

Symptoms of paranoid schizophrenia and anxiety – a dynamic analysis

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Summary

Background and aim: The aim of the work was an analysis of connecting anxiety with other symptoms of paranoid schizophrenia during an episode of the disease. **Material and method:** 66 patients admitted to hospital with an episode of paranoid schizophrenia were examined by a set of tests. Exacerbation of anxiety was measured by the State-Trait Anxiety Inventory (STAI), whilst symptoms of schizophrenia – by the Brief Psychiatric Rating Scale (BPRS) and the Scale for Assessment of Positive and Negative Symptoms (SANS, SAPS). **Results:** Statistically important correlations between anxiety and the majority of positive symptoms were observed. On the other hand, correlations between negative symptoms and the anxiety experienced by the sick appeared variously. **Conclusion:** There are significant correlations when analysing the connection between anxiety and other symptoms of paranoid schizophrenia during an episode of the disease.

Key words: paranoid schizophrenia, anxiety

Introduction

In both, clinical practice and literature it was found many times that the anxiety of schizophrenics is one of the most often found symptoms.

Susołowska [1] doing research work on psychotics' anxiety contents, ascertained that their kind had certain common features differing them from anxieties occurring in healthy people and neurotics, who mostly had individual anxieties found singly and differentiated in contents. Every psychotic's set of experienced anxieties has different contents and similarity refers to single component elements. On the grounds of empirical examinations the following frequency of occurring anxiety contents were found: fear of dreams and hallucinations (22.5%), fears connected with delusion contents (22.5%), fear of other people (20.0%), fear of death (17.5%), fear of himself or herself (10.0%), fear of becoming decrepit (10.0%), fear of disease (7.5%), fear of troubles (7.5%), fear of hospital and doctor (7.5%), fear of loneliness (5.0%), fear of being discredited because of a psychological disease (5.0%), fear for the near and important person (5.0%).

20% of the remaining examined patients had anxieties that were incomparable and not to be categorised. Comparing anxiety contents in the case of psychoses to those of healthy people we found their dissimilarity and incomparability, and also a

certain new kind of anxiety content, which appears in different ways. In examinations on fear for one's own future, a higher level was found in the case of those who were ill with paranoid schizophrenia in comparison with healthy people. Unlike healthy people's fear, the patients' anxiety of their own future didn't depend on its subjective importance and closeness of the problem – all problems that threaten the human race were important [2].

Kępiński [3, 4] who differentiated four kinds of anxiety, ascertained that the anxiety occurring in schizophrenia is mostly of disintegrative character because in the course of the disease, the structures of the outside and the inside worlds disintegrate. According to Kępiński, we can often find anxiety of a social feature begin as a pivotal symptom of persecutory delusions. It is this fear of people who are seen by the patient under the influence of delusional or hallucinatory experiences, differently, as if they were changed, different from the way they were before. Moral anxiety is the fear of somebody's own changed morality, and is mostly present in delusions of messenger feature. Biological anxiety occurs in a form of sudden attacks of panic, or permanent sensation of danger of death, and is connected with a changed perception of somebody's own body with its subjective metamorphosis [4].

Trying to describe anxiety in paranoid schizophrenia, it is difficult to separate it from other symptoms of schizophrenia. It is obvious that the disease process and the patient's actual experiences may arouse fear in him. Norman and Mall [5] examined relations between anxiety and depression, and positive or negative symptoms of schizophrenia. They ascertain that the depressive – anxiety mood is more precisely connected with presently occurring positive symptoms, such as delusions, hallucinations, than negative ones. Besides, the mood may precede the occurrence of acute positive symptoms. Husting and Hafner [6] examining sustained auditory hallucinations among the ill with schizophrenia; they ascertained that in at least half of those examined, there was a statistically considerable correlation between the exacerbation and persistence of hallucinations and delusion intensity.

The more persistent and stressful the hallucinations were, the more fearful the patients were.

