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DEPRESSION IN SCHIZOPHRENICS : AN 'ARAB' SURVEY OF PREVALENCE & MECHANISMS

BY

A. Okasha, A. Ashour

M. Shody A. Sadek and *A.H. Khalil*

Abstract

The study was done on 119 schizophrenic patients; 85 are from Saudi Arabia and 34 Egyptian patients, they were divided into 3 experimental groups. A control group was added; consisting of 40 subjects. Disgnosis was done according to the DSM III system.

The method of the study included: the present state examination (Wing et al., 1974), Hamilton rating scale for depression (Hamilton, 1967), this is in addition to a full clinical study. The results revealed that the prevelance of depression in acute schizophrenic patients before treatment was 62.9% which was statistically significant, while in chronic patients where depression was 27.4% whom are under treatment, and 36.5% in chronic patients without treatment the results were non significant.

No statistically significant data were found between chronic schizophrenic patients and control group. These results to not support the hypothesis that depression in schizophrenic patients is caused by antipsychotic drugs. At the same time the results do not support the hypothesis that depression is a late sequel of schizophrenia.

The study encourages the trend which describes schizophrenia as a developing process characterized in its acute stages by the presence of depression and anxiety.

Introduction

Since Helchen and Hippius (1967) noted a sample of 120 schizophrenics had depressive symptoms at the time of admission more than 30 papers have appeared associating depressive symptoms in schizophrenia with neuroleptic medication. Many authors and clinicians in fact think that a causal relationship has been proven, and the term 'pharmacogenic depression' and the associated concept 'akinetic depression' have come into use.

The Concept of Pharmacogenic Depression

This assumes that depressive symptoms are a side effect of neuroleptic medication. However, reports of the frequency of depression in schizophrenia vary widely according to the method used.

In order to demonstrate that pharmacogenic depression occurs, one needs to be able to show that depressive symptoms are more common in patients receiving neuroleptics than a comparable group receiving no drugs or placebo.

The Concept of Akinetic Depression

This is a variation on the concept of pharmacogenic depression. It was coined by Van Putten and May (1978) because they noted patients without other symptoms of drug-induced Parkinsonism were slow and lethargic as well as seemingly depressed, and rapidly improved when anticholinergics were administered. There are also reports by Johnson (1973) and Alarcon and Carney (1969) of depressive symptoms appearing or worsening during treatment. Depression my result from the interaction of neuroleptics with a genetic defect affecting the nigrostiatal DA system of patients with associated disorders. This depression may actually represent an extra pyramidal (motor) component of DA-related disorder which often induces a subjective dysphoria that is secondary in nature.

One would need to demonstrate that a depressive syndrome can be reliably differentiated from the Parkinsonian syndrome before 'akinetic depression' could be regarded as a separate clinical entity.

The Concept of Post-Psychotic Depression

Refers to the possibility that depression may occur as schizophrenics recover insight into their illness and life situation.

Depression and schizophrenia could, logically, occur together merely as a matter of chance. If so, depression should occur with an equal frequency to any phase in the illness, but reports from Shanfield et al. (1970), plus recent studies by Knights and Hirsch (1981), Johnson (1981-III), and Moller and Von Zerssen (1981), show that this is not the case. Finally depression may be an integral part of the schizophrenic process, commonly present, but unnoticed during the acute phase when the florid psychosis is most evident and other symptoms are understandably ignored.

In this case we could expect depressive symptoms to be more prevalent in the acute phase when the psychosis is more acute and decrease rather than increase with neuroleptic treatment.

Recent studies summarized below have shown that this is the case.

Knights and Hirsch, (1981), Moller and Von Zerssen (1981), Johnson (1981), taken together these results from different centers are incompatible with the hypothesis that neuroleptics are a common cause of depressive symptoms in schizophrenia. All suggest that depressive symptoms are an integral part of the schizophrenic syndrome and must, therefore, share with schizophrenia common pathophysiological process. Like the situation in the game of chess called 'revealed check', these symptoms tend to remain hidden from clinicians behind the florid features of psychosis, only to be revealed during the remission phase.

This new evidence suggests that re-examination of the underlying relationship between depression and schizophrenia is required.

The dopamine hypothesis was originally proposed as a hypothesis for schizophrenia. But several controversial issues have, however, come up, and would

be discussed and their influence on the role of dopamine in schizophrenia and affective psychoses.

