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PSYCHIATRIC EDUCATION OF RELATIVES OF PATIENTS SUFFERING FROM SCHIZOPHRENIA AND SCHIZOPHRENIC SPECTRUM DISORDERS

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Abstract: Interest in the problem of psychoeducation was stimulated by the adoption in 1975 by the American Hospital Association The Declaration on the Rights of the Patient, which states that every patient, including persons with mental disorders, has the right to full information about their illness. Psychoeducation is considered as the realization of this fundamental right in the process of treatment and rehabilitation. It is assumed that such an understanding will help patients with schizophrenia to cope with the disease more effectively, and thereby improve the prognosis.

Key words: psychoeducation, schizophrenia, disorders, rehabilitation.

Introduction: The intensification of psychoeducational work with relatives of patients, since the 1980s, has become a reflection of significant changes in the work of mental health services [1-6]. At the same time, psychoeducation, like other psychosocial approaches in psychiatry, has long been not considered as an alternative to biological approaches, but is part of a single therapeutic and rehabilitation process, one of the types of therapeutic and rehabilitation intervention [7-11].

For decades on families with mentally ill people in their composition people, scientists, doctors and authorities paid little attention. However, at present, thanks to the reforms that are taking place in domestic psychiatry, many family problems have become the subject of study and discussion. A proven fact is the low quality of life in such families, increased stress compared to the general population. The burden of moral and material problems falls on the shoulders of relatives, they suffer from despair, anger, fear and shame [12-18].

When a serious mental illness invades a family, it changes the whole way of her life: the need to maintain a special regime, change plans for the future, redistribute responsibilities. According to experts, from 50 to 80% of mentally ill people with a chronic course of the disease live in families [19-26].

Considering the number of people suffering from chronic mental disorders, it becomes clear that a significant group of the population has experience of living with mentally ill people [27-32].

It was found that for many families with a mentally ill person, a specific style of behavior is characteristic, which manifests itself in persistent, persistent attempts to achieve the restoration of his "full health". These attempts are often accompanied by high expectations, excessive care, censure, constant criticism of the patient's behavior. This style of behavior is called expressed emotion. A.V. Semke and S. Sota pointed out its undoubted connection with the recurrence of psychosis [33-38].

For example, in a family where there is a patient with schizophrenia, specific behavior of parents is characteristic, expressed in control and overprotection on the part of the mother and passivity on the part of the father. Symbiotic relationships are formed with an unpredictable alternation of emotional closeness and distancing, conflicts between parents. At the same time, the effectiveness of family psychoeducation may depend not on the number of participants or the number of sessions, but on the time spent on one participant [39-46].

The social maladaptation of schizophrenia patients poses serious problems for their family members, who have to combine the functions of providing leisure without having specific knowledge and experience. Relatives have to take on leading roles in the lives of patients with schizophrenia. They live together in the same apartment, become friends, take part in treatment, employment. Such a burden often becomes so unbearable for family members that hospitalization in a psychiatric hospital becomes their only salvation. Relatives of a schizophrenic

patient always feel the need for support. They need information about the mental disorder of their sick family member, the opportunity to share their experiences and their experience of living together with the patient, to receive psychological support from such families, including in terms of sharing experiences. In turn, the patient should understand the situation and be able to make a positive contribution to the life of his family [47-52].

Conflicts in everyday life often turn out to be stressful, leading to emotional tension in such families.

The most frequent communicative deviations in the family of a schizophrenic patient include a frequent change of encouragement and blame, a change of emotional closeness and distancing, permeating the entire family climate of emptiness and meaninglessness. Some authors point to the presence in such cases of a "double bond" mechanism, in which the patient is constantly forced to choose between two equally acceptable alternatives with the simultaneous prohibition of discussing this problem. An unfavorable factor in the adaptation of patients with schizophrenia is stigmatization, which inhibits the treatment of patients and their relatives for psychiatric help [53-57].

Patients cannot find a job, their social isolation increases, a negative attitude towards themselves develops and this increases the likelihood of a relapse of the disease. The influence of social factors on the development and course of schizophrenia and bipolar disorder is indicated in a number of works [5, 6, 7].

It is known that up to 60% of all patients discharged from psychiatric hospitals return to their families, while the vast majority of them retain contact with their relatives. Thousands of families face mental disorders every year and are forced to solve the problems that arise [58].

As a rule, patients occupy a dependent position in the family, and relationships with relatives are often complex. Nevertheless, the family provides people with mental disorders with the maximum possible support, often masking their insolvency to a large extent. One way or another, most families find themselves involved in close communication with their sick relatives, support them and take an active part in their fate [59-63].

