Herasymuk V. A. Psychoemotional sphere of spouces whose husbands have schizophrenia of different terms. Journal of Education, Health and Sport. 2017;7(1):865-873. eISSN 2391-8306. DOI http://dx.doi.org/10.5281/zenodo.3732476
http://ojs.ukw.edu.pl/index.php/johs/article/view/7723

The journal has had 7 points in Ministry of Science and Higher Education parametric evaluation. Part B item 1223 (26.01.2017).
1223 Journal of Education, Health and Sport eISSN 2391-8306 7
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The authors declare that there is no conflict of interests regarding the publication of this paper.
Received: 27.03.2017. Revised 28.03.2017. Accepted: 27.01.2017.

PSYCHOEMOTIONAL SPHERE OF SPOUCES WHOSE HUSBANDS HAVE SCHIZOPHRENIA OF DIFFERENT TERMS

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Abstract

The objective: to study the state of the psycho-emotional sphere in the spouses of paranoid schizophrenia (PS) husbands with different duration of the disease.

Object of the research: 120 women with mentally insane husbands and 50 spouses of men without metal and behavioral disorders have been examined. The examination was performed on the basis of Communal Health Protection Institution "O. I. Yushchenko Vinnitsa Regional Psychoneurological Hospital”. The comprehensive examination included clinical, psychological, psychodiagnostic and statistical methods. **Results.** The study found that in almost all spouses of PS men, regardless of the duration of the disease, there is an increased level of neuroticism, which is an unfavorable factor and evidences of pathopersonic transformations attributable to this contingent. For the vast majority of the women under examination, regardless of the duration of their husbands’ disease, a violation of the psycho-emotional sphere in the form of affective anxiety-depressive manifestations are typical, unlike the wives of mentally healthy men. In the structure of depressive response in wives of men with any duration of PS, the ratio of affective-cognitive and somatic symptoms is close, unlike the symptoms of the anxiety circle, in the structure of which the manifestations of "psychic" radical significantly outweigh the somatic symptoms. Intensity and polymorphy of affective anxiety-depressive symptoms and signs in spouses of PS men is directly associated with the duration of the disease, i. e., with increasing

duration of illness in men, there is an increase in psychopathological manifestations of their wives. **Conclusion.** The data obtained should be taken into account in the development of personalized measures of psychocorrection and psychoprophylaxis of disorders of psycho-emotional sphere in the spouses of PS men.

Key words: spouse of mentally ill man; paranoid schizophrenia; psycho-emotional sphere; depression; anxiety.

Introduction. The presence of paranoid schizophrenia (PS) patient in a family is an extremely powerful chronic psycho-emotional stress [1]. The experts point out that the process of family disintegration affects not only schizophrenia patient, but also his relatives, who suffer from emotional deprivation and conflict, frustration, resulting in affective instability with severe negative emotions of disappointment and rage. Fear and embarrassment caused by manifestations of mental illness of a close relative, uncertainty about the prospects of the disease, lack of social support, stigma affect not only the patient's phren, but also his whole microsocial environment, which is subjected to considerable stress and psycho-emotional load [8, 9]. There is a view that the relatives of the patient are "independent patients" who are experiencing serious mental trauma [10].

The objective: to study the state of the psycho-emotional sphere in the spouses of PS men with different disease duration. On the basis of " O. I. Yushchenko Vinnytsia Regional Psychoneurological Hospital" (Ukraine) 120 women whose husbands had PS have been examined. The persons under examination aged from 22 to 55 y. o., with mean age 38 years. Among them, 46.0% of women had a tertiary education, 6.4% had incomplete higher education, 39.4% had vocational secondary education and 8.3% of women had secondary education. Inclusion criteria were the husband's "Schizophrenia, paranoid form" (F20.0 according to the ICD-10 research criteria) and living in the same flat with a diseased person. Women's mental or chronic disabling somatic illnesses were exclusion criteria. In 65.8% of women their husbands' duration of the illness was between one and eight years, these women made up the index group (IG I), in 34.2% - from eight to fifteen years, they made up the index group 2, IG 2). Such a distribution of the persons over the duration of the disease was due to the peculiarities of its course, which according to I. Ya. Gurovich et al. [11], affect the family's homeostasis condition.

Comparison group consisted of 50 women aged 21 - 56 y. o. (mean age 36 years), representative with the index group by basic socio-demographic characteristics, and whose

husbands had no clinically pronounced mental and behavioral disorders.

The complete physical examination included clinical, psychological, psychodiagnostic and statistical methods of investigation. "The Neuroticization and Psychopathization Questionnaire" [12] and "Clinical Rating Scales of Anxiety (HARS) and Depression (HDRS)" by M. Hamilton [13] were used as a psychodiagnostic tool. The statistical method was used to assess differences between groups and relationships between factors.

