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COMPLEX PSYCHOTHERAPEUTIC AND PSYCHO- SOCIAL ASSISTANCE FOR SCHIZOPHRENIA PATIENTS

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Abstract

Schizophrenia is a global health burden with a high economic cost to health systems and an independent risk factor for decreased quality of life. **The objective:** to develop comprehensive measures of psychotherapy and psychosocial rehabilitation taking into account the gender characteristics of paranoid schizophrenia patients, and evaluate their effectiveness. **Methods:** analysis of theoretical heritage, socio-demographic, clinical and psychopathological. **Results:** The system of psychotherapeutic interventions included individual and group work. At the outpatient stage a program directed to restore adaptive skills: household, social, communication was used. In the process of social skills training the principles of social learning were used. At the stage of active therapy normalization of behavior, elimination of psychomotor arousal, reduction of psychotic symptoms severity; partial resumption of criticism was the ultimate aim. At the stage of stabilizing antipsychotic therapy - reverse development of residual productive symptoms and reduction of negative, affective and cognitive symptoms, increasing of social adaptation; at the stage of supportive (preventive) antipsychotic therapy - maintaining the optimal level of social functioning of the patient. **Conclusion:** The use of complex measures of psychotherapy and psychosocial rehabilitation developed allowed to level psychotic manifestations and form a stable remission, reduce maladaptive manifestations in psycho-emotional and cognitive spheres, improve social functioning of a patient and his family.

Key words: psycho-social assistance; social-psychological rehabilitation; paranoid form of schizophrenia.

There are about half a billion people in the world who suffer from various mental illnesses [1]. The vast majority of them are patients with schizophrenia, which in the structure of all mental pathology remains the most socially significant disease [2]. Despite the introduction of new psychotropic drugs in the treatment of schizophrenia, about 30% of patients remain resistant to therapy, which often leads to their disability [1, 3]. The problem of schizophrenia course and treatment is not yet completely studied, besides, the gender aspect, which plays a significant role in the specifics of most pathological conditions, remains outside the research.

Paranoid form of schizophrenia is the most common and complex by its clinical picture and features of the course [4].

With the emergence of social psychiatry, one of the main tasks of which was to improve the patient's relationship with his social environment, interest of the patient's education and his family in psychiatry has increased and finally a desire to teach the patient social skills and contacts [5] has formed. Social psychiatry has expanded the boundaries of schizophrenia treatment, which have become more integrated into rehabilitation, directed the efforts of psychiatrists to combat the stigma of mental illness [6]. Significant progress in the treatment of schizophrenia has been made since the publication of research on environmental therapy and treatment of schizophrenia with the help of the therapeutic community [7]. These therapies improved the patient's contact with the environment, and gave him possibility to see himself from the outside. In addition, the patient began to understand that he is not alone in this world, that there are people who seek to help him and sympathize with him in his suffering [8].

The main task in the treatment of schizophrenia is the social functioning and restoration of the patient's quality of life [2, 6]. When assessing the effectiveness of therapy it is important to take into account the position of the doctor in the interaction doctor-patient-family. To-day there are two models of recovery: clinical which implies the absence of psychopathological symptoms for 5 years and the model of recovery from the standpoint of the consumer - the patient's adaptation to existing conditions in society, i. e. changing of his social roles [9].

The treatment is more efficient and faster in those patients whose relatives understand the need for active intervention in the process of social adaptation of patients [5]. Therefore,

the family becomes for him the most important, and sometimes the only source of support. To provide the patient with family support, medical persons should conduct psychosocial rehabilitation of schizophrenia patients together with relatives [8].

The objective: to develop comprehensive measures of psychotherapy and psychosocial rehabilitation taking into account the gender characteristics of paranoid schizophrenia patients, and evaluate their effectiveness.

Methods: analysis of theoretical heritage, socio-demographic, clinical and psychopathological.

Today "Clinical Protocol for medical care for patients with schizophrenia", approved by the Order of the Ministry of Health of Ukraine № 59 of 05.02.2007 is valid in Ukraine. In recent years, this protocol has not undergone significant changes, while science and practice gained additional experience in medical care for this category of patients [10]. According to the recommendations contained in the above Protocol, medical care for patients with schizophrenia should be provided, if possible, outpatient, except in cases of danger to the patient or his environment and the impossibility of creating appropriate conditions for outpatient treatment. Therefore, when patients were admitted to the specialized unit in an acute psychotic state, we tried as soon as possible to stop pathological psychotic symptoms dangerous for the patient and his environment, and return the patient to his usual living conditions.

Upon admission to the unit, we performed a standard set of measures, stipulated by the Protocol, which included: clinical history, clinical psychopathological and psychodiagnostic methods, as well as, if necessary, instrumental and laboratory examination and, if necessary, consultation with other specialists. The treatment program included, in addition to a purely biological (medical) method, also measures of psychological assistance, social reintegration and support.