It is of great importance that, unlike neurotic disorders, schizophrenia disease entails chronic progressive social consequences for the patient, which are caused not only by his maladaptation in the most important areas of social life, but also by the specific attitude of others, which is expressed in the negative isolation of the patient in society (labeling) followed by stereotypical a set of social reactions to it, that is, stigmatization [64-66].

Despite the excessive negative reactions of society to patients, the origins of these reactions stem from very real circumstances – a mental disorder carries a potential danger to others and the patient himself, communication with a mentally ill person is often burdensome and fraught with unpleasant surprises for his closest relatives and acquaintances.

This "family burden" associated with contact or living with a schizophrenic patient leads to significant emotional stress, which, according to the feedback principle, negatively affects the patient himself [67].

In foreign literature, psychoeducation is presented as one of the most important approaches to training and psychosocial treatment of patients with mental pathology and is considered perhaps the most significant part of psychosocial intervention in the multifaceted system of psychosocial rehabilitation of patients with schizophrenia and their relatives [68].

The effectiveness of psychoeducational work has been shown in different populations of mentally ill, but special attention has been paid in recent years to the psychoeducation of patients with schizophrenia at various stages of the disease [67], and there are indications of the preference for the earliest possible inclusion of this type of intervention in the complex of treatment and rehabilitation measures already at the stage of therapeutic remission in patients who have undergone the first psychotic episode [69], as well as possibly earlier provision of psychoeducational programs to relatives of patients. In general, it is emphasized that psychoeducation is one of the

components of psychosocial rehabilitation that best corresponds to the general humanistic orientation of the partner model of psychiatric care.

Psychoeducational programs set themselves two main tasks, which are especially closely related to each other in mentally ill chronics.

This is actually "education", when a patient receives information about a mental illness, so that a correct understanding of his condition leads, if not to the management of his disease, its course and course, then at least to the timely recognition and control of individual painful manifestations and symptoms. The second task, which is not inferior in importance to the first, is to provide "psychosocial support", when a group for patients is a constant source of support and at the same time a therapeutic environment in which patients can develop adequate behavioral skills, communication, coping with difficult situations in protected, emotionally safe conditions. In addition, through participation in the group, communication needs are met [70].

This makes the problem of effective family and social rehabilitation more and more urgent. The family of a mentally ill person functions in a reality that changes depending on the dynamics of his mental state, changing at the same time his social and family status.

We conducted a study during which, using a specially designed questionnaire with questions addressed to the relatives of patients, their need for information and for mastering the experience of helping a loved one suffering from a mental disorder was clarified.

The purpose of the study: reducing the burden of the disease and improving the quality of life of relatives of patients;

preparation of relatives to perform the role of partners in the treatment of the patient, providing him with support;

development of family members' skills to effectively solve their own socio-psychological problems;

improving the quality of life of relatives of patients through the formation of an idea of the clarity of life, a sense of the possibility to influence their lives and a sense of the significance of life.

Materials and methods of research. In 2022, a psychiatric literacy school was organized at the hospital for relatives of patients suffering mainly from schizophrenia and schizophrenic spectrum disorders undergoing treatment both in general psychiatric "acute" departments and in departments of the first psychotic episode. We took the program [21] as a basis, in which we made some changes.

The model consists in an integrated approach that takes into account the needs of families (in information, psychotherapy, psychological counseling, the development of new social skills). The innovative differences introduced by ami into the program consist in combining some modules proposed by the authors into a single process without their step-by-step implementation. At the same time, the following structural elements were preserved: 1) psychoeducation of relatives of mentally ill; 2) skills training; 3) participation of relatives of patients in the work of a public organization.

This model of psychoeducational family work is not family therapy, but uses its means to support the family.

A combination of various world models of psychoeducational work with the family, cognitive therapy, narrative, dialogical and reflective models of work is used. The foundation is the experience of the family and its explanation. The demonstration of materials (slides) on the cycle of psychoeducation serves as a reinforcement of the acquired knowledge (and often gives an opportunity to begin to speak out and understand the family history from the moment of the illness of one of the family members).

The implementation of this model of psychoeducational family work is based on the sequential step-by-step implementation of three main components:

1. Dating stage (meeting and interviewing adult family members);

2. Planning stage (a meeting on planning work with the family, where a joint analysis of the interview takes place with determination of the amount of available information, competence of

family members, their resource and strengths; determination of personal goals of family members and their expectations). At this stage, it is determined what information and what kind of support the family needs;

3. The stage of direct psychoeducational work with targeted assistance and with the final interviewing of the family.

Logistical support includes an office for group and individual work, a slide projector and slides.

