Curierul medical, December 2015, Vol. 58, No 6

Psychological rehabilitation of patients with endogenous disease

T. Kryvonis

Department of Medical Psychology and Psychiatry
N. I. Pirogov National Medical University of Vinnitsa, Ukraine
Corresponding author: tamara.kryvonis@gmail.com. Received November 13, 2015; accepted December 07, 2015

Abstract

Background: Clinical picture of the mental illness „schizophrenia" includes numerous symptoms, described in detail in the literature on this subject. Diagnosis of the illness involves detection of the present signs and symptoms, which are closely connected with the impaired social and occupational functioning. Schizophrenia presents itself in a form of psychotic disorder. The term „psychotic" refers to a significant breach in the assessment of reality, or in psychodynamic terms, is defined as a loss of communication between the Ego and the reality, as well as a degree of functional impairment. The article provides the substantiation of early psychotherapeutic intervention in combination with psycho-pharmacotherapy in patients with endogenous disorders. It also describes the mechanisms of psychological defences to deal with traumatic experience, used by personalities functioning on a psychotic level. Characteristic behaviour patterns of extended family members in terms of emotional co-dependency are provided.
Conclusions: Individual pathopsychology is considered as a symptom of abnormal functioning of the family. The article places emphasis on the importance of inclusion of family members in psychotherapeutic interaction in order to correct interpersonal relations. Psychosocial rehabilitation of patients with endogenous disorders should be implemented in two stages: inpatient and outpatient.
Key words: psychological rehabilitation, emotional dysfunction, co-dependency.

Introduction

Today, schizophrenia is still one of the most common and severe mental illnesses. Despite the effective application of pharmacotherapy in relieving acute psychotic symptoms and attenuation of the negative ones, what remains unresolved is the achievement of sustained remission with resumption of social functioning and quality of life. The given problem is especially significant due to the high incidence of disability in such patients. Disability, in turn, includes the following adverse aspects such as the socio-economic burden for society and the degradation of the patient's personality, which significantly affects the quality of life not only of the patient but also of his inner circle. For this reason, psychosocial rehabilitation of patients with schizophrenia is one of the most urgent problems of modern psychiatry. In the spectrum of methods of psycho-social rehabilitation, the most common are individual and group psychotherapy, socio-therapy, occupational therapy in occupational therapy workshops, stimulation of social activity, and development of daily living skills, culture-therapy, and others.

Clinical picture of the mental illness "schizophrenia" includes numerous symptoms, described in detail in the literature on this subject. Diagnosis of the illness involves detection of the present signs and symptoms (productive and negative), which are closely connected with the impaired social and occupational functioning.

Schizophrenia presents itself in a form of psychotic disorder. The term "psychotic" refers to a significant breach in the assessment of reality, or in psychodynamic terms, is defined as a loss of communication between the Ego and the reality, as well as a degree of functional impairment.

Psycho-pharmacotherapy of any kind is only a part of the general approach to the treatment of schizophrenia. Medication affects only physiological symptoms, leaving unattended the psychological content of the problem.

It is important to point out so-called functional negative symptoms, which are often caused by the negative influence of the environment, for example - hyper stimulation in a hospital environment, on account of specific conditions and the system of relations in psychiatric hospitals.

Functional negative symptoms may also be initiated and supported by the adverse psychological atmosphere in the family, associated with excessive control, distrust, predisposition of relatives to the unfavorable development of the disease. The study on the patient's family influence should not be limited to observation of the parents only. It is necessary to take into account the role of other family members (in the so-called extended family).

Information about the patient, obtained from the family members, is important. Family members tend to report information about the patient that differs from the information provided by the patient, which is incomplete and insufficiently reliable, due to its passing through the prism of his mental state.

Individual psychopathology needs to be examined in a family context. Since any psychopathology developed by an individual member of the family is at the same time a symptom reflecting the mental problem of the family that may have existed before the emergence of the given abnormality, or a manifestation of the total psychopathology of the whole family. The diagnosis determines the rigidity of the relationship, chronic stress and conflicts within the family, double standards and difficulty in expressing emotions.

Investigation of the family structure of the mentally ill patients discovers symptoms of emotional co-dependency of "healthy" family members. Most often, it takes form of behavioral symptoms, such as the use of control strategies and protection, closely connected with control.

Control strategy takes the following form. "Healthy" family members assume the functions of control (sometimes quite tight) over the behavior of the mentally ill. The role of the controller gives a special meaning to the life of the co-

dependent. The pathological pattern of the behavior means that in case the patient's behavior does not correspond with the scheme existing in the controller's mind, the activities associated with conventional motivations start to be condemned and criticized.