It should be noted that the treatment protocol contains only general recommendations, without specifying the drugs, their dosage, duration of treatment, as well as without taking into account the gender and other characteristics of patients.

A set of therapeutic measures, which were aimed at the patients and their relatives, was carried out in both inpatient and further the outpatient stages. Before therapy started, as well as at the end of inpatient - outpatient stages, a clinical and psychodiagnostic study was conducted. The data obtained allowed to determine disharmonious biological, psychological and psychosocial characteristics of patients and evaluate the effectiveness of the therapeutic complex. Against the background of pharmacotherapy, at the inpatient stage, patients

underwent a course of cognitive-behavioral therapy (CBT), and mastered the technique of PET according to A. Ellis. At the same time, psychoeducational classes for patients and their relatives were held at the inpatient stage. Classes were held in the form of 5 lectures-presentations.

The stage of care after discharge from the hospital often goes unnoticed by specialists. It is very important and requires the organization of comprehensive care in the form of support for both patients and their relatives. Therefore, the fourth stage of the study, which coincided with the period after discharge, was the support of patients and their relatives. It included medical, psychological and psychosocial measures. At this stage patients received basic pharmacotherapy and underwent "Training of social skills and cognitive functions." Self-help groups and an Internet forum were organized for the patients' relatives at the outpatient stage. Both relatives and patients at the stage of support attended classes "Training of Communication Interaction". Within the framework of this program "Training of communicative interaction" participants of therapeutic groups were taught to use adaptive strategies of behavior, communication, conflict-free communication, as well as technologies of effective interaction in the family. Also at this stage, separate Internet portals were organized for patients and their relatives, thanks to which these categories of respondents were able to communicate with each other and ask questions to specialists. In order to psychosocial adaptation of the patients, an author's course "Training of social skills and cognitive functions for schizophrenia patients" was developed and conducted at the outpatient stage of care. The system of psychotherapeutic work, which was organized in the framework of this study, was comprehensive and included, in addition to measures aimed at the patients, also psychotherapeutic interventions for the patients' relatives.

At the inpatient stage, psychoeducational activities were conducted for the patients and their relatives. Work in this area is an integral component of modern comprehensive psychiatric care, one of the methods of psychosocial intervention. Psychoeducational programs were modular, carried out in closed groups, which worked under the guidance of specialists. Classes were held in the form of 5 lectures-presentations on the following topics: "Schizophrenia. The main manifestations. Positive and negative symptoms", "Features of socio-psychological maladaptation of a patient with paranoid form of schizophrenia", "Patient with schizophrenia in the family - features of interaction", "Basic principles of complex therapy for the patient", "Socialization and adaptation programs for patients". Each lecture lasted 90 minutes.

The basic module of psycho-educational work included providing the patient and his relatives with information about the disease and developing an adequate psychological attitude to it. The content of such a module in patients included: 1) providing information about the disease, its causes, effective treatment, prognosis; 2) description of symptoms and types of the disease; 3) identification of situations and circumstances that provoke deterioration; 4) explanation of the role of social support, communications, professional adaptation; 5) proof of information on drugs used in the treatment of the disease, their mechanisms of action, the main effects and side effects, the possibility of eliminating side effects; 6) explanation of the need for constant interaction with the doctor who observes the patient.

Psycho-educational programs helped patients and their relatives to learn more about the disease, its manifestations, dispel misconceptions about its prognosis, results, success of therapy, as well as to learn about the means used to treat the disease, wrong painful behavior and its consequences, the problems that arise in this case, and the means to overcome them. The lectures were interactive, after the lecture each of the patients and relatives had the opportunity to ask questions to any of the specialists. The discussion helped patients to understand their experiences, identify the initial manifestations of exacerbations and symptoms of the disease, the effects of drugs and their possible side effects, receive support for the right actions, become an informed participant in the therapeutic process. Successful psychoeducational work was a prerequisite for effective treatment of the patient, maintaining a high level of compliance and the possibility of full implementation of psychosocial programs.

Also at the outpatient stage psychotherapeutic work with patients was conducted. The main method of psychotherapy used in the process of providing comprehensive care to the patient was the approach of CBT, which is currently effective and used in the process of comprehensive care for patients around the world. Psychotherapy can reduce the severity of productive psychopathological symptoms and affective disorders of the depressive spectrum (anxiety, fear, feelings of hopelessness, etc.) and is more effective than other methods of psychotherapy. Also, psychotherapy improves the flexibility of the patient’s thinking, modifying his dysfunctional belief system, increases the level of his social and labor adaptation.

The objectives of cognitive therapy when working with schizophrenia patients were: stimulation of cognitive activity; identification of problems facing the patient, search for solutions; weakening the severity of positive symptoms (hallucinations and delusions);

activation of the patient, expanding the circle of his communication in order to combat negative symptoms; acquisition of depressive spectrum disorders (postpsychotic depression); reduction of some manifestations of cognitive deficits (improvement of concentration, memory, executive functions).