In the analysis of the expressed contents, we can find that the schizophrenics' anxiety occurs in certain domains. At an early stage of the disease, actual psychopathological symptoms are the direct source of anxiety. Further on, in the chronic phase, the consciousness of having a psychiatric disease, anxiety of the health deteriorating, inefficacy of treatment may all determine the factor causing anxiety and sense of endangerment [7]. The consciousness of a social dimension of the disease may cause fear of being rejected and a lack of acceptance. Clinical observations and empirical data suggest that schizophrenics show a level of social anxiety in social contacts and qualify 'shyness' as a serious problem. A high level of social anxiety may be a factor of social isolation, which is a common problem for the patients [8]. Penn et al [9] in examining social anxiety in schizophrenia, suggest that it may be a bigger problem among the patients with an overbalance of negative symptoms. Those patients have bigger problems in social relationships and the quality of their lives is worse in comparison with patients with a majority of positive symptoms. Inclination to withdrawing from

interpersonal contacts among those patients may result from attempts of struggling with a high level of social anxiety. In a conducted examination, it was confirmed that the negative symptoms were considerably connected with behavioural factors of social anxiety. A higher number of negative symptoms was connected with more intensive global anxiety, rocking, slower speaking, little fluency in speaking with long breaks. On the other hand, symptoms correlated positively with stronger agoraphobia, stronger anxiety connected with the stay in hospital, a fear of being hurt, and also with difficulty in making eye contact.

The aim of the study was an analysis of the connection between anxiety and other symptoms of paranoid schizophrenia during an episode of the disease.

Subjects and methods

In the examination, previously known and used clinical tools were applied. Their accuracy and correctness were estimated in many prior examinations.

State-Trait Anxiety Inventory (STAI) by Spielberger [10, 11] was applied for the estimation of the level of anxiety. Psychopathological symptoms were estimated by the Brief Psychiatric Rating Scale (BPRS) by Overall [12] and also by the Scale for Assessment of Positive and negative Symptoms (SANS < SAPS) by Andreasen [13, 14]. To observe the dynamics of anxiety and the paranoid symptoms in the course of hospitalisation, these scales were used thrice: in the first week after admission to the hospital, after 3-, 4- week stays and before discharge, i. e. after the symptoms had ceased. A Sociodemographical Inventory was used once (for the specification of the examined group). The 'Statistica' program was used for statistic counting and a correlation matrix was applied. Data, with a level of statistical importance ('p') smaller than 0,05, were analysed.

In the examined group, there were 66 patients ill with paranoid schizophrenia, 33 women and 33 men.

Most of the examined patients were hospitalised for the first time – 69.9% (women 72.2% and men 66.7%). 62 people were hospitalised for the first, second or third time (93.9%). In the group, there were mostly young people, up to 30 years old (77.3%), with men outnumbering women, especially in the age of 18 and 24, 25 years, each being 15.2%.

The women's age range was more regular, with its majority in the later age: 29 years (9.1%) and 35 years old (12.1%). The average age of the entire group was 26.4 years, for the men – 25 years, and for the women – 27.7 years. Because of the genetic conditions of schizophrenia the hereditary transmission of those examined seems to be interesting.

Half of those examined didn't have any hereditary transmissions but the other half was burdened with schizophrenia (21.2%), alcoholism (13.6%), suicidal tendencies (9.1%) and affective disturbances (3.0%). Men were mostly burdened with alcoholism (18.2%), women with schizophrenia (27.3%). The patients stayed in hospital during the course of the observed schizophrenic episode usually for 1 to 3 months (44 people, i. e. 66.7%), 13 patients (19.7%) stayed for 3 to 6 months and only 2 patients stayed for more than 6 months. Seven patients (10,6%) were discharged in a month for various reasons.