Control involves suspicion, accompanied by questions like, "Where have you been? Who did you speak to? What did you do?" This behavior has negative consequences for all family members, provoking the emergence of negative feelings in the patient with respect to the controller, and vice versa. This vicious circle reinforces negativity.

Control leads to the aggravation of autism and behavioral passivity of the patient. It can also provoke aggressive patients, due to pathological restriction of life space and actualization of paranoid reactions.

Patients' inner circle preconceives any non-obedience as a form of a negative attitude, fixing their time and attention on it.

It is important to remember that the ambivalent interpersonal relations, perceived as pathological a priori, may well be within the normal range. "Exposing" pathology in ambivalence can significantly impair interpersonal relationships.

The second strategy, used with the emotional co-dependency, is protection, closely associated with control. The patient is protected from the consequences of his active behavior, so he does not communicate with others, as this may undermine the credibility and prestige of the family. In some cases, doctors and family members work together - for example, in reaching the decision that the patient should not work or study for some time, reinforcing passive subordinate behaviors. As a result, motivational-volitional problems of the patient, as one of the characteristics of endogenous disease, get only worse.

In terms of interpersonal relations, any mental illness should be viewed as a result of the whole complex of traumatic experiences that occur in the life of the patient.

With endogenous mental disorders, a patient has hidden negative experiences (topics) that he does not intend to discuss with random people or persons he (perhaps for painful reasons) does not trust [1].

The patient may have sufficient grounds for mistrust, as he can view a specialist not only as a person ready to come to his aid, but also as the one able to hurt him.

Disruption of information processing is aggravated by the impairment of the information conveyance. Patients with schizophrenia demonstrate significant difficulties in recognizing the value of emotional states and reactions of others, increasing their social exclusion. Impaired information processing is accompanied by adoption of inadequate response options, and the enhancement of pathological (rigid) patterns of behavior.

The psychotic patient operates on the preverbal or rather pre-object level. The illness involves his primary senses (pre-feelings) or an early ego state experienced in the first months of his life, before the child learns to differentiate I from not I [1]).

In the 1960s of the last century, Dr. Silvano Arieti in1962 [2] had already written: "If you can establish interpersonal situation with the patient, functioning on psychotic level, you can apply psychotherapeutic methods which will enable him to become aware at first of his psychotic intra-psychic mechanisms, and later, of the dynamic conflicts, interpersonal by origin, that are causing these intra-psychic mechanisms. These processes allow the patient to abandon his symptoms and to focus himself on the greater maturity and non-psychotic life. "

In accordance with modern views, psychosocial rehabilitation of patients with endogenous pathology should be carried out in two stages: inpatient and outpatient. It is obvious that each stage of psychosocial rehabilitation should have its own approaches and characteristics, based on the principles of continuity.

To address the problems of increase in efficiency of psychosocial rehabilitation of this group of patients, we conducted a series of studies on the use of individual and group psychotherapy as basic psychological methods of rehabilitation of patients with schizophrenia. The research task is to determine realistic and achievable therapeutic goals for each stage and to find the optimal forms and methods of psychotherapy.

As the result of the studies, carried out in the Academician Yuschenko Vinnytsia Regional Psychoneurological Hospital as part of the "primary psychotic episode" program, it was found that at the inpatient stage, it is advisable to use psychotherapy with the patients from the first days of arrival, despite the presence of acute psychotic symptoms.

The possibility of verbal contact with the patient is a prerequisite here. As practical experience has proven, at this stage, the most appropriate are the methods of individual psychotherapy, aimed primarily at reducing the emotional stress of the patient by releasing aggression without damaging the perception of reality. Amelioration and onset of restitutional symptoms indicate that the level of aggression has decreased enough to be neutralized to the extent necessary to resume contact with objects, bringing back the interest in the external world. Emotional stress is caused not only by the patient's psychotic experiences, but also by the behavior of others towards him, which is perceived as groundless violence; stressful conditions of staying in the closed ward, in particular connected to the perception of psychopathology of other patients; frustration of the individual behavioral patterns of the patient, such as limited communications with the family, etc.

Instillation of the thought that the patient must be less aggressive is a good way to make him more ill. Accumulated aggression must be adequately expressed. The process of expression is neutralizing aggression to some extent, and the task of the psychotherapist is to remove obstacles for the release of the accumulated aggression [3]. When this is done, psychotic symptoms decrease and the patient can learn a healthier way of dealing with aggression.

In this work process, realization of the transfer, occurring during communication with the therapist, helps the patient to observe him in dealing with other people, which increases the realistic assessment of reality and effectiveness of social behavior. The transfer, subjective to the patient, does not mean distorted perception, but believable point of view, based on his recurrent life experience. This does not mean a specific

retrieval, but the revitalization of the conflict attitudes and behavior patterns, integrated into the personality structure. The patient was forced to cope alone with the effects of traumatic experiences, sometimes for quite a long time, and he was able to survive only due to the presence of psychological defense mechanisms – denial, rejection and depersonalization.