The patients under observation had specific gender features of disorders in the psycho-emotional sphere, and they were taken into account when develop psychotherapy programs. Thus, in working with men, the prevailing psychotherapeutic targets in the psycho-emotional sphere were a high level of anxiety and the presence of suicidal tendencies; women had a high level of depression and a subjective feeling of loneliness. The main principles we used in the process of organizing the therapy program were: focusing the patient's attention on relatively neutral experiences; limited use of frustrating therapy techniques, methods of confrontation; minimization of psychological interpretation of disease symptoms; distancing the patient from delusions and hallucinations through the use of special terms and visual aids that reflect the structural and functional changes of the brain in schizophrenia; formation of coping strategies aimed at reducing the symptoms of psychosis; control over the severity of symptoms; therapy session planning; research in the field of cognitive therapy. In the course of therapy we tried to change the cognitive sphere of a patient with schizophrenia through beliefs, attributions, logical actions, problem-oriented solutions.

In the early stages of cognitive therapy, we tried to determine the peculiarities of perception of reality by each of the patients. We found out how the patient evaluates his own condition, opinion about plans for the future, the peculiarities of self-perception.

There was gender specificity in maladaptive changes in the psychosocial sphere, and most often they concerned the roles distribution and functioning in the family. The targets of psychotherapeutic interventions in women were dissatisfaction with relationships with husbands, children, parents and the search for social support; in men it was the desire to dominate the family. During therapy it was important to ensure a number of conditions, namely, stable family requirements for the patient during treatment, attention to key cognitive operations, rehearsal, regulation of cognitive processes and consolidation of adaptive responses.

In psychotherapy, we took into account that emotional and cognitive stressors can provoke a recurrence of schizophrenia, so one of the tasks of psychotherapy was to deal with external situations that can exacerbate the disease, so during psychotherapy the patient was taught behavioral skills in difficult situations. To do this we used techniques for structuring

the situation, role-playing games aimed at forming "coping strategies". The structure of the classes also included elements of relaxation.

The system of psychotherapeutic interventions included individual and group work. For group psychotherapy (trainings) the patients were divided into groups on the basis of gender. During psychotherapy, importance was attached to the structuring of homework, recording of dysfunctional thoughts and irrational beliefs.

An important aspect of patient support at the outpatient stage was a program to restore adaptive skills: household, social, communication. This approach was aimed at increasing the resilience of patients vulnerable to stress (societal requirements, family conflicts), contributed to the development of instrumental skills (interaction with different institutions, household budgeting, housekeeping, shopping, leisure) and interpersonal skill. (conversations, friendly and family relationships). It was also envisaged to restore patients' social skills from simple, everyday, which provide an independent existence, to more complex socio-psychological formations (problem-solving behavior, ability to communicate, interact in society, use coping strategies), which determine social competence.

In the process of social skills training, well-known principles of social learning were used. They have proven to be effective when working with a contingent under study, among them: 1) instructing how to behave in one situation or another; 2) feedback, i.e. analysis and reinforcement of certain types of behavior; 3) modeling - reproduction of a behavior model either vivid (with the participation of a therapist) or symbolic (use of film or video); 4) role-playing; 5) social reinforcement - the use of praises when the desired behavior took place; 6) homework to practice the desired behavior.

At different stages for the ultimate aim of medical and psychosocial care we have chosen: at the stage of active therapy - normalization of behavior, elimination of psychomotor arousal; reduction of psychotic symptoms severity; partial resumption of criticism. At the stage of stabilizing antipsychotic therapy - reverse development of residual productive symptoms and reduction of negative, affective and cognitive symptoms, increasing of social adaptation; at the stage of supportive (preventive) antipsychotic therapy - maintaining the optimal level of social functioning of the patient.

Later on we conducted a comprehensive analysis of the provided therapeutic interventions effectiveness. At the stage of evaluating therapy effectiveness, clinical and psychological diagnostics and analysis of changes that occurred in the field of clinical manifestations of the disease, as well as in the individual psychological and psychosocial spheres were performed.

Quality criterion of treatment were: clinical - the degree of reduction of psychopathological symptoms for at least 6 months and mental stability for 6 months and socio-psychological - the degree of ability to autonomous social functioning.

Evaluation of the effectiveness of the implemented treatment and rehabilitation complex allowed to state significant positive changes in terms of clinical and psychopathological, individual psychological and psychosocial characteristics.

Conclusion: The use of complex measures of psychotherapy and psychosocial rehabilitation developed allowed to level psychotic manifestations and form a stable state of remission, reduce maladaptive manifestations in psycho-emotional and cognitive spheres, improve social functioning of a patient and his family.

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