Results

Connections between the State–Trait Anxiety Inventory (STAJ) anxiety measures and different psychopathological symptoms measured with the Scale for Assessment of Positive Symptoms (SAPS) and Negative Symptoms (SANS), and also the Brief Psychiatric Rating Scale (BPRS) were analysed. (Table 1)

Table 1
Anxiety correlation with other symptoms measured by STAI in the first week of treatment

	SANS 11	SAPS 3	SAPS 5	SAPS 33	BPRS 5	BPRS 9	BPRS 14
x-1	-.3345		-.3102	-.3289			-.2433
x-2		.2422			.2430	.2510	-.2539

* - $p < 0.05$, *** - $p < 0.001$

As we can see in table 1, anxiety as a state (x – 1) actually experienced by patients, correlates highly negatively with increased response latency (SANS 11) ($p < 0.001$) and with olfactory hallucinations (SAPS 5), ringing speech hallucination (SAPS 33) and a lack of co – operation with the examiner (BPRS 14) ($p < 0.05$). We think that the most intensified thought disorders perceptible in the patient’s way of speaking may be connected with a slighter exacerbation of the actually experienced anxiety.

Patients feeling extraordinary fragrances may not be afraid of them, but may perceive them as pleasant ones.

Anxiety as the patient’s personality trait (x – 2) correlates slightly positively with the occurrence of hallucinations such as discussing voices (SAPS 3), feelings of guilt (BPRS 5), mood aggravation (BPRS 9) and slightly negatively with a lack of co – operation with the examiner (BPRS 14). In the acute phase of the disease, voices ‘heard’ by the patient, talking about him, may cause his feeling of guilt and mood aggravation (accusing, hostile contents), and by those, increase the predisposition to react with anxiety; whereas intensified anxiety, both personality conditioned and actually experienced because of complaints of the disease can cause an increased need for co-operation and support of the examiner.

Then, the anxiety correlation factors such as state (x – 1) and trait (x- 2) were calculated and compared with psychopathological symptoms present after a three-

Table 2

Correlation of anxiety with other symptoms estimated by STAI after 3-week treatment

	SANS 11	SAPS 4	SAPS 19	SAPS 21	BPRS 14
x-1	-.3280	-.3031	-.3533		
x-2				-.3073	-.2390

* - $p < 0,05$

-week treatment, (Table 2)

In the second stage, the currently experienced anxiety of a patient ill with paranoid schizophrenia is correlated slightly negatively with speech blockade (SANS 10), somatic and tactile hallucinations (SAPS 4), somatic delusions (SAPS 13). The patient's perception of the disease as relating to his body as being close to his internal domain, in contrast to the other domains, may cause him to be less afraid of them.

The anxiety usually present among patients ($x-2$) also correlated slightly negatively with an eccentric appearance (SAPS 21) and a lack of co-operation with examiner (BPRS 14). The patients with a high predisposition to reacting with anxiety may look for the examiner's support; they don't have enough courage to wear themselves oddly, or change their looks.

In the third stage of examination, there were mostly correlations of anxiety with psychopathological symptoms. In the cases of negative symptoms, it referred to anxiety as a feature, and not anxiety experienced actually. Table 3 presents correlation of

Table 3
Correlation of anxiety with negative symptoms by STAI scale on discharge

SANS	4	14	15	16	17	18
	*	*	*	*	*	*
x-2	-.2458	.2456	.2450	.2545	.2673	.2522

* - $p < 0.05$

anxiety as a trait ($x-2$) with negative symptoms estimated by SANS scale.

Anxiety as a trait ($x-2$) correlated slightly positive with lack of persistence (SANS 14), physical energy (SANS 15), apathy – volitionality (SANS 16), loss of interest (SAN 17) and reduced sexual activity (SANS 18). It correlated negatively with poor eye contact. Susceptibility to reacting with anxiety is stronger in apathetic patients with little persistency who do not have enough energy to cope with anxiety. We could also say that patients with a more intensified anxiety feature do not avoid eye contact with the examiner, which reduces their fear.