Results and Their Discussion. When analyzing the distribution of neuroticism signs among the persons under examination, the following results were obtained (Table 1).

Table 1

Distribution of the women under examination by the level of neuroticism, %

Levels of Neuroticism	Test groups			P		
	IG I, n=79	IG 2, n=41	CG, n=50	IG I/IG 2	IG I/CG	IG 2/CG
Low	3.8	2.42	20.0	>0.05	<0.05	<0.05
Decreased	7.6	4.9	20.0	>0.05	<0.05	<0.05
Indefinite	12.7	7.3	34.0	>0.05	<0.05	<0.05
Increased	39.2	14.6	22.0	>0.05	<0.05	<0.05
High	31.6	36.6	4.0	>0.05	<0.05	<0.05
Very high	5.1	34.1	-	<0.05	<0.05	<0.05

Note: p is the level of statistical significance of differences between groups

The data presented in Table 1 suggest that the prevalence of low and moderate levels of neuroticism in IG I and IG 2 was approximately the same, with no significant differences between groups ($p > 0.05$), unlike CG ($p < 0.05$). Thus, a low level of neuroticism was found in 3.8% of IG 1 and 2.4% of IG 2 persons and 20.0% persons of CG. This testified that theses examined had emotional stability, ability to adapt effectively and use constructive behavior.

Decreased level of neuroticism was detected in 7.6% of IG 1 persons, 4.9% of IG 2 and 20.0% of CG examined (differences between IG I and IG 2 were not statistically significant, and between these groups and CG they were significant at $p < 0.05$). These individuals were characterized mainly by a positive attitude, ability to adapt, willingness to actively resist problems and stress.

An indefinite, undetectable level of neuroticism was diagnosed in 12.7% of IG I, 7.3% of IG 2, and 34.0% of CG subjects (differences between all groups were significant, $p < 0.05$). The undetectable (borderline) level of neuroticism testified to the instability of protective psychological mechanisms, absence of responses clear pattern to psycho-traumatic situations, variability of adaptive mechanisms and reactions.

In our opinion, the relatively low prevalence among women of the index groups of low and moderate levels of neuroticism, became an unfavorable factor, indicating a profound pathopersonological transformation in PS patients spouses, regardless of the duration of the disease.

The prevalence of increased levels of neuroticism among the index groups contingent turned out to be much higher. Thus, an increased level of neuroticism was detected in 39.2% of IG I, 14.6% of IG 2 and 22.2% of CG subjects (differences between all groups were significant, $p < 0.05$). Such individuals were characterized by increased emotional arousal, the presence of negative experiences of anxiety, fear, tension, confusion, irritability, impaired ability to work, impaired ability to concentrate and retain attention, as well as somatic vegetative symptoms.

High neuroticism was recorded in 31.6% of IG I, 36.6% of IG 2 and 4.0% of CG persons (differences between IG I and IG 2 were not statistically significant, and between these groups and CG they were significant at $p < 0.05$). This led to the presence of a pronounced emotional excitement in combination with rapid and deep exhaustion, clear signs of asthenisation, stably lowered mood, expressed anxiety, feeling of own inferiority, significant spread of obsessive thoughts and fears and somatovegetative disorders with formation of clinically designed variants of their course.

A very high level of neuroticism was found in 5.1% of IG I and 34.1% of IG 2 ($p < 0.05$) subjects. This goes to prove the phenomena of deep asthenisation, combined with excessive excitability and irritability, depressed mood, severe sleep disorders, somatovegetative disorders, significant decrease in performance capability.

The distribution of the persons under observation according to Hamilton Depression Survey (HDRS) is shown in Table. 2, from which resulted that the patients' spouses according to the objective criterion for assessing the severity of depressive syndrome were significantly different. Thus, psychopathological symptoms, which in terms of severity did not reach clinically defined depression, were found in IG 1 in 39.2%, in IG 2 in 14.6%, and in CG in 92.0% ($p < 0.05$) of cases. Minor depressive episode was diagnosed in IG 1 in 53.2%, in IG 2 in 63.4%, and in CG in 8.0% ($p < 0.05$) of cases. Severe depressive episode was diagnosed in IG I in 7.6%, in IG 2 in 22.0% ($p < 0.05$) of the persons. No severe depressive episode was found in CG ($p < 0.05$).

The average score according to HDRS scale (Fig. 1) in IG I was: no depression - 4.0 points, small depressive episode - 10.0 points, severe depressive episode - 21.0 points, in IG 2, respectively, 6.0 points, 15.0 points, 35.0 points; in CG, respectively, the absence of depression - 2.0 points, small depressive episode - 7.0 points (differences between all groups were significant, p

<0.05).