Aim

The aim of this study is to survey schizophrenic patients at different stages of illness (acute and chronic) as regards the depressive symptoms and to see how these depressive symptoms correlate with the degree of psychopathology and with drug intake, and we will use the results of this survey as an attempt to explore the relationship between schizophrenia and depression, and to answer the question of, whether depression symptoms are an integral part of the schizophrenic process.

Material

119 schizophrenic patients, 85 were Saudi Arabian and 34 were Egyptians, their ages ranged between (16-40 years), males were 81 while females were 37, collected consecutively from January 1983 to March, 1984.

Four types of subject were studies:

(1) 27 Acute schizophrenic patients, first admission, duration more than 6 months, without any history of neuroleptic medication before admission.

(2) 51 chronic schizophrenic patients, duration more than two years. Maintained on neuroleptic medication, either depot medication, the most recent injection within four weeks before admission or oral medication within the last few days.

(3) 41 chronic schizophrenic patients, duration more than two years, not maintained on neuroleptic medication. No oral neuroleptic medication for two months, or received no depot neuroleptic injection within the last three months.

(4) Normal control (40) to evaluate clinically and objectively the prevalence of depressive symptoms in normal population, 25 were males while females were 15. Selected from the workers and nursing staff. Their ages ranged between (17-45 years).

The diagnosis of schizophrenia was based upon the presence of DSM-III criteria (Diagnostic and statistical manual of mental disorders, American Psychiatric Association, 1980).

Tools

Present state examination (PSE) (Wing et al., 1974):

The symptoms were elicited by the present state examination 9th edition (Wing et al., 1974), using the standardized arabic translated interview schedule made by Okasha and Ashour, 1981.

Hamilton Rating Scale for depression (HRSD) (Max Hamilton, 1967):

For the purpose of this study depression was defined as a change of affect so that the patient had a lowered mood state, with subjective changes of sadness, misery, fearfulness or hopelessness. The aim was to record depression as present only if it could reasonably be regarded as clinically meaningful, all patients diagnozed as clinically depressed in (PSE) for a minimum period of 1 week, the severity of depression was rated on the Hamilton rating scale for depression. In assessing the severity of depression, the questioning should be directed to his condition in the last few days or week.

Ain Shams Psychiatric Sheet

A complete psychiatric sheet was structured for the study derived from Ain Shams University Psychiatric sheet.

The Procedure

The sample collected consecutively from the in and out-patients of Media Psychiatric Hospital and in-patients of Abbasia and Okasha Hospitals, 68 were out-patient, while in-patients were 51.

In the first meeting each patient was examined by the present state examination (PSE) the inverview was tape recorded in 51 Saudi patients after taking their oral consent. In case of inaccessible patients, symptoms of behaviour, affect and speech were rated and the rest postponed for few days. This followed by the assessment of the severity of depression by the Hamilton rating scale of depression, with minimum score of (15) to consider the patient is suffering from meaningful clinical depression.

An aetiology schedule (Medical Research Council, 1974), is completed for each patient to assess the organic, social and psychological factors, personality before first onset and intellectual level during episode. Ain Shams University psychiatric sheet is completed for each patient.

The general characteristics of the sample:

Table (1) Distribution of patients according to their age.

Age	Acute Schiz. N= 27	Chronic Schiz. maintained on treatment N= 51	Chronic Schiz. without treatment N= 41	Total
15-24	22	16	12	50
25-34	5	29	26	60
35-40	-	6	3	9
Age range	16-28	19-40	19-40	
Mean and S.D.	20.8 ± 3	27.3 ± 5.3	26.7 ± 4.3	

Distribution of patients according to their sex 22 (81.4%) of the acute schizophrenic patients were males and 5 (18.5%) were females, while in the chronic patients (65.2%) were males and 32 (34.7%) were females.

The distribution of patients according to the marital state 22 (81.4%) of the acute schizophrenic patients and 60 (65.2%) of the chronic patients were single, and 2 (7.4%) of the acute schizophrenic patients were married and 3 (11.1%) were divorced while in chronic patients 18 (19.5%) were married, 12 (13%) divorced and 2 (2.1%) were widowed.

Table (2) Distribution of patients according to the duration of illness.

Duration of illness	Acute Schiz. N= 27	Chronic Schiz. maintained on treatment N= 51	Chronic Schiz. without treatment N= 41	Total
6-9 mon.	27	-	-	27
3-5 yrs.	-	22	18	40
6-10 yrs.	-	25	19	44
11-15 yrs.	-	4	4	8

Distribution of patients according to th DSM-III diagnosis.