Estimated anxiety correlation by STAI with positive symptoms measured by the SAPS scale, referred to many points. Table 4 illustrates the connection of anxiety with

Table 4
Correlation of anxiety with positive symptoms by the STAI scale upon discharge

SAPS	1	2	3	11	19	23	28	29	31
	*	*	*	*	**	*	**	*	*
x-1	.2670	.2390	.2677	.2430	-.5700	.2651	.3906	.2366	.2810

* - $p < 0.05$, *** - $p < 0.001$

positive symptoms according to the SAPS scale on the day of discharge.

Actual pre-discharge anxiety level correlates highly negatively with delusions of

having thoughts stolen (SAPS 19) and positively with speech incoherence (SAPS 28) and slightly positively with experienced auditory hallucinations (SAPS 1), with a third person making a commentary (SAPS 2) and discussing voices (SAPS 3), delusions of grandeur (SAPS 11), aggressiveness and excitement (SAPS 23), non – logical thinking (SAPS 29) and speech accumulation (SAPS 31). The correlation between the currently experienced anxiety with experienced hallucinations and also formal thought disorders hindering contact with the environment is confirmed once again.

Delusional conviction of having special abilities or possibilities is in a given moment the source of increased anxiety in a patient.

The correlation between anxiety as a trait of personality (x-2) and positive symptoms concerned many SAPS scale points. (table 5)

Table 5

Correlation of anxiety with positive symptoms by STAI scale upon discharge

SAPS	1	2	3	7	8	11	14	15	18	20	23	26	28	29	
x-2	.2827	.3300	.3374	.2837	.3882	.3105	.3074	.3054	.4108	.2872	.3400	.2481	.2715	.3000	.2748

* - $p < 0.05$, ** - $p < 0.01$, *** - $p < 0.001$

High factors of correlation of anxiety traits (x - 2) with the following symptoms: persecutory delusions (SAPS 8) and display though disorder (SAPS 16), commenting voices (SAPS 2) and discussing voices (SAPS 3), delusions of grandeur (SAPS 11), delusions of reference (SAPS 14), general level delusions (SAPS 20) and incoherent speech (SAPS 28) were found. Slightly positive correlations with experienced auditory hallucinations (SAPS 1), a general level of hallucinations (SAPS 7), distant control delusions (SAPS 15), thoughts being sent (SAPS 18), aggressiveness, excitement (SAPS 23), absent-minded thinking (SAPS 26) and also incoherent (SAPS 28) and non-logical speech (SAPS 29) were shown. We think that in the case of the patients with a high personality disposition to reacting with anxiety under the influence of hallucinations or delusions in formal thought disorder manifesting itself in speech, the feature will be intensified. The patients will defend themselves with aggression, or they will be excited.

Afterwards, connections between anxiety estimated by BPRS (symptom 2) and SANS and SAPS were analysed.

Table 6

Anxiety correlation between BPRS symptom 2, and symptoms measured by SANS and SAPS upon admission to hospital

	SANS 25	SAPS 8	SAPS 10	SAPS 15	SAPS 23	SAPS 30
BPRS Anxiety	*	**	**	*	*	*
	-.2419	.3725	.3300	.3281	.2707	-.3506

* - $p < 0.05$, ** - $p < 0.01$

A reasonably positive correlation can be noted between anxiety and persecutory delusions (SAPS 8), delusions of guilt (SAPS 10), remote control (SAPS 15) and a

slightly positive one with aggressiveness (SAPS 23). A reasonably negative correlation was noted between anxiety and diffuse speech (SAPS 30) and a slight negative correlation with concentration (SAPS 23). We think that anxiety experiences are closely connected with imaginary symptoms experienced by those patients who aggressively defend themselves against the symptoms. Thought disorders hinder concentration and fluency.

After the 3rd week of hospitalisation, the correlation between anxiety estimated by BPRS, symptom 2, and symptoms noted in the SANS and SAPS are shown in table 7.

