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CLINICAL AND PSYCHOPATHOLOGICAL FEATURES OF THE COURSE AND OUTCOME OF THE FIRST PSYCHOTIC EPISODE

V. V. Kosovsky

I. HorbachevskyTernopil National Medical University

Abstract

The article presents the results of the study of the clinical-anamnestic, clinical-psychopathological and clinical-dynamic features ofthefirst psychotic episode (FPE), taking into account the nosological specificity. It was determined that FPE (F20) is characterized by an early onset and significant duration of the prodrome (more than 3 years), the presence in the clinical picture of a moderate level of negative symptoms (apato-abulous symptoms, manifestations of flattening and rigidity of affect and austic tendencies). FPE (F23) defines the shortest (up to 3 months) prodromal period, the presence in the clinical picture of excitement and anxiety of a high and moderate level, disorganization and physical tension. FPE (F25) is characterized by a rather long prodrome (from 3 months) with manifestations in the form of emotional disorders, the presence in the clinical picture of pronounced symptoms of excitement, depression, anxiety, physical tension and impulsivity, negative symptoms in the form of apatho-abolic manifestations and anhedonia - asociality. According to indicators of the dynamics of the condition of patients with FPE, an unfavorable prognosis for recovery at F20 was determined.

Key words: firstpsychotic episode; clinical-anamnestic; clinical-psychopathological; clinical-dynamic features

The topicality of study of the psychosis initial stages is determined by their critical importance for further course and dynamics of the psychotic process [1-4]. The first psychotic episode (FPE) marks the peak of the psychotic phase of the disease and, in practical terms, determines the possibility of the first treatment experience [2]. It is the FPE that is considered a "critical period" when a long-term clinical and functional prognosis of the disease and possibility of early prevention of mental disorders and maladjustment are laid down [1, 3, 5]. It is noted that the critical period for providing care and improving recovery from psychosis is the first 2-5 years of psychotic experience, during which pathological processes are most amenable to correction [2, 3]. FPE combines syndromes set of acute mental conditions, is characterized by a considerable polymorphism of clinical and psychopathological manifestations, and is the debut of various nosological forms of mental illness, including schizophrenia, schizoaffective disorder, organic, intoxicating psychosis, bipolar affective disorder, etc. [4]. The heterogeneity of the clinical picture and outcomes of FPE determines difficulties in providing timely and adequate treatment and actualizes the need for research and development in this area.

The aim: to investigate the clinical and anamnestic, clinical and psychopathological, clinical and dynamic features of patients with FPE.

Study sample: 177 patients who were first hospitalized with an episode of psychosis in an inpatient department: 53 patients with a diagnosis of schizophrenia (F20); 96 patients with a diagnosis of acute polymorphic psychotic disorder (F23); and 28 patients with schizoaffective disorder (F25).

Methods of study: *clinical and psychopathological* (Positive and Negative Syndrome Scale (PANSS) (Mosolov S.N, 2001); Scale for the Assessment of Negative Symptoms (SANS) (Andreasen N.S. 1989), Brief Psychiatric Rating Scale (BPRS) (Overall J.E., Gorham D.R., 1988), CGI-I subscale of the Clinical Global Impression Scale (CGI) (Busner J., Targum S.D., 2007); *clinical and cathartic* (analysis of medical records, interviewing patients, their relatives and immediate environment); *clinical and statistical method* (methods of descriptive and comparative (Student's t-test, two-sided Fisher's test) statistics) [6-9].

Research results and their discussion

Based on the results of the analysis of anamnestic data on the disease development, it was found that FPE(F20) was characterized by an early prodrome onset (mainly before 16 (33.96 ± 5.31 %) or before 20 years old (41.51 ± 6.11 %)) with a significant duration (more than three years - in 33.96 ± 5.31 %) and a variety of prodromal manifestations, among which socialization problems prevailed (conflict and relationship problems (43.40 ± 6.28) %, social isolation and solitude (32.08 ± 5.08) %); decrease in energy potential and volitional disorders (30.19 ± 4.85) %, sharp decline in activity (20.75 ± 3.55) %, suppression of emotions (15.09 ± 2.67) %, emotional disorders in form of anxiety (35.85 ± 5.52) %, as well as increased sensitivity and unusual perceptions (16.98 ± 2.98) %. There was also a high frequency of fatigue preceding the psychotic state (35.85 ± 5.52) %.