Axis I Diagnoses: 35 schizophrenic patients were diagnosed Disorganized, (11 were acute and 24 were chronic patients, 46 patients were paranoids (9 acute and 37 were chronic patients), 19 patients were undifferentiated type (6 acute and 13 were chronic patients), 18 chronic residual schizophrenia and one acute catatonic schizophrenia.

Axis II Premorbid personality: 70% of the patients, their premorbid personalities were undetected.

Axis III Physical disorders and conditions: none

Axis IV The severity of psychosocial stressors: None in 93 patients, minimal in 3 patients, mild in 12 patients, moderate in 10 and was severe in one patient.

Axis V Level of adaptive functioning part year: It was very good in one patient, good in 18 patients, fair in 16, 23 were poor, 45 patients were very poor and 16 patients were gross impaired.

The Results

The results summarized in Table (3) have shown that, symptoms of restlessness, depressed mood, hopelessness, loss of weight, delayed sleep, delusions of reference, and misinterpretation, systematization, preoccupation, acting out, agitation, mannerism and posturing, observed anxiety and depression, perplexity and incoherence of speech were significantly more prevalent in acute schizophrenic patients compared with chronic schizophrenic patients maintained on treatment, and the reverse was true regarding blunted affect.

Symptoms of depressed mood, loss of weight, delayed sleep, derealization, acting out, slowness and underactivity, observed depression and perplexity were significantly more prevalent in acute schizophrenic patients compared with chronic patients not maintained on treatment.

Finally, comparing the two groups of chronic schizophrenic patients, with and without treatment, we have found that symptoms of delayed sleep, irritability, obsessional checking and insight, agitation, mannerism and posturing, observed anxiety, suspicion and perplexity were significantly more prevalent in the chronic schizophrenic patients not on treatment, and the reverse was true regarding blunted affect. In conclusion, we could say that acute schizophrenic patients were characterized primarily by more prevalent depressive symptoms compared with chronic schizophrenic patients, whether they were maintained on treatment or not. Which cannot be attributed to the effect of the treatment, as the difference between the two groups of chronic schizophrenic patients regarding depression was rather nonsignificant statistically. The effect of the treatment was rather

Table (3) Statistical analysis and comparison of the present state examination (PSE) symptoms that showed statistical significant differences between the three schizophrenic groups.

	Acute schiz. (N=27) %	Ch. schiz. on treatment (N=51) %	Ch.schiz. without treatment (N=41 %	Acute schizo. VS Ch. schiz. on treatment	Acute schizo. VS Ch. schiz. without treatment	Ch. schizo. on treat. VS Ch. schiz. without treatment
8. Restlessness	77.7	47	58.5	0.01>p>0.0027	NS	NS
23. Depressed mood	77.7	43.1	53.6	0.01>p>0.0027	0.046	NS
24. Hopelessness	22.2	5.8	7.3	0.046>p>0.01	NS	NS
34. Loss of weight	37	11.7	14.6	0.01>p>0.0027	0.046>p>p0.001	NS
35. Delayed sleep	92.6	52.9	73	0.001	0.046	0.05
40. Irritability	54.2	37.2	68.3	NS	NS	0.01>p>0.002
44. Obsessional checking	18.5	15.6	39	NS	NS	0.01
47. Derealization	18.5	7.8	2.4	NS	0.04>p>0.01	NS
72. Delusions of reference	81.4	56.8	82.9	0.05>p>0.046	NS	0.01>p>0.002
73. Delusional mis-interpretation	62.9	37.6	51.2	0.04>p>0.01	NS	NS
93. Systematization	92.6	66.4	85.3	0.01>p>0.0027	NS	NS
95. Preoccupation	95.7	76.4	87.8	0.046>p>0.01	NS	NS
96. Acting out	77.7	35.2	22	p<0.001	0.046	NS
104. Insight/ psychotic	77.7	60.7	85.3	NS	NS	0.01>p>0.002
110. Slowness under-activity	25.9	13.7	7.3	NS	0.04>p>0.01	NS
111. Agitation	37	5.8	36.5	p<0.001	NS	p<0.001
116. Mannerism/ posturing	14.8	1.9	12.2	0.04>p>0.01	NS	0.05
120. Observed anxiety	37	5.8	51.2	p<0.001	NS	p<0.001
121. Observed depression	62.9	23.5	31.7	p<0.001	0.046	NS
125. Suspicion	7.4	1.9	21.9	NS	NS	0.002>p>0.001
126. Perplexity	59.2	1.9	17	p<0.001	p<0.001	0.046>p>0.01
128. Blunted affect	14.8	50.9	19.5	0.002>p>0.001	NS	0.002>p>0.001
136. Incoherence of speech	48.1	21.8	39	0.04>p>0.01	NS	NS

more obvious in the psychotic and neurotic symptoms.

