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CLINICAL AND PSYCHOLOGICAL ANALYSIS OF THE RISK OF SECOND ADMISSION OF PATIENTS WITH PSYCHOSES OF THE SCHIZOPHRENIA SPECTRUM TO A PSYCHIATRIC HOSPITAL

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Abstract: Despite significant progress in the development of psychopharmacotherapy and psychotherapy, as well as the active restructuring of the ideology of the organization of psychiatric services aimed at its institutionalization, the problem of rehospitalization in specialized hospitals remains relevant for both medical staff and practicing psychiatrists. According to research, the worst hospitalization statistics are found in patients with schizophrenia spectrum psychoses, with almost half of them being re-admitted to psychiatric hospitals in the same year, which is a serious problem today.
Key words: Schizophrenia, psychopharmacotherapy, psychotherapy, psychiatric hospital.

Introduction: Schizophrenic patients constitute a cluster of patients for whom inpatient psychiatric care is ineffective when they are frequently hospitalized [1-14]. The main "reference point" for each such patient is the period of initial hospitalization and first remission, which determines the attitude to mental disorders and drug therapy [15-25]. According to the materials of complex studies [26-31], less than 25% of patients undergoing outpatient treatment after discharge from the hospital understand the purpose of treatment and react positively to further relationships with the doctor [32-40]. About 25% of outpatients passively accept the need for care therapy, so their adherence to treatment largely depends on external factors (the influence of relatives, the activities of outpatients) [41-53]. More than 50% of patients completely stop care therapy within a month after discharge from a psychiatric hospital [54-62]. The identification of risk factors for re-hospitalization in a psychiatric hospital and the development of practical recommendations aimed at psychoprophilactic complex work with patients during remission not only significantly reduce the percentage of repeated hospitalization, but also increase the syndromic "cleanliness" of the remission period and at the same time the quality of life of patients [63-72].

The purpose of the study: Identifying the clinical and psychological factors of the first remission of schizophrenia spectrum disorders, they contribute to repeated hospitalization and improve the set of measures to prevent re-hospitalization of these patients in a psychiatric hospital.

Materials and methods. In the study, 41 patients between the ages of 18 and 90 were admitted to district-regional psychiatric units for the second time in their lives with schizophrenia spectrum disorders. Among the patients examined, men prevailed (85% and 15%, respectively). The criteria for joining the study included: 1) the admission of patients to a psychiatric hospital for the second time in their life; 2) the leading clinical picture depends on the violation of the Schizophrenia Spectrum; 3) the presence of contacts with relatives and outpatient doctors to objectify information about the course of the remission period. The examination of patients was carried out outside the acute stage of the disease during the period of preparing the patient for discharge from the hospital. When assessing the condition of patients, the diagnostic criteria ICD-10 are used. The general sample of patients consisted of three groups of patients: 1) patients

whose clinical picture of the disease corresponds to the description of the heading F20 "schizophrenia"; 2) patients whose mental state corresponds to the conditions described in the heading F21 "schizotypal disorder; 3) hospitalized status was determined by the high severity of psychotic experiences, and patients qualified under the descriptions of sections F25 and F23 ("acute and transient (transient) psychotic disorders" and "schizoaffective disorders"). In the overall sample, there were no patients with schizophrenia spectrum psychoses corresponding to other ICD-10 headings. Clinical-psychopathological, psychometric, experimental psychological and observational methods have been used as the main research methods. A modified PANSS questionnaire for relatives of patients for data objectification (SP Kay, L.A. Opler and A. According to fitzbain) the PANSS scale for assessing positive and non-positive syndromes has been used. For further analysis, 40 parameters were identified, divided into four groups (General Demographic, Social, Psychological and clinical). When assessing the dynamics of personality disorders, the conclusions of the experimental psychological study were taken into account. To objectify the Somato-neurological condition, we used the advice of specialists (neurologist, internist, endocrinologist, gynecologist), and, if necessary, data from instrumental studies (EEG, ECG, CT and MRI of the brain).