Methods of conducting groups.

The program is designed for relatives or loved ones involved in caring for a relative suffering from a mental disorder. Preference is given to the homogeneity of the group in nosology, but heterogeneous in social characteristics (gender, age, education, etc.), with different types of response to the occurrence of the disease in the family. The leaders of the groups should also be representatives of both sexes, which makes it possible to improve the interaction of participants.

Contraindications for participation in group classes are: the presence of a mental disorder in the parent himself or a severe somatic illness, categorical refusal to participate in the group, ill will towards the leaders or other group members, a high degree of kinship with a sick relative (twins, twins).

The number of participants in one group can vary from 7 to 15 people.

The program is designed for 12 classes, at the end of the cycle, all participants are given the necessary literature. The duration of one lesson is 2 hours, classes are held 1 time a week. The first three classes the group is "open", after the group is "closed". The main requirement for participants is strict attendance of classes, compliance with the rules of the group, which are accepted at the 4th lesson. Group classes are conducted by a psychiatrist.

The structure of each lesson includes: greeting, identification of participants' requests on the topic of the lesson; the main part in the form of a lecture; the final part, which summarizes the lesson and repeats what has been passed. Each lesson begins with "working out the feelings" of the group members, conducting training exercises. At the end of the lesson, homework is given, the results are summed up.

To assess the effectiveness of educational programs, a rating scale (original questionnaire) was used, including such indicators characterizing the patient's position in relation to mental illness as increased knowledge about the disease, changes in behavior, in relationships with others, in particular, in the family, following medical recommendations, expanding knowledge about measures in urgent circumstances related to with a sudden exacerbation of the condition, the patient's awareness of mental disorders.

The results of the study and their discussion. 202 relatives of patients suffering from schizophrenia and schizophrenic spectrum disorders took part in the survey.

The most active users of the educational cycle were women with higher education, aged 41 to 60 years, with a good social status (working, married and having a family of 3-4 people). 97% of respondents were parents of patients and lived together with them.

At the first lesson, a visual table of expectations and fears is created, which are formed by the group members themselves, at each subsequent lesson each participant can supplement their fears or expectations. When compiling a visual table of fears and expectations, all group participants put in the first place: lack of knowledge about methods of treating mental disorders; lack of knowledge about the causes of the disease; lack of knowledge about the prognosis and their own role in the treatment process; lack of knowledge about available services and forms of assistance in the presence of a mental disorder. There was also a lack of awareness about the methods of correcting side effects, about the symptoms of the disease.

During the study, all the patients' families agreed that there is an information deficit concerning many issues related to mental disorders and the need to fill it, as well as all noted that the "disease" had an impact on their own well-being and on the atmosphere within the family (100%). They indicated the appearance of low mood (8%), fright (8%), fear, including living in the same apartment (23%), anxiety (54%),

confusion (38%), fatigue (8%), tension (30%). Among the changes within the family, respondents indicated a "lack of peace and quiet" (8%), a decrease in tolerance (8%), an "increase in explosiveness" (15%), tension (38%), loss of communication (15%). Only 46% of respondents believed that family relations remained at the same level.

Conclusion. In addition, the study confirmed the well-known fact that families lack knowledge about the nature of mental illnesses, their treatment and modern medicines. The lack of sufficient information about the treatment of mental disorders was indicated by all the surveyed families (100%).

Individual and family psychological counseling is usually offered to relatives after attending classes as part of a special psychiatric literacy program. Psychological counseling is aimed at a more in-depth, in comparison with psychoeducational classes, consideration of the problems of specific families. The purpose of counseling is to help relatives in understanding problems, understanding the hidden causes of problems and conflicts, identifying ways to solve them. Skills trainings are recommended for relatives who live with a patient who has a relapse of the disease more often than once a year, who has numerous conflicts or shows physical violence, as well as single relatives who are engaged in caring for a seriously mentally ill. The purpose of such trainings is to harmonize relationships and emotional atmosphere in the family, increase stress tolerance.

During the final survey, family members indicated an increase in personal competence in the field of psychiatric literacy (100%), improvement of communication skills (100%), reduction of the burden of subjective anxiety (62.5%); "reconciled and accepted the illness of a loved one" (25%); "received the necessary help and knowledge how to live in new conditions" (12.5%); formed the idea of a mental disorder as a disease that must be treated (100%).

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