Table 7

Anxiety correlation between BPRS symptom 2 and symptoms measured by SANS and SAPS after a 3-week treatment

	SANS 9	SANS 13	SANS 15	SANS 16	SAPS 12	SAPS 15	SAPS 23	SAPS 25	SAPS 28	SAPS 31
BPRS anxiety	.3348*	.2021	.3400*	.2210	.2850	.3350	.4484**	.3448	.3340	.4251

* - $p < 0.05$, ** - $p < 0.01$

Anxiety estimated by the examiner, correlates reasonably positively with aggressiveness and excitement (SAPS 23) and prolix speech (SAPS 31) and slightly positively with the appearance of negligence (SANS 13), lack of perseverance (SANS 14), energy and apathy (SANS 15 and 16), religious delusions (SAPS 12), distant control delusions (SAPS 15), freakish behaviour (SAPS 25) and incoherent speech (SAPS 28). During the 3rd week of stay in the hospital, patients were still afraid of being controlled and had delusions of religious experience; they defended themselves with aggressiveness and excitement. At the same time they felt helpless and more susceptible to anxiety because of apathy, the lack of activity enabling them to deal with the anxiety. Similar problems in communicating with the environment because of formal thought disorders and freakish behaviour did not decrease the anxiety.

At the end of treatment, the connection between anxiety, measured by the BPRS, with psychopathological symptoms measured by the SANS and SAPS were studied. (table 8)

Table 8

Anxiety correlation with BPRS symptom 2 and symptoms measured by SANS and SAPS upon discharge

	SANS 8	SANS 11	SANS 12	SANS 15	SAPS 10	SAPS 11	SAPS 32	SAPS 33
BPRS anxiety	.2354	.2714	.2752	.3454	.4480	.3722	.3250	.4040

* - $p < 0.05$, ** - $p < 0.01$, *** - $p < 0.001$

Analysing the interdependence, we could say that anxiety measured by the BPRS correlates highly positively with the following positive symptoms: delusions of guilt

(SAPS 10), ringing voices (SAPS 33). It correlated reasonably with delusions of exposure (SAPS 16) and incoherent speech (SAPS 32), and slightly positively with negative symptoms, such as: the poverty of expression (SANS 8), increased latency of response (SANS 11), alogia (SANS 12) and physical energy (SANS 15). Patients under the influence of the experienced sense of guilt and also sensation of thought-reading in their minds by somebody else, experience strong anxiety. At the same time the anxiety increases due to the difficulties in communicating with the environment owing to alogia and inclination to inactivity.

It was interesting to analyse the interdependence between anxiety measured by BPRS and other symptoms measured by the scale. Those connections are presented in table 9.

Table 9

Anxiety correlation measured by BPRS symptom 2, with other symptoms measured by the scale upon admission to hospital

BPRS	1	3	5	6	8	9	10	11	13	14	17
BPRS anxiety	---	---	---	---	*	---	---	---	---	---	---
	.4720	.3547	.3347	.5053	.2010	.4075	.4113	.4001	.3540	.3070	.4240

* - $p < 0.05$, ** - $p < 0.01$, *** - $p < 0.001$

In the initial period of hospitalisation, anxiety highly positively correlates with care for the patient's own health (BPRS 1), autism (BPRS 3), sense of guilt (BPRS 5), emotional tension (BPRS 6) worsening mood (BPRS 9), hostility (BPRS 10), suspicion (BPRS 11), lack of co-operation with the examiner (BPRS 14) and also excitement (BPRS 17). It correlates reasonably positively with motor inhibitions (BPRS 13).

Anxiety correlated slightly negatively with expansive contents (BPRS 8). We think that at the beginning of hospitalisation, autistic patients suffering from delusions of guilt, experiencing strong anxiety, react with increased emotional tension, hostility towards other people (examiner, too), and defend themselves by presenting motor excitement, irritability, or on the contrary: inhibition and worsened mood. Expansive contents give a sense of strength and importance to a patient and decrease his anxiety level.

Correlation between anxiety and other symptoms noted in BPRS after a 3-week treatment are shown in table 10.