Table 2

Distribution of the persons under examination by depression level according to Hamilton Scale (HDRS)

Presence / Depression level, point	Test groups			P		
	IG I, n=79	IG 2, n=41	CG, n=50	IG I/IG 2	IG I/CG	IG 2/CG
None (0 -7)	39.2	14.6	92.0	<0.05	<0.05	<0.05
Minor depressive episode (7-16)	53.2	63.4	8.0	<0.05	<0.05	<0.05
Severe depressive episode (16-52)	7.6	22.0	-	<0.05	<0.05	<0.05

Consequently, both the prevalence and severity of depressive manifestations in IG 2 were higher than in IG I, which, in turn, were higher than in CG.

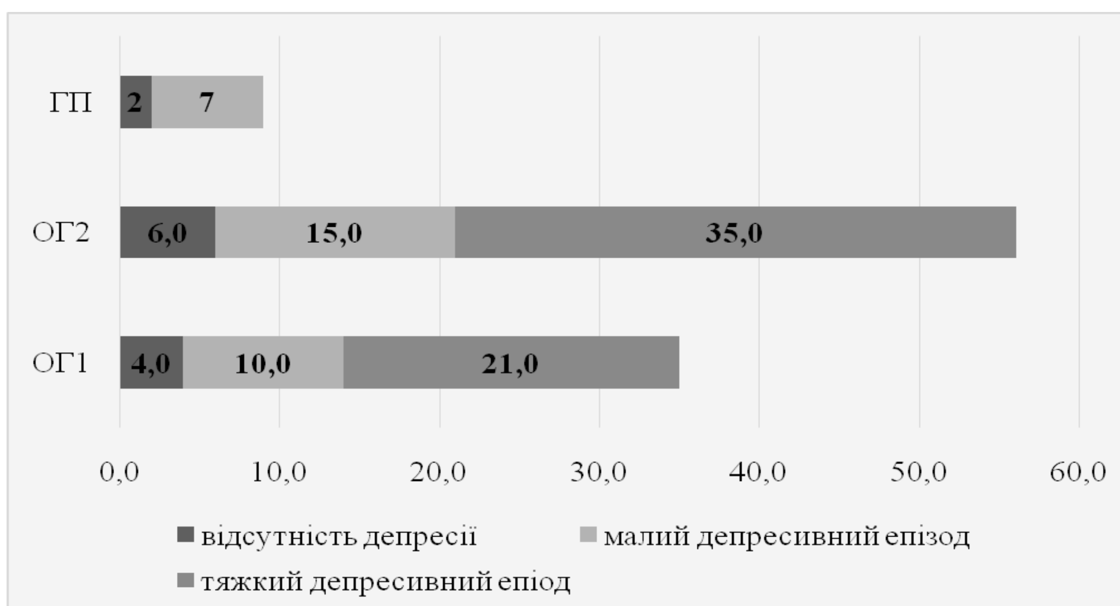

Fig. 1. The severity of depressive manifestations according to HDRS level of depressions, mean point

In general, in IG I and IG 2 the whole spectrum of depressive disorders was recorded, namely: low mood, feelings of guilt, difficulties in falling asleep, insomnia, early awakening, retardment of thinking, excitement, mental and somatic anxiety, somatic disorders of the

gastrointestinal tract, general medical symptoms, sexuality disorders, hypochondrial, obsessive and compulsive disorders (p <0.05). In CG there also were some depressive symptoms, such as: low mood, feelings of guilt, difficulties in falling asleep, insomnia, early awakening, retardmnet of thinking, restlessness, mental and somatic anxiety, gastrointestinal disorders, general somatic symptoms, but they did not reach the syndrome level (p < 0.05).

As a result of anxiety level study according to HARS (Table 3), it was found that the severity of anxiety symptoms was significantly different among the women under examination.

Table 3

Distribution of the persons under examination by the level of anxiety according to Halimton scale (HARS), %

Clinical level of anxiety intensity, points	Test groups			P		
	IG I, n=79	IG 2, n=41	CG, n=50	IG I/IG 2	IG I/CG	IG 2/CG
Subclinical anxiety (<8)	41.8	12.2	90.0	<0.05	<0.05	<0.05
Anxiety condition (8-20)	51.9	73.2	10.0	<0.05	<0.05	<0.05
Anxiety disorder (20-56)	6.3	14.6	-	<0.05	<0.05	<0.05

Thus, psychopathological symptoms of subclinical severity were revealed in 41.8% of IG I subjects, in 12.2% in IG 2 subjects and 90. 0% of CG (p <0,05) subjects. Anxiety condition was diagnosed in 51.9% in IG I, in 73.2% of cases in IG 2 and in 10.0% of cases in CG (p <0.05). Anxiety disorder was diagnosed in 6.3% of IG I subjects and 14.6% of IG 2 subjects (p <0.05). In CG subjects none anxiety disorders were detected (p <0.05).