FPE(F23) were characterized by a short prodromal period (mostly up to 3 months (32.29 ± 2.80) %), the age of onset of which, in the vast majority, was 20-25 years old (30.21 ± 2.66), and which manifested itself somewhat “erased”, with less expressive and less diverse manifestations. In most cases, hospitalization was preceded by stressful conflict situations (70.83 ± 4.03) %.

FPE(F25)was characterized by a rather long prodromal period from 3-6 months (32.14 ± 9.81) % to 1 (25.00 ± 8.02) % or 3 years (25.00 ± 8.02) %; the age of prodrome onset in the vast majority was after 16 to 20 years old (35.71 ± 10.61) %, and prodromal manifestations in the vast majority included emotional disorders in the form of depressive manifestations (50.00 ± 13.09) %, anxiety/nervousness (42.86 ± 12.00) %, as well as problems with concentration (39.29 ± 11.34)% and problems in relationships (32.14 ± 9.81) %. There was a high frequency of stress factors (60.71 ± 14.09) % and overwork (39.29 ± 11.34) % that preceded hospitalization.

According to the comparative analysis, it was found that in FPE(F20) duration of the prodromal period of more than 3 years was determined significantly more often (33.96 ± 5.31) % than in FPE(F23) (10.42 ± 1.04) %, at $p \leq 0.0005$ and in FPE(F25) (10.71 ± 3.75) %, at $p \leq 0.02$. In addition, duration of prodrome from 1 to 3 years was also significantly more frequent in FPE(F20) (30.19 ± 4.85) % compared with F23 (17.71 ± 1.69) %, at $p \leq 0.04$. A short prodromal period of up to 3 months was characteristic of FPE(F23), which in patients of this group was determined significantly more often (32.29 ± 2.80) %, compared with FPE(F20) (1.89 ± 0.36) %, at $p \leq 0.000001$ and with FPE(F25) (7.14 ± 2.55) %, at $p \leq 0.004$. In FPE(F25), a prodromal period lasting from 3 to 6 months was significantly more often

determined (32.14 ± 8.81) %, compared with patients with FPE(F20) (13.21 ± 2.37) %, at p ≤ 0,03.

Statistical differences in age of prodrome onset were found when comparing patients with FPE(F20) and FPE(F23): in patients with F20, early prodrome onset was significantly more common before the age of 16 (33.96 ± 5.31) % and from 16 to 21 years old (41.51 ± 6.11) %, compared to F23 (14.58 ± 1.42 and 26.04 ± 2.36) %, with p ≤ 0.04 and p ≤ 0.02, respectively. Whereas in patients with F23, the age of prodrome onset was significantly more frequent in later age periods after 20 years old: 21-25 years old (30.21 ± 2.66) % and 26-30 years old (19.79 ± 1.87) %, compared to F20 (16.98 ± 2.98 and 5.66 ± 1.06) %, with p ≤ 0.03 and p ≤ 0.01, respectively.

According to the results of a comparative analysis of the study groups by frequency of prodromal manifestations, it was found that in FPE(F20), problems in relationships and conflict were significantly more frequent (43.40 ± 6.28) %, compared with F23 (17.71 ± 1.69) %, at p ≤ 0.0006;social isolation and seclusion (32.08 ± 5.08) %, compared to F23 (13.54 ± 1.33) % and F25 (7.14 ± 2.55) %, at p ≤ 0.005 and p ≤ 0.008, respectively; decreased energy and will (30.19 ± 4.85) %, compared with F23 (11.46 ± 1.13)%, at p ≤ 0.004;suppression of emotions (15.09 ± 2.67) %, compared to F23 and F25, where such manifestations were not observed at all, with p ≤ 0.002 and p ≤ 0.03, respectively; anxiety and fears (35.85 ± 5.52) %, compared with F23 (16.67 ± 1.60) %, at p ≤ 0.005; problems with focus and attention (39.62 ± 5.92)%, compared with F23 (17.71 ± 1.69) %, at p ≤ 0.002; a sharp decline in activity (20.75 ± 3.55)%, compared with F23 (6.25 ± 0.64) %, at p ≤ 0.007; increased sensitivity and unusual perceptions (16.98 ± 2.98) %, compared to F23 (3.13 ± 0.32) % and F25, where such prodromal manifestations were not recorded at all, at p ≤ 0.004 and p ≤ 0.02, respectively.