It is important to note that in the process of psychotherapy with patients in acute condition, some methods proved to be ineffective and in some cases even provoked a short-term increase in symptoms. These are the methods, aimed at immersing the patient in his experience, activation of unconscious processes for their clearer identification and interpretation as a psychotherapeutic tool, as well as methods of severe confrontation of inadequacy of psychopathological experiences of the patient. In most cases, premature interpretation and reaction of the therapist is viewed by the patient as rejection, and the fact that the therapist is afraid or unable to bear the situation corresponds to the reaction of the patient's inner circle in his past experiences. Interpretation is more appropriate for emotional reactions that are a template of reactions from the past superimposed on actual behavior.

Recognition of maladaptive psychological defense mechanisms meets inevitable resistance from the patient, which is not limited to aggression, but can take forms of passivity and various forms of denial [4].

The patient usually appreciates the doctor's intervention to eliminate alien to his personality symptoms and direct manifestations of the disease, but has a negative attitude to attempts to eliminate the symptoms that take form of psychological defenses and feel like part of his personality (ego-syntonic).

Understanding the processes of psychodynamic state experienced by the patient and the analysis of rather severe countertransference reactions by the therapist should be an integral part of the therapy. Since it is the understanding of the deep essence of what is happening that allows the therapist to retain his psychotherapeutic position and constructively accompany the patient in the way of treatment [1].

The main thing is that countertransference feelings and emotions do not get involved into play to meet the infantile needs of the patient in dependence and aggression.

To non-specific means of overcoming resistance belong tools for increasing the motivation of the patient to treatment and his emotional support. The resistance decreases in proportion to increase in confidence in the interaction with the therapist.

Another important goal of psychotherapeutic interventions is the correction of the patient's behavior in the ward, increasing the level of conformity of the patient regarding the conditions of stay in a psychiatric hospital, and compliance with his treatment with psychotropic drugs, despite their side effects.

Therefore, the most reasonable and effective tools are containment of the material by the patient's psychotherapist, expression of empathy to the patient's experiences and support of all constructive manifestations of the patient ("mirroring" manifestations of the ego-functions).

With the reduction of psychotic symptoms, it is advisable to expand the arsenal of psychotherapeutic interventions and methods, ultimately resulting in the inclusion of the patient into the group therapy as a safe model of society.

Psychotherapeutic group creates a favorable, secure environment in which the patient learns to talk about what is bothering him, instead of keeping it to himself, to express his feelings, and learn from others how he looks, what impression he makes, to recognize what measure of responsibility he must bear for his own life, regardless of the support received from the others. Dynamics of the patient's behavior in the group is a clear indicator of the increasing adaptability of his social behavior [5].

In the course of group interaction, patients will inevitably begin to display rigid patterns of behavior. The group makes optimal correction of maladaptive attitudes possible, which then can be followed by the rehearsal of adaptive behavior.

Conclusions

When working with people with schizophrenia, it is not productive to use the models, only designed to work through global and general group phenomena. The main objective is the greatest possible individualization of tasks for each member of the group. An individual interview with each member of the group is advisable after each session of group psychotherapy to review the material. Such a combination of individual and group approaches is optimal, because it allows you to combine deep insight into intimate problems (in individual conversations with the doctor) with potential means to diagnose communicative disorders and correction of interpersonal conflicts, provided by the interaction in the group.

Psychosocial rehabilitation of patients with endogenous disorders should be implemented in two stages: inpatient and outpatient. The condition for a successful psychological recovery is the combined use of individual and group therapy at all stages, taking into account the severity of psychopathology: in the direction from support (holding, containment) to a balanced application of genetic reconstruction and analysis of interpersonal relations in individual therapy and solving individual problems in the context of the general group phenomena.

References

1. Hoffmann A. Clinical analysis in psychiatric practice. *MED press-Inform*. 2006;353-363.
2. Reznik S. Dissociation and "unrealistic" associations of thinking with psychosis. *Bridge between Eastern and Western psychiatry*. 2003;1(2):63-72.
3. Vartanian M. Modern mental health problems: state and perspectives. *Neuropathology and Psychiatry Journal*. 1989;10:3-12
4. Shumakov V. Some issues of psychodiagnostics and psychocorrection in the rehabilitation activities at different stages of mental health care (state and perspectives). New in the theory and practice of rehabilitation of mentally ill. L., 1985;59-64.
5. Kabanov M. Immediate tasks in the development of the concept of rehabilitation of the mentally ill. New in the theory and practice of rehabilitation of the mentally ill. L., 1985;5-15.