The results summarized in table (4) have shown that syndrome of incoherent speech, catatonic syndrome, non-specific psychosis, delusion of reference, simple depression, worrying, general anxiety, irritability, agitation and tension were more prevalent in acute schizophrenic patients and chronic schizophrenic patients not maintained on treatment compared with chronic schizophrenic patients maintained on treatment, and the reverse was true regarding the syndrome of affective flattening which was more prevalent in the latter and syndrome of simple depression and non-specific psychosis were more prevalent in acute schizophrenic patients compared with chronic schizophrenic patients without treatment and non-significant difference regarding the rest of syndromes.

The clusters of depressive symptoms that appeared significantly in our depressed schizophrenic patients were that of simple depression (depressed mood, observed depression on examination, hopelessness, suicidal plans or acts and inefficient thinking) syndrome of other symptoms of depression particularly those of loss of weight and libido, and loss of interest and concentration.

Those symptoms of guilty ideas of reference, pathological gluit, delusions of guilt, depressive hallucinations, morning depression and early awakening were not presented significantly in our depressed patients.

In conclusion, from our results we may conclude that the psychotic and neurotic symptoms, which were more prevalent in the untreated acute and chronic schizophrenic patients, are decreased primarily by the effect of the treatment, but in case of depression, it is decreased significantly in chronic schizophrenic patients whether they were on treatment or not, and this decrease might be attributed to the development of affective flattening and chronicity itself as probable factors.

The results summarized in table (5) have shown that catatonic syndrome, incoherent speech, nonspecific psychosis, delusions of reference, worrying, irritability, agitation and tension were more severe in untreated

Table (4) The syndrome that have shown statistical significant differences between the three schizophrenic groups.

Symptoms		Acute schizophrenia VS Chronic schizophrenia on treatment	Acute schizophrenia VS Chronic schizophrenia without treatment	Chronic schizophrenia on treatment VS chronic schizophrenia without treatment
Catatonic syndrome	(CS)	0.01>p>0.0027	NS	0.046>p>0.01
Incoherent speech	(IS)	0.046>p>0.01	NS	p=0.046
Non-specific psychosis	(NP)	p<0.001	NS	p<0.001
Delusions of reference	(RE)	0.046>p>0.01	NS	0.046>p>0.01
Simple depression	(SD)	0.01>p>0.0027	p=0.046	NS
Worrying	(WO)	0.01>p>0.0027	NS	p=0.0027
General anxiety	(GA)	0.046>p>0.01	NS	p<0.001
Tension	(TE)	0.0027>p>0.001	NS	0.046>p>0.01
Affective flattening	(AF)	p<0.0027	NS	0.046>p>0.01
Irritability	(IT)	p=0.046	NS	0.0027>p>0.001
Agitation	(AG)	p<0.001	NS	p<0.001
Obsessional neurosis	(ON)	NS	NS	p=0.01
Self-neglect	(NG)	p=0.05	NS	NS

acute and chronic schizophrenic patients compared with chronic schizophrenics on treatment and the reverse in the syndrome of affective flattening.

Simple depression was more severe in acute compared with chronic schizophrenic patients, whether they were on treatment or not.

Depersonalization syndrome was found to be significantly severer in the acute schizophrenic patients compared with chronic schizophrenic patients not maintained on treatment. Thus, the same results were obtained by comparing either the prevalence or the intensity of the psychopathology.

The prevalence of depression in the three groups of schizophrenic patients and control:

The prevalence of depression as appeared in the present state examination (PSE) and its intensity as measured by the Hamilton rating scale were shown in table (6).

The results summarized in the table (7) have shown that there are statistically significant differences between the prevalence of depression in acute schizophrenic patients and chronic schizophrenic patients whether they were maintained on treatment or not ($P=0.0027$) and ($0.046>p>0.01$) respectively, and non-significant difference in the prevalence of depression between the chronic schizophrenics whether they were on treatment or not ($0.317>p>0.5$) or between them and control ($P=0.50$) and ($0.37>p>0.1$) respectively, and there was a significant difference between the acute schizophrenics and control (P 0.001).