Whereas in FPE(F25), depressive symptoms and mood fluctuations (50.00 ± 13.09) % compared with F23 (14.58 ± 1.42) %, at p ≤ 0.0002; anxiety and nervousness (42.86 ± 12.00) %, compared to F20 (20.75 ± 3.55) % and F23 (16.67 ± 1.60) %, at p ≤ 0.02 and p ≤ 0.04, respectively; and problems with focus and attention (39.2 ± 11.34) %, compared with F23 (17.71 ± 1.69) %, at p ≤ 0.01, were significantly more often identified as prodromal manifestations.

The analysis of factors preceding hospitalization revealed that in patients with FPE of all study groups, in most cases, stressful conflict situations and overwork were the factors provoking the onset of psychosis. At the same time, in patients with FPE(F23) and (F25), stressful conflict situations preceding hospitalization were determined significantly more

often (70.83 ± 4.03 and 60.71 ± 14.09) %, compared with F20 (32.08 ± 5.08) %, at p ≤ 0.00001 and p ≤ 0.009, respectively. Whereas overwork was significantly more often identified as a provoking factor in patients with F20 (35.85 ± 5.52) % and patients with F25 (39.29 ± 11.34) %, compared with F23 (21.88 ± 2.04) %, at p ≤ 0.03 and p ≤ 0.04, respectively. In addition, in patients with F20 significantly more often the factors preceding hospitalization were not determined at all (15.09 ± 2.67)%, compared with patients with F23 (2.08 ± 0.22) %, at p ≤ 0,004.

The results of the analysis of the severity of clinical and psychopathological symptoms according to the PANSS positive and negative symptomatology scale revealed that the highest level of clinical and psychopathological symptoms was determined in FPE(F20) (86.7±1.76), the level of severity of psychopathological disorders in F23 and F25 was somewhat lower and equalled 79.00±1.62 and 77.8±1.57 points, respectively. In the clinical structure of FPE in patients of all groups of examined, positive symptoms prevailed over negative ones, as evidenced by the positive values of the composite index, while in the group of patients with F20 this index was the lowest 4.16±0.26, compared to patients with F23 (10.1±0.38) and F25 (11.2±0.41), at p≤0.03 and p≤0.05, respectively.

In structure of positive symptoms of FPE(F20), hallucinations (4.46 ± 0.33) and delusions (4.28 ± 0.3) were pronounced, which were complemented by moderately pronounced symptoms of agitation (3.84 ± 0.21), suspicion (3.73 ± 0.26) and conceptual disorganization of thinking (3,65 ± 0,27).

In FPE(F23), the structure of positive symptoms was represented by pronounced delusional ideas (4.6 ± 0.33), hallucinatory behaviour (4.54 ± 0.28) and agitation symptoms (4.35 ± 0.36), which were also supplemented by disorganization of thinking (3.52 ± 0.25) and persecutory ideas (3.42 ± 0.25), which did not exceed a moderate level.

The structure of positive symptoms of FPE(F25) was characterized by the dominance of agitation symptoms (4.6 ± 0.35), delusions (4.4 ± 0.32) and hallucinatory behaviour (4.3 ± 0.3), combined with perseverative ideas of moderate severity.

Manifestations of negative symptoms in patients of the study groups were less pronounced compared to positive symptoms, while in patients with F20 the level of negative symptoms was significantly higher (20.16±1.32) points compared to F23 and F25 (13.84±0.95 and 12.1±0.8, respectively, at p≤0.05). In the structure of negative symptoms of FPE(F20), which were represented mainly by a moderate or mild level of severity, moderate passive-apathetic social isolation (3.36 ± 0.28), impoverished contact (3.24 ± 0.26) and emotional alienation (3.2 ± 0.25) were determined, in addition, initial, mild, closer to moderate,

disorders were diagnosed in the form of insufficient spontaneity/fluency of speech (2.75 ± 0.24), stereotypical thinking (2.7 ± 0.23) and abstract thinking disorders (2.65 ± 0.22), as well as mild manifestations of affect flattening (2.26 ± 0.18). At the same time, the level of all negative symptoms listed in the PANSS scale in patients with F20 was higher compared to manifestations of FPEat F23 and F25, in particular the severity of abstract thinking disorders (2.65 ± 0.22, compared to F23 (1.46 ± 0.14) and F25 (1.3 ± 0.11), at p≤0.05); impoverishment of contact (3.24 ± 0.26, compared to F23 (1.9 ± 0.16) and F25 (2.1 ± 0.18), at p≤0.05); emotional alienation and flattening of affect (3.2 ± 0.25 and 2.26 ± 0.18, compared with F25 (1.65 ± 0.15 and 0.8 ± 0.1), at p≤0,05).

