Turaev Bobir Temirpulatovich
Assistant of the department of psychiatry,
medical psychology and narcology
Samarkand State Medical University,
Samarkand, Republic of Uzbekistan
e-mile : bobir.turaev.89@mail.ru

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WAYS TO PREVENT NEGATIVE DISORDERS IN SCHIZOPHRENIA

Abstract: In modern psychopathology, high cognitive, emotional and psychological dysfunction to negative symptoms of schizophrenia is one of the problems of dorzarb. At the same time, negative symptoms remain constant and an integral part of schizophrenia. This requires further improvement in ways to prevent negative disorders in schizophrenia

Key words: Schizophrenia, negative disorder, psychopathology, cognitive function

Introduction: The share of negative disorders in all major types of schizophrenia (fur-like, recurrent, continuous, excluding paranoid) is 29-40% [1-3]. The problem of negative disorders in schizophrenia and schizophrenic spectrum disorders is insufficiently studied .

Modern psychopathology of negative disorders is based on a long historical experience, laid down in the prenosological period [7-10]. According to J. Jackson, negative symptoms reflect the "loss" of reflexes at the level of higher cognitive, emotional and psychological functions, while positive ones represent a "phenomenon of release" (i.e. they are secondary to primary - negative disorders - AS) and only distort or hyperbolize normal functioning

At the same time, negative symptoms are persistent and persist in 20-40% after the first episode of schizophrenia [17-21], and in 16-35% - within a year after its passing [22-27] and in 35% - even 2 years after the first hospitalization. Another argument is the incompleteness of the clinical analysis of the schizophrenic defect, despite the understanding of negative symptoms as a "key domain of the psychopathology of schizophrenia" [28-34].

Thus, the conditions that formed the subject of this study can be rightfully attributed to the space of deficit disorders conceptualized in a number of modern publications within the framework of negative schizophrenia [35-42].

The purpose of the study. To carry out a conceptual analysis of negative disorders in schizophrenia and schizophrenic spectrum diseases.

The results of the study. The results of the study indicate that this distribution is not accidental, but obeys the dichotomy of the basic symptoms of "common syndromes". Although, according to the psychometric assessment, the structure of each of the general syndromes under consideration presents both a volitional defect - abulia with the phenomenon of dependence, and an emotional defect, i.e. both components reflecting the dichotomous structure of the schizophrenic defect, the distribution of these patterns of negative disorders in the clinical space of general syndromes is uneven.

The analysis of the casuistry at our disposal allows us (as already mentioned above) to assume that the ranking of psychopath-like disorders in accordance with the dichotomy of the basic defect is possible (and feasible) not only within one single cluster of RL, but acquires a more universal character and is valid for the distribution of all psychopath-like disorders regardless of the cluster of RL to which they belong.

The general structure of deficit changes by the type of volitional defect, extrapolated to all the syndromes of the defensive pole that represent it, is characterized by a gross decrease in psychophysical endurance (when overlapping volitional disorders with asthenic symptoms) and/or volitional regulation of mental activity (apathy-abulia according to SANS - 4.3± 0.7 points; volitional disorders according to PANSS - 5.1± 0.3 points; asthenia according to MFI-20 - 77±15.3 points), with an increase in passivity, listlessness and indecision, the addition of features of asthenic autism and dependence on a narrow circle of significant others (decreased sociability according to PANSS - 3.5± 0.5 points; lack of close friends according to SPQ-A - 5.6 ± 0.4 points; relationships with colleagues and loved ones according to SANS - 3.2±0.2 points; excessive social anxiety according to SPQ-A - 6.2±1.3 points; passive social self-isolation according to PANSS - 5.2± 0.4 points; interpersonal anxiety according to SCL-90-R - 1.5±0.3 points; $p \leq 0.01$).

Emotional disorders in this group are expressed to a non-negligible degree and reflect the impoverishment of the general level of social activity (associated primarily with asthenic symptoms, sharply pointed reflexive mechanisms, as well as the tendency of patients to form sensitive ideas of attitude) and the narrowing of the range of emotional attachments to the boundaries of symbiotic ties with relatives or spouses (anhedonia-asociality according to SANS - 3.0 ± 0.2 points, flattened affect according to SPQ-A - 3.7 ± 0.4 points).

The structure of deficit changes, which is uniform for all "common syndromes" of the expansive pole (with a picture of an emotional type defect), differs on a statistically significant basis (as opposed to deficit disorders of the volitional type) by maintaining a general psychophysical pressure, in which the phenomena of energy potential reduction are manifested not by a decrease in the level of mental energy, but by its distortion in the form of chaotic, purposeless and volitional control of activity.

This is especially evident when comparing the characteristics of the labor status of patients with the indicators of the scales of apatoabulic changes (apathy -abulia according to SANS - 3.6 ± 0.3 points; volitional disorders according to PANSS - 2.7± 1.2 points; asthenia according to MFI-20-25 ± 11.2 points).

Pronounced changes in emotionality proper (anhedonia-asociality according to SANS - 4.3± 0.2 points, flattened affect according to SPQ-A - 6.8± 0.4 points) come to the fore, common for the entire group of negative emotional disorders, manifested by its gross impoverishment with the formation of regressive syntonicity traits, loss of the ability to empathy and the formation of deep emotional attachments, pathological sharpening of the features of rationalism, egocentricity and pragmatism (absence of close friends according to SPQ-A - 8.3 ± 0.4 points; decrease in sociability according to PANSS - 5.1 ± 1.2 points; relationships with colleagues and relatives according to SANS - 4.5± 0.3 points; eccentric behavior according to SPQ-A - 5.7±1.8 points; excessive social anxiety (SPQ-A) - 0.9±0.2 points; interpersonal anxiety according to SCL-90 - 0.2±0.5 points; hostility according to SCL-90 - 1.9±0.3 points).

It has been established that psychopathological manifestations of the defect in schizophrenic spectrum disorders are represented by deficient symptom complexes of the psychopathic

register (psychopath-like disorders), are of a limited (circumscriptional) nature, have a monosyndromic structure, are detected already at the level of prodromal disorders and are associated with premorbid pathoharacterological dimensions. The trajectory of negative disorders in schizophrenic spectrum disorders characterized by limited progrediency is determined - ending at the prodromal stage with either a prodromal or a phase course. Aspects of psychopharmacotherapy of negative disorders with drugs of modern generations are also discussed.

Conclusion. Thus, psychopathic symptom complexes acting in the space of "general syndromes" can be qualified as secondary to basic deficiency disorders. Accordingly, the allocation of a psychopath-like defect as a syndromic (ordained by others) form of negative disorders, according to our research, seems unlawful.

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