

negative symptoms (Mc phillips & Barnes, 1997). Moreover, a growing body of evidence, points to the significance of negative symptoms as indicators of the genetic and neurobiological underpinnings of Schizophrenia. The early speculations made by Henry Maudsley reported in Turner (1988) is consistent with the research findings by Tsuang and his colleagues (Tsuang, 1994) that the more affect-related negative symptoms are more heritable than the intellectually-related positive symptoms such as thought disorder.

While, the relationship between negative symptoms and abnormal cerebral structure has proven to be weaker than implied in Crow's hypothesis, the relationship between negative symptoms and disordered cerebral function has proven robust (Liddle et al., 1994). It appears that the pattern of cerebral activity associated with negative symptoms is not a static loss of frontal function (hypofrontality), but part of a dynamic imbalance between cortical and subcortical activity (Liddle et al., 1992).

This study confirmed the dual sub-component model of positive symptoms proposed by Liddle (1987) into: reality distortion (Hallucinations and delusions, factor II in this study, table 3-b) and disorganization (thought disorder and disorganized behavior, factor III in this study, table 3-c). A recent study by Lenzenwegers and Dworkin (1996) using confirmatory analyses (LISREL, EQS) rather than exploratory factor analysis used by Liddle and us, revealed four dimensions : negative symptoms, premorbid social adjustment (each stands alone as a dimension) and the same dual components of positive symptoms proposed by Liddle and confirmed by this study. The same authors indicated very clearly that deficits in premorbid social functioning should be included in any com-

prehensive consideration of Schizophrenia phenomenology.

With regard to positive symptoms, definitive evidence for a neurohumoral mechanisms is still lacking. Changes in symptoms severity are associated with a complex pattern of change in the metabolites of monoamine neurotransmitters, but many of the observed associations apply to both positive and negative symptoms (Khan et al., 1993). Furthermore, the partial success of atypical antipsychotics in alleviating all three of the major dimensions of Schizophrenic symptoms (Meltzer, 1992) shows that negative symptoms are subject to pharmacological influence in some circumstances.

In support of the 4 dimensions (factors extracted in this study), Crow in Liddle et al., (1994) considered the Kraepelinian dichotomy between Schizophrenic and affective psychoses a brake to progress and the categorical approach to psychiatric diagnosis unsustainable. But if there are 4 dimensions (positive, negative, disorganization and affective change) of pathology, to what variations in normal function do these correspond ?

From an evolutionary point of view, Liddle et al., (1994) considered the psychoses as boundaries of the variation which is intrinsic to Homo Sapiens. Such variations may be presumed to relate to man's recent evolutionary history (including the evolution of the capacity of language) and to be subject to continuing selective pressures. In this context, the key question is; what are the dimensions of variations of which the various pathological syndromes (negative and nuclear symptoms, etc.) form the boundaries?

The delineation of the core dimensions or domains of Schizophrenia clearly has implications beyond facilitating efforts concerned with the etiology of

the illness. For example, knowledge of such core dimensions of schizophrenia phenomenology could also be of use in improving diagnostic criteria for the illness and clarifying those dimensions that have greatest prognostic significance (Mc Glashan & Fenton, 1992). They can also help in enhancing a more differential and tailored approach to therapeutics e.g. social skill training for social deficits, or affect-oriented interventions for flattened affect and negative symptoms (Dworkin, 1992).

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Etude sur l'ensemble de symptômes et de syndrome de patients de la schizophrénie, fréquentant les

Les recherches publiées récemment sur le diagnostic et le phénomène de la schizophrénie et les désordres qui lui sont relatifs reflètent une transformation graduelle quant à l'intérêt allant des catégories jusqu'aux dimensions et les symptômes individuels (Copolov, 1996). Pourtant la déficience méthodologique ainsi que l'appui sur des hospitalisés de cas chroniques (Barquera et autres, 1996) ont abouti à un besoin croissant d'investiguer cette transformation chez les patients de la communauté, fréquentant des cliniques et recevant des médicaments neuroleptiques.

Soixante cinq patients diagnostiqués de schizophrénie selon le DSM-IV ont été évalués en utilisant le BPRS, Le Sns Et Saps de Andreasen.

L'âge moyen était 32,8 ans entre (19-56) dont 16 femmes (24,6%) et 49 hommes (75,4%) dont 29 patients âgés (44,6%), 38 célibataires (58,5%) et 45 qui suivent le traitement pendant l'évaluation (69,2%).

Enfin l'analyse des éléments principaux des symptômes individuels-chacun a part-a eu comme résultat un ensemble de quatre dimensions: positive, négative, désorganisée et affective. Les concepts conclus de ces résultats ainsi que leurs applications cliniques ont été également discutés.

دراسة لتركيب الأعراض / الزمالات لدى عينة من مرضى الفصام المترددين على العيادات الخارجية

تعكس البحوث المنشورة حديثاً في تشخيص وظاهرة مرض الفصام، والاضطرابات وثيقة الصلة به، تحولاً تدريجياً في الاهتمام من المراتب إلى الأبعاد، والأعراض المنفردة، لكن القصور في منهجية الأبحاث والنتائج عن التركيز على عينات لحالات مزمنة ونزلاء مستشفيات أدى إلى احتياج متصاعد لبحث هذا التحول لدى مرضى يعيشون في المجتمع، ويتردون على عيادات خارجية ويتناولون عقاقير مضادة للذهان.

وفي هذا البحث تم تقييم ٦٥ مريضاً بالفصام تبعاً للتشخيص الإحصائي الأمريكي الرابع باستخدام النسخة المختصرة للمقياس المعياري الطبقي، وجدولي أندرياسين (الموجب والسالب) لتقصي الأعراض.

وقد بلغ متوسط العمر في العينة ٣٢,٨ عاماً (١٩-٥٦)، وضمت العينة ١٦ من الإناث (٢٤,٦%) و ٤٩ من الذكور (٧٥,٤%)، كما اتضح أن ٢٩ فرداً من العينة جاء ترتيب ميلادهم الأول، وكان ٣٨ فرداً (٥٨,٥%) غير متزوجين، و ٤٥ فرداً منهم (٦٩,٢%) يتناولون الأدوية خلال التقييم.

وقد نتج عن تحليل المكونات الأساسية لأوزان الأعراض - كل على حدة - أربعة أبعاد تركيبية هي: السالبة، الموجبة، المفككة، والوجدانية، وتمت مناقشة المفاهيم المستخلصة من هذه النتائج، وكذا تطبيقاتها الإكلينيكية.