Negative symptoms in FPE 23 were slightly pronounced and represented by mild manifestations of social isolation (2.5 ± 0.21), emotional alienation (2.45 ± 0.23) and lack of spontaneity/fluency of speech (2.18 ± 0.18). Impaired thinking and its stereotypy were very weakly expressed or absent.

Negative symptoms in FPE(F25) were also mild, among which the most significant were social manifestations in the form of passive-apathetic social isolation (2.64 ± 0.2) and impoverished contact (2.1 ± 0.18).

In the structure of general psychopathological symptoms in FPE(F20) at a moderate level, signs of unnaturalness of the content of thinking (4.16 ± 0.33) were determined, which was significantly (p ≤ 0.05) higher than in F25 (2.75 ± 0.23); decreased criticality (4.1 ± 0.32) and anxiety (3.5 ± 0.27); hypochondriac ideas (3.2 ± 0.28), autisation (3.2 ± 0.27) and withdrawal from social contacts (3,27 ± 0,28) were at a low level of expression.

Among the general psychopathological manifestations of FPE(F23), the most pronounced at a level above moderate there were manifestations of anxiety (4.35 ± 0.35); moderate manifestations corresponded to manifestations in the form of reduced criticism (3.75 ± 0.29) and at a weak level there were manifestations of disorientation (3.26 ± 0.25), unnatural content of thinking (3.24 ± 0.23) and physical stress (3.0 ± 0.26).

In the structure of the general psychopathological symptoms of FPE(F25), depressive manifestations dominated at the level of above moderate severity (3.75±0.27), which were significantly higher than in F20 (2.4±0.18) and F23 (2.62±0.2), at p≤0.05, as well as anxiety disorders (3.76±0.29), physical tension (3.6±0.3) and impulsivity (3.4±0.23).

The analysis of psychopathological symptoms by individual clusters revealed a significantly higher level of anxiety in patients with FPE(F20) (10.68 ± 1.32) points, compared with FPE(F25) (6.86 ± 0.79) points, at p ≤ 0.01, in patients with F23 this figure was 9.56 ± 1.14 points.

The analysis of negative symptoms by the Scale for the Assessment of Negative Symptoms (SANS) revealed significantly higher level of severity in patients with FPE(F20) (52.8 ± 3.67) points compared withFPE(F23) (36.7 ± 2.54) points, at $p \leq 0.01$. In FPE(F25), the level of severity of negative symptoms was intermediate compared to other study groups and amounted to 42.5 ± 4.13 points.

In the structure of negative symptoms of F20, the prevalence of apato-abulic disorders was observed ((59.00 ± 4.82) % of the total possible number of points on the scale).Among them, the most pronounced and presented at an above-average level were such signs as: decreased productivity at work (3.6 ± 0.52) points and decreased physical energy potential (3.4 ± 0.43) points, which were also confirmed by a high global subjective assessment by the doctor of apato-abulic disorders in patients of this group (3.2 ± 0.38) points. Also, in the structure of negative symptoms of patients in this group, a significant representation of symptoms of flattening and rigidity of affect ((42.00 ± 4.36)% of the total possible number of points on the scale) was determined, among which the most expressive and presented at a level closer to the average degree of manifestations severity there were signs of avoidance of eye contact (2.8 ± 0.37) points and at an average level of severity there was a subjective assessment of the emotions loss feeling (2.4 ± 0.37) points. In addition, there were symptoms of anhedonia-asociality ((41.2 ± 4.81) % of the total possible number of points on the scale), primarily manifestations of autistic behaviour (tendencies to solitude, narrowing of the circle of contacts) (2.6 ± 0.35 points) and decrease in leisure time activity (2.5 ± 0.41 points), which were presented at a noticeable level.