Comparison of the severity of depression between depressed acute and chronic schizophrenics as measured by the Hamilton rating scale (HRS):

We have found no significant statistical differences between the depressed patients in the three schizophrenic groups regarding the severity of depression as measured by Hamilton rating scale (HRS).

Table (5) The syndromes that have shown statistical significant differences between the three schizophrenic groups regarding the severity in terms of mean SCL-scores.

Syndrome		Acute schiz. (N=27)		Chronic schiz. on treatment (N=51)		Chronic schiz. without treatment (N=41)		Acute schiz. VS. Ch. schiz. on treatment	Acute schiz. VS Ch. schiz. without treatment	Ch. schiz. on treatment VS Ch. schiz. without treatment
		Mean	SD	Mean	SD	Mean	SD			
Catatonic syndrome	(CS)	0.44	0.970.039	0.28	0.29	0.71		0.046>p>0.01	NS	0.046>p>0.01
Incoherent speech	(IS)	0.96	1.010.43	0.83	0.82	0.99		0.046>p>0.01	NS	0.046
Non-specific psychosis	(NP)	1.88	1.010.82	1.21	1.82	1.2		p<0.001	NS	p<0.001
Delusions of persecution	(PE)	1.11	1.010.58	0.92	0.92	1.0		0.046>p>0.01	NS	NS
Delusions of reference	(RE)	2.22	1.051.54	1.31	2.17	1.09		0.046>p>0.01	NS	0.046>p>0.01
Affective flattening	(AF)	0.2	0.640.90	1.0	0.39	0.80		p<0.001	NS	0.01>p>0.0027
Self-neglect	(NG)	1.33	0.960.86	1.0	1.12	1.0		0.046	NS	NS
simple	(SD)	2.1	1.221.07	1.29	1.34	1.31		p<0.001	0.046>p>0.01	NS
Simple depression	(WO)	2.92	0.261.96	1.23	2.6	0.62		p<0.001	NS	0.001
Worrying	(GA)	0.92	1.070.45	0.94	1.17	1.07		NS	NS	p<0.001
General anxiety	(TE)	2.03	0.971.17	1.26	1.7	1.18		p<0.001	NS	0.046
Tension	(IT)	1.29	1.030.80	1.02	1.48	0.92		0.046	NS	p<0.001
Irritability	(AG)	0.74	0.980.11	0.47	0.73	0.97		0.0027>p>0.001	NS	p<0.001
Agitation	(ON)	1	1.070.76	1.22	1.41	1.32		NS	NS	0.046>p>0.01
Obsessional neurosis	(DE)	0.48	1.050.19	0.69	0.04	0.31		NS	0.046>p>0.01	NS
Depersonalization										

The differences between the depressive symptoms in acute and chronic schizophrenia as appeared in the (PSE) and (HRS) of depression

The (PSE) profile of depressive symptoms in acute and chronic schizophrenia has shown that symptoms of depressed mood, hopelessness, oberved depression and loss of weight were more prominent in acute schizophrenia compared with chronic schizophrenia, whether on treatment or not, and suicidal plans or acts and loss of libido were prominent in chronic schizophrenic patients without treatment in comparison with chronic schizoprenic patients maintained on treatment and acute schizophrenics, but not to statistical significant level.

The comparison has been made between the depressed acute and chronic schizophrenic patients and not the whole schizophrenic sample. We found no statistical significant differences between acute and chronic schizophrenic patients regarding the depressive symptoms, except the symptom of middle insomnia was significantly more prevalent in the acute schizophrenic patients compared with the chronic patients maintained no treatment and the reverse was true regarding the symptom of hypochondriasis.

The distribution frequency of the depressive symptoms in the depressed paranoid, undifferentiated and disorganized schizophrenic patients as appeared in the Hamilton rating scale (HRS).

We have found that the symptom of retardation was significantly more prevalent in the depressed undifferentiated schizophrenic patients compared with the depressed paranoid patients ($p = 0.046$) and the reverse was true regarding agitation, which was significantly more prevalent in the paranoid patients compared with the undifferentiated patients ($0.046 > p > 0.01$). The symptom of anxiety (somatic) was more prevalent at statistical significant level in the depressed paranoid and undifferentiated patients compared with the disorganized patients ($0.04 > p > 0.01$).

Discussion

The results of the study have shown that depression

Table (6) The prevalence and severity of depression in the schizophrenic patients and control.