Statistical processing of the data obtained was carried out using the Statistica 8.0 software package for statistical analysis, the main method was multidimensional correlation analysis.

Research results and discussion. According to the ICD-10 criteria, 49% of patients examined belong to Group F20 ("schizophrenia"), 27% are patients admitted in acute condition with diagnoses in rubrics F23 and F25 ("acute polymorphic psychotic disorder" and "schizoaffective psychosis"), and 24% - F21 are "schizotypal disorder" title diseases. In the group of patients with schizophrenia, 95% of patients suffer from various forms of paranoid schizophrenia (F20.0), 5% - other forms of schizophrenia, including childhood schizophrenia. The main types of the course of the endogenous process in patients of the "F20" group: episodic with an increasing defect – 60%, continuous – 40%. In the group of patients with schizotypal disorder, patients with a diagnosis of "Psychopathic schizophrenia" F21.4 (70%) prevailed, 20% were patients with neurosis-like schizophrenia (F21.3), 10% - schizotypal personality disorder (F21.8). 14,9% of patients had concomitant alcohol or drug addiction, 8% of patients at the time of the second hospitalization were disabled group II for mental illness, 10% disabled group II for somatic disease. Before the disease, only 12,5% of patients seemed to have harmonious personalities and had no neurotic spectrum disorders, while the majority of patients in the F20 and F21 groups in premorbidity showed hystero-neurotic disorders and / or personal schizoidization. On average, patients with paranoid schizophrenia were first admitted to the hospital at 31,9 years old, patients in the schizotypal disorder group at 32,0 years old, and patients in the F23 and F25 group were subsequently placed under the supervision of Psychiatrists. Patients averaged 29,8 k/s on their first hospitalization, 32.2 K/s on their second hospitalization, and the duration of hospitalization with the F20 group diagnosis was 39,9 K/S and 36 k/s. , F21 groups – 17,2 and 23,1 k / d, groups F23 and F25 27 and 34,3 k / d.

The majority of patients in the overall sample (75,5%) received standard antipsychotic therapy during their first hospitalization, including different doses of haloperidol, chlorpromazine, and cyclodol. At the time of the first discharge, about 15% of patients were transferred to long-term drugs (mainly haloperidol-Decanoate injections).

After discharge from the hospital, more than 65% of patients in one way or another experienced a decrease in social and professional status (mainly due to divorces, disability due to residual psychopathology, side effects of psychotropic therapy in the hospital and negative symptoms that shape mental disorders. the basis of the clinical and psychopathological picture of remission). Despite the recommendations of doctors, less than 20% of patients continued to visit an outpatient psychiatrist after discharge, received care therapy, and the proportion of fully compatible patients was only 9%. The rest of the patients received therapy in irregular remission, tended to self-correct drug doses, preferred long-term therapy with antidepressants, rejected

antipsychotics. Patients with Paranoid schizophrenia have shown the highest adherence to therapy. In this group, about 60% of patients visited the doctor regularly and received therapy. The lowest concordance to nonconformity was observed in patients in Group F21, with only 15% of patients in this group being observed by a physician. The main reasons for incompatibility in the F20 group are negative signs of the underlying disease with a decrease in energy potential, in the F21 group - anosognosia and unwillingness to continue to be observed by a specialist associated with distrust of specialists. the main reasons for reducing adherence to therapy in the physician, F23 and F25 groups were somatic problems, side effects of psychopharmacotherapy.

According to objective data from the words of relatives of patients, as well as outpatient psychiatrists who observed patients after discharge from the hospital in IPA conditions, the "cleanliness" of remission significantly depended on two factors - the course of the underlying disease. and the degree of adherence to therapy. Thus, according to a survey of relatives using the adapted PANSS-n scale (maximum score - 49), the average score in the F20 group was 30,65, F21 – 22,8, F23 / 25 – 26,4. From the results obtained, it can be seen that in patients with schizotypal disorder, the "purity" of remission is significantly higher than in patients with the most severe forms of the disease.