In FPE(F23), the structure of negative symptoms was dominated by manifestations of attention disorders (45.3 ± 5.12 % of the total possible number of points on the scale), which were manifested by symptoms of inattention in contact (2.3 ± 0.34 points) and during testing (2.2 ± 0.3 points), which were presented at a noticeable level. The overall subjective score for this subscale also confirmed the results described above (2.3 ± 0.38 points).

In the structure of negative symptoms of patients with FPE(F25), the prevalence of apato-abulic manifestations (45.5 ± 4.92 % of the total possible number of points on the scale) and symptoms of anhedonia-asociality (44.8 ± 4.21%) was determined. Among the apato-abulic manifestations at a level closer to the average severity there were determined a decrease in productivity in work and study (2.7 ± 0.36 points) and a decrease in physical energy potential (2.5 ± 0.32 points), which was also confirmed by the overall subjective assessment of the indicated subscale (2.5 ± 0.28 points). Symptoms of anhedonia-asociality in patients of this group included, first of all, a decrease in interests and activity in leisure time

(2.7 ± 0.39 points) and sexual activity (2.5 ± 0.34 points), these symptoms were noticeably pronounced.

Statistical comparison of groups of patients with FPE allowed us to determine that in patients with F20 in the structure of negative symptoms there was a greater severity of apato-abulic disorders (59.00 ± 4.82) % and flattening/rigidity of affect (42.00 ± 4.36) %, compared to F23 ((32.00 ± 3.21) %, $p \leq 0.001$, and (25.3 ± 2.93) %, $p \leq 0.01$, respectively). In the structure of apato-abulic syndrome in FPE(F20), a decrease in productivity in work and study (3.6 ± 0.52) points was significantly more pronounced, compared to F23 and F25 (2.1 ± 0.32, at $p \leq 0.01$ and 2.7 ± 0.36, at $p \leq 0.05$) and a decrease in physical energy potential (3.4 ± 0.43) points, compared with F23 (1.8 ± 0.26) points, at $p \leq 0.01$. The overall level of subjective assessment of apato-abulic manifestations in patients of this group was also significantly higher compared with F23 (3.2 ± 0.38 and 1.6 ± 0.24) points, respectively, at $p \leq 0.01$. Among the manifestations of flattening/rigidity of affect in FPE(F20), the following were significantly more pronounced: avoidance of eye contact (2.8 ± 0.37) points, compared to F23 and F25 (1.8 ± 0.26 and 1.5 ± 0.21, respectively, at $p \leq 0.05$ and $p \leq 0.01$); higher level of inadequacy of affect compared with F25 ((2.3 ± 0.34 and 1.3 ± 0.21) points, respectively, $p \leq 0.05$) and more higher level of monotony/reduced expressiveness of speech (1.9 ± 0.27) points and more pronounced impoverishment of motor expressiveness (1.6 ± 0.22) points compared with F23 (1.8 ± 0.26) points, at $p \leq 0.01$. The overall level of subjective assessment of apatho-abulic manifestations in patients of this group was also significantly higher compared to FPE(F23) (3.2 ± 0.38 and 1.6 ± 0.24) points, respectively, at $p \leq 0.01$.Among the manifestations of flattening/rigidity of affect in FPE(F20), the following were significantly more pronounced: avoidance of eye contact (2.8 ± 0.37) points, compared with F23 and F25 (1.8 ± 0.26 and 1.5 ± 0.21, respectively, at $p \leq 0.05$ and $p \leq 0.01$); more higher level of inadequacy of affect compared to F25 ((2.3 ± 0.34 and 1.3 ± 0.21) points, respectively, $p \leq 0.05$) and more higher level of monotony/reduced expressiveness of speech (1.9 ± 0.27) points and more pronounced impoverishment of motor expressiveness (1.6 ± 0.22) points compared to F23 (0.7 ± 0.14 and 0.5 ± 0.12 points, respectively, $p \leq 0.05$).The level of subjective assessment of the severity of disorders in the form of flattening/rigidity of affect in patients with F20 was also significantly more pronounced (2.4 ± 0.37) points, compared to F23 and F25 (1.2 ± 0.19 and 1.4 ± 0.26, respectively, at $p \leq 0.05$).In the structure of antisocial manifestations of patients with F20, a significantly higher level of severity of autistic tendencies (2.6 ± 0.35) points was determined, compared to F23 (1,3 ± 0,21), $p \leq 0,05$.