Sample	Sample		Depression		Hamilton rating scale scores		
	N	Sex	Present	%	15-19	20-25	25
Acute schizophrenic patients	27	(M22-F5)	17	(M13-F4) 62.9	10	7	
Chronic schizophrenic patients on treatment	51	(M33-F18)	14	(M9-F5) 27.4	11	3	
Chronic schizophrenic patients not on treatment	41	(M27-F14)	15	(M11-F4) 36.5	8	6	1
Control	40	(M25-F15)	9	(M5-F4) 22.5	Mean=5.8		

Table (7) The statistical differrnces between the schizophrenic groups and control regarding the prevelance of depression.

Sample	Differences between the percentages	Standard error diff. %	Number of standard error	Probability
1. Acute schizophrenics VS chronic schizophrenics on treatment	35.51%	11.64	3.05	P=0.0027
2. Acute schizophrenics VS chronic schizophrenics not on treatment	26.38%	12.37	2.13	0.046>p>0.01
3. Chronic schizophrenics on treatment VS chronics not on treatment	9.13%	9.74	0.93	0.317>p>0.5
4. Acute schizophrenics VS control	40.46%	12.13	3.3	P<0.001
5. Chronic schizophrenics on treatment VS control	4.95%	9.17	0.54	p=0.50
6. Chronic schizophrenics not on treatment VS control	14%	10.14	1.38	0.317>p>0.1

was significantly more prevalent in the untreated acute schizophrenia patients (62.9%) compared with the chronic schizophrenic patients whether they were maintained on treatment or not. 27.4% and 36.5%, respectively.

Depression in chronic schizophrenic patients, whether they were maintained on treatment or not, was found to be non-significant statistically compared with the prevalence of depressive symptoms in the general population (22.5%).

The concept of drug-induced depression was rather disconfirmed by our results, as we found no significant statistical difference between chronic schizophrenic patients with treatment and those without treatment regarding the prevalence of depression.

The concept of post-psychotic depression was also disconfirmed by the findings that none of our chronic residual schizophrenic patients was found to be suffering from depression, plus the high prevalence of depression in the untreated acute schizophrenic patients.

Depression in the general population

The prevalence of depressive symptoms in the control sample in the current study was 22.5 percent, 20% in males and 26.6% in females, with nonsignificant statistical differences compared with the chronic schizophrenic patients whether they were maintained on treatment or not.

Brown and Harris (1978) had found it 15% for one year study using the PSE.

Is depression an integral part of the schizophrenic process?

Although recent studies of Knights and Hirsch (1981), Von Zerssen (1981), and Johnson (1981), confirmed this notion plus our results, it is still questionable, is this concept or notion proved by excluding the above mentioned concepts and the other question which is more important is the meaning of integral part. If it means the old concept of unitary psychosis and that they share the same pathophysiological processes, it would be hard

to believe, because inspite of the presence of a lot of controversy regarding the pathogenesis of both disorders with consequent nosological problems there are evidences derived from the neurophysiological and pathophysiological studies that the two disorders are distinct from each other and that they are heterogenous in pathogenesis and phenomenology with subsequent subdividing each condition to more homogenous subtypes, and if this assumption is based on the involvement of certain systems as the dopaminergic, noradrenergic, serotoninergic, GABAergic etc....., in the pathophysiology of both conditions, they are involved in many conditions known to be distinct from each other. And if the notion that depression is an integral part of schizophrenia, because of the high frequency of depressive symptoms, occurring whether the patients are on neuroleptics or not, their tendency to recur, and the fact that they remit rather than increase after treatment has begun. The same will be applied to anxiety symptoms appearing in untreated acute schizophrenics and to conclude that they are an integral part of the schizophrenic process and sharing the same pathophysiological mechanism as they decreased also by treatment in temporal relation with the schizophrenic symptoms.

In conclusion, though our results agree with that of Knights and Hirsch (1981), and Johnson (1981), that depression is more prevalent in acute patients compared with chronic schizophrenic patients, whether they were on treatment or not. We do not find a convincing answer to the above mentioned question, but what would be a more plausible explanation for this relationship between depression and schizophrenia, than to consider psychosis as an end point of an evolving process characterized by anxiety and depressive symptoms at the onset. Besides, considering more than one disorder, known to be heterogenous as a unitary condition or psychosis, will hinder the efforts in reaching to the aetiology, as subdividing each condition to more homogenous subgroups are more beneficial in offering more precise information regarding the aetiology.

Review of the Therapeutic trials of depressive symptoms in schizophrenia

Electro-Convulsive Shock (ECS)

Folestein et al. (1973), found that almost all schizophrenic patients who improved had affective features and responded to approximately eight treatments. In the acute schizophrenic patients, the psychiatrists should consider convulsive therapy at least in acute schizophrenic patients after studying the longitudinal life history, cross sectional clinical picture and symptoms profile for each patient separately and not just labelling.

