FORMATION OF REHABILITATION MOTIVATION IN THE CONDITIONS OF THE MEDICAL AND REHABILITATION DEPARTMENT OF A PSYCHIATRIC HOSPITAL

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Abstract. *Psychosocial rehabilitation is the restoration or formation of cognitive, motivational, emotional resources of an individual lost or impaired as a result of a disease-skills, knowledge, interaction, problem solving, the use of coping strategies with social adaptation defects in the mentally ill, ensuring their integration into society. In the context of the rehabilitation process, the problem of motivation is very relevant and actively developed in medicine.*

Keywords*: psychosocial rehabilitation, motivation, medical rehabilitation, psychiatric hospital.*

Introduction. Based on the modern concept of rehabilitation, a special intervention (by type of module) has been developed that is" economical", forms and maintains the patient's motivation for rehabilitation. Motivation is a system of stable motives that determine behavior, as well as the selectivity of a particular person's relationship with other people and various problems [1-3]. Motivation can be assessed not by individual actions (which can be situational), but by stable trends in activity and communication. Motives can be conscious, associated with the promotion of conscious goals, and unconsciously – in the form of readiness for a certain activity, for certain actions. Motivation is not only the direction of behavior in terms of achieving the goal, but also its intensity in achieving the goal (the volume of effort invested in behavior) and persistence (perseverance and perseverance) [4-6].

In modern psychology, regulation is seen as the appropriation and conscious management of one's own mental processes and behaviors, while emphasizing its integral role in the organization of mental activity. In schizophrenia, the integral role of regulation in the organization of mental activity can be significantly impaired. Research by local psychologists has shown that in this case the need-motivational component plays a leading role [7-10]. The most obvious change in this component is due to the weakening of the decisive role of the social factor in the regulation of complex forms of mental activity. The effect of this factor is weakened by a decrease in social orientation in patients due to insufficient need for communication.

In patients with schizophrenia, social interaction motivation, self-esteem motivation (specifically achievement motivation) may be impaired. The desire to limit social contacts, the lack of skills necessary to start and maintain interpersonal contacts, a decrease in the communication – enhancing role of interpersonal stimuli are all communication disorders, before

the onset of the disease and, having predetermined its outcome, begin to satisfy the basic, basal needs of the patient only in an autistic way [11-13].

A number of symptoms of the disease clearly reflect serious problems (self-esteem needs and social contact needs) in terms of meeting certain needs. Psychotic behavior becomes a common tool for the patient to get pleasure or suppress unpleasant sensations. Direct call for psychotic symptoms is not effective [14, 15].

In this sense, the communication style used by qualified personnel in communication with the mentally ill is therapeutically justified. In patients with schizophrenia, the formation of an "abnormal personality" occurs as a result of narrowing of the range of motives, interruption of their semantic and stimulating functions [16]. With an increase in the experience of the disease, there is a weakening and loss of motivation for social recovery. Its component, expressed in the patient's desire to return to full life as the main and highest rehabilitation goal, is increasingly disappearing. Instead, the patient's aspirations will be limited and justified (e.g. primitive social interactions and entertainment, etc.) [17-19].

Behind any motive lies the influence of need (biological and material, social and spiritual). The needs of social interaction correspond to the motives of love, tenderness, social inclusion, identification; the needs of self – esteem are the motives of achievement, recognition and approval. In needs, two levels can be distinguished-lower and higher. Thus, the need for clothing to protect against the cold is one of the vital needs. But to fully socialize and adapt the patient, it is not enough just to follow this. When dressing, the patient must comply with at least the minimum este fashion requirements. The same can be said about the satisfaction of the patient's need for food, home, personal life, recognition of others [20-24].

Weakening and loss of social recovery motivation is one of the manifestations of psychological changes as the disease progresses. The hospital and a long stay in it (hospitalization) contribute to the narrowing of the needs of patients, a decrease in their level, limitation of the hospital scope (agenda, treatment measures). Even in the hospital, the question arises of creating opportunities for the formation of new needs in patients, which in turn corresponds to a new type of motivation. It is necessary to increase the level of efforts of the patient to change his life so that he has the opportunity to make his social claims in constructive, changing actions [25-29].