In patients with FPE(F23), attention disorders in social activity were statistically significantly more pronounced (45.3 ± 5.12) %, compared to F20 and F25 (14.7 ± 2.37 and 26.7 ± 3.28, respectively, at $p \leq 0.0001$ and $p \leq 0.01$), in particular, such manifestations as "inattention in social contact" (2.3 ± 0, 34 points) and "inattentiveness in communication during testing" (2.2 ± 0.3 points), compared to F25 (1.4 ± 0.23 and 1.3 ± 0.25 points, at $p \leq 0.05$), which coincided with the results of the assessment of the subjective perception of attention loss, which in patients with F23 were assessed as more pronounced (2.3 ± 0.38 points), compared to patients with F25 (1.3 ± 0.19), $p \leq 0.05$. There was also a higher level of speech disorders in the form of "thought breaks" (1.6 ± 0.22) points, compared to F25 (0.7 ± 0.15) points, $p \leq 0.05$.

At FPE(F25), a significantly more pronounced decrease in sexual interest (2.5 ± 0.33) points was determined, compared to F20 and F23 (1.6 ± 0.26 and 1.3 ± 0.21 points, respectively), $p \leq 0{,}05$ and $p \leq 0{,}01$).

A detailed analysis of productive symptoms according to the Brief Psychiatric Rating Scale (BPRS) did not reveal any differences in the overall level of severity of productive symptoms between the study groups. However, depending on the study group, certain specifics in the structure of positive symptoms were identified. Thus, in the structure of positive symptoms in FPE(F20), the prevalence of thinking disorders (11.4 ± 1.36) points, anxiety-depressive manifestations (11.3 ± 1.25) points and apathy/inhibition (10.3 ± 1.16) points was determined. Among the individual symptoms in patients of this group, the most pronounced above average there were hallucinations (3.8 ± 0.46), emotional immersion (3.8 ± 0.51), anxiety (3.7 ± 0.44), suspicion/paranoia (3.7 ± 0.58), affective flattening/dullness (3.6 ± 0.39) and pretentious thinking (3.5 ± 0.47).

The structural features of positive symptoms in FPE(F23) were the prevalence of anxiety-depressive manifestations (12.2 ± 1.45), agitation/tension (11.2 ± 1.36) and thinking disorders (11.00 ± 1.28). Among the individual symptoms, the most pronounced and presented at an above-average level were: anxiety (4.7 ± 0.57) points, tension (4.3 ± 0.49) points, suspicion/paranoia (4.2 ± 0.53) points, agitation (3.7 ± 0.42) points and hallucinations (3.6 ± 0.51) points.

In patients with F25, the most pronounced positive manifestations were anxiety-depressive (13.7 ± 1.52), in particular, the most pronounced and presented at a high level were symptoms of depression (4.4 ± 0.51), anxiety (4.2 ± 0.48) and tension (3.7 ± 0.42). Also, symptoms of agitation (3.4 ± 0.46), suspicion/paranoia (3.4 ± 0.39), emotional withdrawal (3.2 ± 0.41), and hallucinations (3.1 ± 0.33) were presented at a higher than average level.

According to the statistical comparison of the study groups with each other, it was found that in FPE(F20) the level of severity of apathetic manifestations was significantly higher (10.3 ± 1.16) points compared with F23 (7.7 ± 0.96) points, $p \leq 0.05$. In terms of individual symptoms, patients with F20 had a significantly more pronounced level of emotional self-absorption (3.8 ± 0.51) and a higher level of affective flattening/dulling of affect (3.6 ± 0.39) compared to F23 (2.6 ± 0.37 and 2.3 ± 0.32), $p \leq 0{,}05$.

Patients with FPE(F23) were characterized by a significantly more pronounced overall level of manifestations of arousal/tension (11.2 ± 1.36), compared to F20 and F25 (8.8 ± 1.1 and 9.00 ± 1.32) points, respectively, $p \leq 0.05$, and in particular the level of tension as a separate symptom (4.3 ± 0.49), compared with F20 (3.2 ± 0.38), $p \leq 0.05$.

Also, patients with F20 and F23 determined a higher level of thinking disorders (11.4 ± 1.36 and 11 ± 1.25) points, compared with F25 (8.5 ± 1.17) points, $p \leq 0.01$.