Lithium

Although a diagnosis of schizophrenia usually indicates that the patient will not respond fully to lithium ,Cade (1979), it is conceivable that some patients who were suffering from schizophrenia or schizo-affective disorder, may benefit from lithium treatment (Alexander et al., 1979).

Anticholinergics

Johnson (1981) in a double-blind trial of orphenadrine 50mg twice daily in the treatment of 40 depressed schizophrenic patients, maintained in remission with depot neuroleptic injection and free from overt extrapyramidal symptoms, showed a small non-significant excess of patients whose depression improved on orphenadrine.

Tricyclic antidepressants

Johnson (1981) found no significant difference between non-triptyline or placebo blindly allotted in 50 schizophrenic patients, maintained on remission and free from extrapyramidal signs on regular depot injections of neuroleptics, who developed an acute episode of depression.

Raskin et al. (19), in the study of the differential response to chlorpromazine, imipramine, and placebo in hospitalized depressed patients, including depressed

schizophrenics reported that chlorpromazine was somewhat better than either impiramine or a placebo for depressed mood, whereas impiramine was better than chlorpromazine for loss of interest in activities. Schizophrenic depressives who had been receiving chlorpromazine showed greater improvement at six and seven weeks than those who had received imipramine or placebo.

Adding antidepressants to neuroleptics is indicated in schizo-affective patients, with an admixture of affective (depressive) and schizophrenic symptoms.

The psychodynamic view of depression revealed in schizophrenia and psychodynamic approach to drug therapy. (Ostow, 1979):

Ostow, suggested that in addition to the protective effect of schizophrenic delusions formation against the pain of object loss, there is also a more basic reciprocal opposition between detachment on the one hand and depression on the other. That is, a depressive process undoes or limits the tendency to psychic detachment. hile detachment, when used as a defense, might make depression unneccessary. But the mechanism of this opposition is unknown, whether a depressing drug undoes delusions or whether a drug that undoes delusions also produces depression, and how can one know whe er, under the influence of an antipsychosis drug, the patient will re-establish a true object relation or lapse into depression. In a sense the development of psychotic symptoms,hospitalization,and the introduction of an acute organic mental syndrome by giving electric shock, may all help the patient achieve tranquility. The patient is isolated from his problem by withdrawing from object relations, by psychotic detachment, by hospitalization, and by regression.
This isolation prevents object-related anxiety and undermines objectrelated hostility. However, it cannot be tolerated indefinitely because in turn it induces shame, anxiety and feelings of numbness, deadness and emptiness. To a certain exten antianxiety agents may permit continuing object relations by alleviating the anxiety that appear in association with them. Anti-depression drugs, on the other hand, will strengthen drives toward object relations before the patient can handle them,

and thus may precipitate untoward clinical effects, for example, denial, psychotic detachment or destructive acting out.

When a drug or any other therapeutic modulity succeeds in removing depression, the patient is confronted once more with the pathogenic situation which provoked, depressive retreat in the first place-unless he can bring a new approach to this situation, he will have to mobilize some other defence such as, schizophrenic or hysterical detachment, depersonalization, or denial. Upon the verge of recovering, the patient may be thrown back each of the first few times he attempts to resume object relations and that detachment and depression may be seen as two alternative responses to ambivalence. Energizing drugs facilitate the former and tranquilizing drugs facilitate the latter. In simple depression, therefore, merely an energizing drug is required, though if it is pressed too hard, it may precipitate a dissociative state after the patient has recovered from the depression. In that case its effect can be countered by the administration of phenothiazine or perhaps simply by reducing the dose. In a case of psychosis, if there is merely psychotic detachment with no component of depression the tranquillizing type of drug will handle the situation well. However, such is many cases of schizophrenia, both dissociative and depressive elements appear either together or alternating with each other, full control over the situation in those instances requires concurrent use of both energizers and tranquillizers (Ostow 1979).