The mean point by HARS scale (Fig. 2) in IG I was: subclinical anxiety - 4.0 points, anxiety state - 13.0 points, anxiety disorder - 29.0 points; in IG 2 - 7.0 points, 16.0 points, 41.0 points, respectively; in CG - 3.0 points, 9.0 points, respectively (differences between all groups were significant, p <0.05). Thus, the prevalence and intensity of anxiety symptoms were higher in IG 2, compared to IG I, which indexes were significantly higher than in CG. In most IG I and IG 2 women anxiety condition was moderately symptomatic (p <0.05), and anxiety disorder had a severe intensity (p <0.05). In addition, it was found that about half of the index groups women had a tendency to "conceal" the anxiety symptoms, which was revealed during the objective assessment (p <0.05).

In general, in the index groups women among the leading symptoms of the anxiety circle prevaled anxiety, tension, insomnia, depressive mood, somatic muscle, somatic sensory, cardiovascular, respiratory, gastrointestinal, urinosexual and vegetative symptoms ($p < 0.05$). In terms of severity, the symptoms of "psychic" radical significantly outweighed the symptoms of "somatic" one ($p < 0.05$).

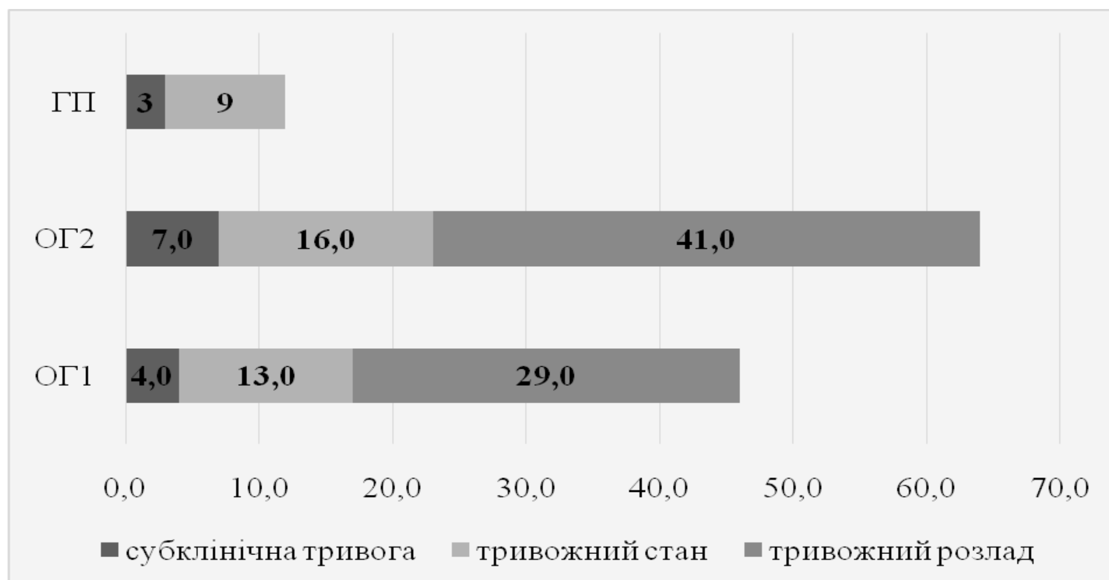

Fig. 2. The severity of anxiety symptoms according to HARS in the persons under examination, mean point

Conclusions. Almost all the spouses of PS husbands, regardless of the duration of the disease, demostarte an increased level of neuroticism, which is an unfavorable factor and evidence of patho-personal transformations inherent in this contingent.

For the vast majority of the spouses with PS husbands, regardless of the duration of the disease, there is a violation of the psycho-emotional sphere in the form of affective anxiety-depressive manifestations, unlike the wives of mentally healthy men.

In the structure of depressive response in the spouses of PS men with any duration of the disease, the ratio of affective-cognitive and somatic symptoms is close, unlike the symptoms of the anxiety circle, in the structure of which manifestations of "psychic" radical significantly outweigh the somatic symptoms.

The severity and polymorphism of the affective depressive-anxiety symptomatology in the spouses of PS husbands is directly associated with the duration of the disease, that is, the longer

lasts a husnad's illness, the more aggravated are his wife psychopathological manifestations.

The data obtained should be taken into account when develop personalized measures of psychocorrection and psychoprophylaxis of psycho-emotional sphere disorders in the spouses of men suffering from PS.

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