Patients with FPE(F25) had a significantly higher level of anxiety and depression (13.7 ± 1.52) compared to F20 (11.3 ± 1.25), $p \leq 0.05$, including depression (4.4 ± 0.51), which was significantly higher compared to F20 and F23 (2.8 ± 0.39 and 3.1 ± 0.42), $p \leq 0{,}05$.

The dynamics of the condition of patients with FPE was studied in the short and long term. In the short term, the overall degree of improvement according to the CGI-I scale and reduction of psychopathological symptoms according to the PANSS scale were assessed based on the results of inpatient treatment. Indicators of the dynamics of the patients' condition in the long-term aspect included the calculation of the average duration of remission after the first hospitalization and the number of exacerbation episodes within 2 years after the initial hospitalization (based on the results of the cathamnestic analysis of medical records). It was found that the greatest positive dynamics in recovery of patients with FPE due to reduction of psychopathological symptoms as a result of inpatient treatment was determined in FPE with F23 (37.45±1.39) and F25 (34.65±1.27), which was significantly ($p \leq 0.05$) higher than in FPE(F20) (26.2±1.13) (Table 1).

The CGI-I scale also showed more pronounced improvement in patients with FPE(F25) (1.46±0.11) and F23 (1.53±0.12), in patients with F20 the improvement rate was slightly lower and amounted to 1.8±0.15 points. The longest duration of remission in FPE was determined in patients with F25 (10.5±0.94 months) and F23 (9.7±0.82), while in the group of patients with F20 the duration of remission after the first hospitalization was significantly shorter and amounted to 7.23±0.68 months, at $p \leq 0.05$ compared with F25. In terms of the number of exacerbation episodes during the first two years after the first hospitalization, the highest rates were determined in patients with F20 (2.8±0.33), the lowest in patients with F23

(1.6±0.18), at p≤0.05 when comparing F20 and F23, in F25 the average number of episodes was 2.3±0.21. At the same time, in patients with F23, in some cases, with existing episodes of exacerbation, in the absence of a noticeable reduction in symptoms, the diagnosis of schizophrenia was transformed (in 34.38±2.93 % of cases).

Table 1. Indicators of the dynamics of the state in case of FPE according to the results of inpatient treatment and data of cathamnestic analysis

Index	F20 (n = 53) M ± m	F23 (n = 96) M ± m	F25 (n = 28) M ± m
Overall level of reduction of psychopathological symptoms (*PANSS, points*)[1,2]	26,2±1, 13	37,45±1,39	34,65±1,27
Overall degree of improvement (*CGI-I, points*)	1,8±0,15	1,53±0,12	1,46±0,11
Average duration of remission after the first hospitalization (*in months*)[1,2]	7,23±0,68	9,7±0,82	10,5±0,94
Number of exacerbation episodes during 2 years (*abs. value*)[1]	2,8±0,33	1,6±0,18	2,3±0,21
Conventional notation: - data are presented in the format: arithmetic mean ± error of the arithmetic mean (M ± m) - statistically significant differences (p < 0.05): [1] - between groups F20 and F23; [2] - between groups F20 and F25; [3] - between groups F23 and F25			

Thus, according to the study, it was determined that the clinical and psychopathological characteristics of FPE include the presence of dominant positive symptoms (delusions and hallucinations) of high and moderate severity, which in **FPE (F20)** was combined with moderate negative symptoms in the form of apato-abulic syndrome, manifestations of flattening and rigidity of affect, autistic tendencies, passive-apathetic social detachment and impoverishment of contact; in**FPE(F23)**- with high and moderate level of excitement and anxiety, reduced criticism, disorganization, unnatural content of thinking, physical tension of moderate severity and negative symptoms of low severity, in form of symptoms of inattention in social contacts, social isolation, emotional alienation and lack of spontaneity of speech; in **FPE (F25)** - with pronounced manifestations of agitation, depression, anxiety, physical

tension and impulsivity, as well as negative symptoms of medium severity in the form of apato-abulic manifestations and anhedonia - antisociality.

The analysis of the indicators of the dynamics of patients' state with FPE indicates an unfavourable both short-term and long-term prognosis of recovery at F20. The prognosis of recovery at F23 and F25 is more favourable.

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