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Authors

A. Okasha, FRCP, FRC psych., D.P.M.: Professor & Head of Psychiatric Department.

A. Ashour, M.D., MRC Psych, D.P.M. D.M.: Ass. Professor of Psychiatry.

M. Shohdy, Senior Registrar in Psychiatry, Medinat Hospital S.A.

A. Sadek, M.D. FRC psych. D.P.M.: Professor of Psychiatry Ain Shams University, Faculty of Medicine, Cairo.

A. H. Khalil, M.D., Lecturer in Psychiatry, Ain Shams University

الاكتئاب فى الفصاميون : دراسة عربية عن الانتشار والميكانزوم

موجـــــز

شملت الدراسة ١١٩ مريضاً بالفصام منهم ٨٥ سعودياً و ٣٤ مصرياً وانتظموا فى ٣ مجموعات تجريبية وأضيف إليهم مجموعة ضابطة من الأسوياء قوامها ٤٠ شخصاً استخدم الـ دى ـــ اس ـــ ام ٣ كمرشد .

تمت الدراسة بتطبيق فحص الحالة الحاضرة (ونج واخرين ١٩٧٤) ومقياس هاملتون للاكتئاب (هاملتون ١٩٦٧) إلى جانب الدراسة الأكلينيكية الشاملة .

كان شيوع الاكتئاب فى الحالات الفصامية الحادة قبل العلاج ٦٢,٩٪ وهو أعلى بطريقة دالة احصائياً عن شيوعه فى الحالات الفصامية المزمنة حيث كان الاكتئاب ٢٧,٤٪ فى الحالات المزمنة تحت العلاج ٣٦,٥٥٪ فى الحالات المزمنة بدون علاج .

ولم يوجد فوق ذو دلالة احصائية بين شيوع الاكتئاب فى الحالات الفصامية المزمنة والعينيه الضابطة .

تدحض هذه النتائج الافتراض القائل بأن الاكتئاب فى الفصاميين سببه العلاج بالعقاقير المهدئة .

كما تدحض هذه النتائج الافتراض القائل بأن الاكتئاب هو عقبى متأخرة للذهاب تشجع الدراسة على تبنى وجهة النظر التى تصف الفصام بأنه عملية متطورة تتميز فى المراحل الحادة منها بشيوع الاكتئاب والقلق .

ABSTRAIT

La depression chez les schizophrenes: une etude arabe sur la prevalence et le mechanisme

L'etude a porté sur 119 schizophrenes, selon le DSM-III, comprenant 85 seoudites et 34 Egyptiens. Les malades ont été ragés dans 3 groupes auxquels un groupe de 40 temoins normaux a été ajoute.

Le PSE de Wing et al. (1974), l'echelle de depression de Hamilton (1967), ainsi qu'un examen clinique complet ont été utilisés.

La prevalence de la depression a été estimée d'être 62.9% chez les schizophrenes aigus avant le debut de traitement. Ce pourcentage a été statistiquement significative que celui de la depression chez les schizophrenes chroniques sous traitement (27.4%), ainsi que chez les schizophrenes chroniques sans traitement (36.5%).

Entre les schizophrenes chroniques et le groupe temoin, il n'y avait pas une difference statistiquement significantive.

Ces resultats s'opposaient à l'hypothese supposant que la depression chez les schizophrenes était la consequence du traitement avec les neuroleptiques. Aussi, ils s'opposaient a l'hypothese disant que la

depression etait le resultat tradif de la psychose.

L'étude presente à encourager l'opinion que la schizophrene est un processus evolutif characterizé par la depression et l'anxieté dans ses etapes aigus.

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SOMATIC PRESENTATION OF PSYCHIATRIC DISORDERS IN AN OUTPATIENT GROUP OF SAUDIS

By

Kutaiba Chaleby

ABSTRACT

The phenomenon of somatization in Saudi Arabia is considered in a review of 270 case records of patients who presents to the hospital during a period of four months. A high rate (56%) of conversion of psychic problems into bodily symptoms was found. Males and females showed an equal tendency to somatize; young, single, student and professional, and patients with an associated chronic physical disease were less likely to somatize than the others. Psychotic patients presented with somatic symptoms less frequently than patients with depressive or anxiety disorders; patients who reported psychosocial stresses as influencing their symptoms showed a greater tendency to somatize.

INTRODUCTION

Somatization is definied by specific criteria in the American Psychiatric Association's Diagnostic Statistical Manual [DSM III], but the word is freely used in psychiatric literature and its meaning varies with its context. In psychoanalytic literature somatization means a defensive conversion of psychic derivatives into bodily symptoms (Zetzel et al., 1973). Occasionally the word is used to describe the expression of psychiatric symptoms in a bodily language regardless of the etiology or the dynamic nature of this expression. This last meaning is the one used in this paper.

Somatization disorders are frequently unrecognized or misdiagnosed. The diagnosis depends on patients