Anxiety in BPRS correlates highly positively with care for the patient's own health

Table 10

Anxiety correlation noted in BPRS symptom 2, with other symptoms noted in the scale after a 3-week treatment

BPRS	1	3	6	10	11	14	15	17
BPRS anxiety	***	***	***	**	**	*	*	**
	.6033	.4747	.6777	.4101	.4229	.3572	.3533	.4451

* - $p < 0.05$, ** - $p < 0.01$, *** - $p < 0.001$

(BPRS 1), autism (BPRS 3) and emotional tension (BPRS 6). It correlates reasonably positively with hostility (BPRS 10), suspicion (BPRS 11) and psychomotor excitement (BPRS 17) and slightly positively with lack of co-operation with the examiner (BPRS 14) and thought contents disorder (BPRS 15). Just like at the admission to hospital, complaints which are still strongly connected with the experienced anxiety are; thought contents disorder, suspicion, alienation from environment – towards all these, patients react with hostility, excitement and increased emotional tension.

Hallucinations (BPRS 12) and psychomotor excitement (BPRS 17) correlated

Table 11

Anxiety correlations with other symptoms in BPRS upon discharge

BPRS	1	3	5	6	9	10	11	12	15	17
x-1								*		*
								.2602		.3862
x-2			*	*	*	*	*		*	*
			.2856	.2460	.2403	.3132	.3011		.2785	.3040
BPRS	***	**	**	**	***	*	*			
anxiety	.5816	.3122	.5140	.5676	.4699	.2625	.2464			

* - $p < 0.05$, ** - $p < 0.01$, *** - $p < 0.001$

slightly positively with anxiety as a state (x – 1). Sense of guilt (BPRS 5), emotional tension (BPRS 6), worsened mood (BPRS 9), suspicion (BPRS 11) and thought content disorders (BPRS 15) correlated slightly positively, and hostility (BPRS 10) correlated reasonably positively with anxiety as a personality trait (x – 2).

Intercorrelations of anxiety with other symptoms noted in the BPRS were highly positive in the case of patients' care for their own health (BPRS 1), sense of guilt (BPRS 5), emotional tension (BPRS 6), worsened mood (BPRS 9), reasonably positive for autism (BPRS 3) and slightly for hostility (BPRS 10), suspicion (BPRS 11). Both at the beginning and after 3 weeks of hospitalisation, patients who felt as alienated from their environment, delusional patients, those worried about their health, those with a sense of guilt and lowered mood, reacted with increased anxiety. Emotional tension and hostility towards the environment were apparent in this state.

Discussion

Analysing connections of negative and positive symptoms with the anxiety experienced by patients, Penn et al. [9] found that the high level of social anxiety among patients is connected more with the negative than the positive symptoms. In the examination carried-out, patients with increased symptoms of apathy – volatility (SANS 13 - 16) and with decreased interests (SANS 17) and decreased sexual activity (SANS 18) were characterised by a considerably increased level of anxiety as a trait (x – 2) and anxiety measures in the BPRS. As it appeared from the data, the disorder in a motivation domain, lack of activity, incline to inactivity, lack of activity perseverance and direct eye contact with the examiner increases the patient's anxiety. Likewise,

disorders of the emotional domain as noted in the BPRS are as follow: care for health (BPRS 1), affective alienation (BPRS 3), sense of guilt (BPRS 5), evident somatic and motor signs of emotional tension (BPRS 6), worsened mood (BPRS 9), hostility (BPRS 10), being unfriendly towards the examiner (BPRS 14) and also excitement (BPRS 17, SAPS 23) or motor inhibition (BPRS 13) were all closely connected with the growing anxiety among patients.