However, a study of the dynamic aspect found that patients in the F20 group showed a stable condition during remission with immediate deterioration until the day of the second hospitalization. Patients in this group returned to their usual way of life, continued and completed their studies, majored and worked. During remission, patients in Group F21 changed significantly from a personal point of view, finding a significant correlation with low levels of conformity and decreased social and professional functioning. The most pronounced decrease was manifested in patients with psychopathic schizophrenia. During remission, F23/25 patients showed the most stable condition both clinically and socially.

On average, the duration of the remission period in the overall sample was about three years (2,745 years), but this period differed significantly in groups with different nosologies. In the F20 group it was 3,7 years, in the F21 group it was less than 1,2 years, and in the F23/25 Group the average duration of remission was 2,9 years. The main clinical causes of exacerbation in Group F20 were the subsequent development of the psychotic state and a change in therapy for various reasons with a deterioration in the condition against the background of discontinuation of drug therapy. The main clinical causes of hospitalization in the F21 group were episodes of psychomotor psychopathic arousal, which developed after a long deterioration in the condition. In the third group, most patients were laid against the background of general well-being or due to a psychotic state associated with a deterioration in somatic condition and subsequent deterioration in mental state. The study showed that therapy during inpatient treatment (during the first and second hospitalizations), as well as during remission, does not have a stereotyped, biologically oriented and individual differential approach. These patients actually did not have any psychotherapy, socially oriented rehabilitation assistance and psychoeducation. Based on this, patients, especially the F21 group, quickly began to show that they did not fit into therapy first partially, and then completely. Only 5-8% of patients took part in Psycho-correctional work after discharge from the hospital. Stigmatization, including self-condemnation, had a significant impact on patient compliance. After the first discharge, 59% described their reaction to the disease as "shame and fear", more than 45% experienced difficulties in the process of buying prescription drugs in pharmacies, waiting for a condemnation and protest reaction from pharmacists and other buyers. pharmacy. For some patients, such experiments caused a decrease in adherence to therapy and the rejection of the existence of psychopathology.

Thus, in three study groups, different forms of the remission period were observed, characterized by a specific clinical and psychological appearance, which leads to a decision on the need to study the remission characteristics as widely as possible in each. characterized groups and the choice of specific approaches to the management of these patients.

Conclusion: 1. Patients with various diseases of the Schizophrenia Spectrum show significant differences in the clinical and psychological structure of the remission period. Thus, patients with paranoid schizophrenia exhibit a much more stable and longest (3,7 years) remission, the structure of which is determined by changes in the voluntary area with negative symptoms and a decrease in energy potential. A group of patients with diseases under the rubric of schizotypal disorder forms a risk group on the frequency of re-hospitalization, indicating the shortest duration of the remission period (1,2 years), the structure of which is represented by a change in personality with a significant decrease. in social activities, a low level of adherence to psychopharmacotherapy and work with a psychiatrist.

2. The most important factors affecting the duration of the remission period and its clinical-psychological structure are: (a) diagnostic approved therapy and timely correction of side effects during the first hospitalization, (B) the social and professional condition of the patient and its dynamics. after discharge from the hospital, C) psychological aspects, as well as options for the individual's reactions to the disease, d) the degree of adherence to therapy, contact with a psychiatrist, psychotherapist and psychologist during the period of remission.

3. In patients with schizophrenia spectrum disorders, adherence to therapy during remission depends significantly on clinical, social and psychological factors. The most common clinical causes of decreased compliance are a complex of side effects of pharmacotherapy, organizational problems associated with prescribing and purchasing drugs. Among the social factors, the dynamics of professional and marital status have the most important influence. Psychological factors represent the patient's extensive experiences, from self-condemnation to denial of the existence of mental illness. The absence of psychological, psychocorrectional and psychopedagogical work during remission significantly worsens the prognosis of patients.

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