Much data dealing with occurrences of perception, thought, concentration disorders and also the rules of information interpretations in schizophrenia have been previously noted [15, 16, 17, 18, 19]. Clinical symptoms of those abnormalities are thought disturbances, concentration and perceptive disorders appearing with the onset of the disease. In the presented study, connections between anxiety and those symptoms were analysed. During the whole time, from the beginning of the hospitalisation, patients reacted with anxiety directly ($x - 1$; $x - 2$, BPRS 2) towards the experienced hallucinations, among them: auditory, such as commenting and discussing voices (SAPS 1 – 3 and 7, BPRS 12). It confirms Husting and Hafner's [6] observations that the more persistent and stressful the hallucinations are, the more anxious the patients become. However, olfactory (SAPS 5), somatic and tactile delusions were all connected with a slighter exacerbation of anxiety as an actual state ($x - 1$), which can be explained by their connections with the internal domain of the patient. Delusional convictions also appeared to be anxiogenic, which is confirmed by Norman and Mall's [5] examinations and clinical observations. A general level of delusions (BPRS 11 and 15; SAPS 20), persecutory delusions (SAPS 8), delusions of guilt (SAPS 10), delusions of grandeur (SAPS 11), religious delusions (SAPS 12), delusions of reference (SAPS 14), remote control delusions (SAPS 15), thought exposure delusion (SAPS 16), sent thought delusions (SAPS 18) – they all increased anxiety as a personality feature ($x - 2$) and anxiety measured by the BPRS. Conversely, the patients reacted to experienced somatic delusions (SAPS 13) and thoughts begin stolen (SAPS 19) with a decrease in anxiety. Maybe the delusions referring to the patient's body are closer, personal and by this less frightening than convictions about altered external reality. Similarly, feeling of having unpleasant thoughts stolen by some external force is for the patient less unpleasant than their presence.

Some formal thought disorders appearing in speech were also connected with an increased level of anxiety. Anxiety as a feature ($x - 2$) and anxiety measured by BPRS were intensified among patients with absent-mindedness (SAPS 26), in-coherent speech (SAPS 28) as well as in those having a difficulty in logical conclusions (SAPS 19) and those with a flood of words and ringing voices (SAPS 31 and 33). On the contrary, speech prolixity (SAPS 30) causes a decrease of anxiety. Negative symptoms from alogia were also connected with the anxiety experienced by schizophrenics. And as it follows; increased latency of decreased level of anxiety at the moment ($x - 1$), undoubtedly, in result of difficulties in the verbalisation of actual experiences, where as the reduction of speech (SANS 8), general level of alogia (SANS 12), difficulties in concentration (SANS 23) increased anxiety measured by BPRS, which may be explained an inadequacy of cognitive and thought processes among the patients.

In course of the disease, the patients' personality is disintegrated in various inten-

sities. Complaints of having the impression of changing oneself are often expressed by patients, especially at the beginning of the disease and are connected with experienced anxiety and unrest [20]. The occurrence of disintegration anxiety in early stage schizophrenia was found in 45% patients [7, 21]. As an external symptom of a schizophrenic's psychic disintegration, strange behaviour (SAPS 25) can be considered. The more the psychotic patient differs from social standards, the stronger his anxiety is. At the same time, patients with a high value of anxiety ($x - 2$) in their personality abstain from wearing themselves in an extraordinary way (SAPS 21) and they are co-operating more willingly with examiner (BPRS 14), especially in the period of acute psychotic symptoms.

Conclusions

1. During the episode of paranoid schizophrenia, an increased anxiety as a trait ($x - 2$) and anxiety measures in BPRS were found at each stage of hospitalisation; from hallucinations, delusions, formal thought disorders, freakish behaviour to alogia, apathy - volitionality, care for health and sense of guilt.
2. Lowered level of anxiety as a feature ($x - 2$) was connected with difficulties in concentration, poor eye contact and speech prolixity.
3. The patients with a high level of anxiety, reacted with increased emotional tension, worsened mood, hostility, aggressiveness, motor excitement or inhibition. At the same time patients with an increased anxiety feature ($x - 2$) were more willing to co-operate with the examiner, which is probably due to their need to be helped and supported.
4. Anxiety as an actual state ($x - 1$) increased in correlation with the presence of auditory hallucinations, delusions of grandeur, incoherence, non-logical thinking, prolix speech. It decreased in correlation with increased speech latency and tactile hallucinations, and somatic delusions and stolen thoughts.

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