The entire spectrum of psychosocial activities is carried out in one way or another. In the process of psychosocial therapy, a learning process occurs, as a result of which the formation of certain skills is carried out. The educational process is built according to a number of laws [13]. Thus, in order to form a skill, the patient must have a state that encourages him to take appropriate actions ("the law of readiness"); the more often any action is performed by the patient, the more often he can repeat this action or then choose this action more often ("the law of exercise"); often the action that has a positive effect is repeated ("law of influence"). The patient can act stereotypically, formatively, without taking into account specific conditions. In the process of psychosocial therapy, the behavior he receives allows him to better adapt to living conditions. Skill helps to flexibly change and modify behavior. As a result, the patient can meet a certain need, choose his social requirements and the method that best suits a particular situation [30-35].

Saving-preventive rehabilitation in Psychiatry: the problem of influencing the motivational sphere of patients' modern requirements for Psychiatric Services is such that the formation of motivation for the rehabilitation of the patient becomes one of the main tasks of specialists. It was at that time that the rehabilitation component in the provision of psychiatric care had its real

quality, allowing the patient to maintain social achievements and positions, as well as maintain these achievements later [36-41].

The early stages of the disease are accompanied by the most pronounced dynamics of social losses, when the progressive process determines its particularly destructive nature. During this period, the loss of the patient's social achievements reduces the likelihood of optimal social recovery in the future. As part of rehabilitation efforts in the early stages of mental illness, special measures allow to prevent loss of motivation to maintain social achievements and positions. During the period of active flow of the process, social losses and social decline continue to grow – special interventions are also necessary here, which form the patient's rehabilitation motivation [42-46].

The purpose of the study: is practical approval as a new specialized organizational form in the rehabilitation system, which is in the process of forming this intervention in the conditions of the medical and Rehabilitation Department (MRO) and needs modern methodological equipment.

Materials and methods. Patients with schizophrenia and schizophrenia spectrum disorders who participated in the psychosocial rehabilitation program in the conditions of the medical and Rehabilitation Department of the psychiatric hospital. The intervention that forms and maintains the patient's rehabilitation motivation is based on a number of principles (they are adapted to the characteristics of the target group): a model of behavior change, principles of "stimulating conversation", methods of improving self-efficacy, methods and skills for setting realistic goals, principles of "learning without errors" (exercises that exclude errors in the performance of tasks). etc. The module was used in two variants: as an independent intervention, as well as an installation intervention in the implementation of other modules of the psychosocial rehabilitation program of patients of the medical and Rehabilitation Department. Each of the options responded to its own intervention procedure (from one to 4 functional blocks), the structure and content of classes, as well as educational materials offered to patients.

The Department's staff met the requirements set out in the "procedure for providing psychiatric care". Currently, the available resources of the department by state include: the department employs 5 psychotherapists, 14 medical psychologists, 1 social work Specialist, 2 Social Work nurses, 1 exercise therapy doctor, 1 Exercise Therapy Teacher, 1 Labor Teacher, 1 older sister and 1 nurse. In addition, in connection with the reorganization of four psychoneurological dispensaries and their addition to the hospital, 4 cabinets of the relevant PND branches went to the subordination of the medical and Rehabilitation Department.: 1 psychiatrist, 1 psychotherapist, 1 medical psychologist, social work specialist (0,25 bet), 1 nurse.

Results and their discussion. Practical approval of the module for the formation of rehabilitation motivation was carried out. Group training cycles were conducted. The sequence of modules passed by patients of the medical and rehabilitation department was as follows: from rehabilitation motivation-to metacognitive training – then to "medical" psycho – educational modules: formation and increase compliance, recognition of the first signs of exacerbations, prevention of repeated hospitalization.

Both when carried out as an independent intervention and when used as an installation intervention – this intervention served as one of the main regulators of the rehabilitation process, having a dynamic and organizational effect on patients. The process of encouraging patients to rehabilitation, personal and social recovery could be managed to some extent-to stimulate, organize, direct, provide favorable conditions.

In the process of assistance, a polyprofessional brigade approach was implemented, which included constant interaction and joint work of specialists: a psychiatrist, a psychotherapist, a medical psychologist, a social worker, as well as leading studios and clubs.

Interdisciplinary and interdepartmental cooperation, cooperation with other departments of the psychiatric hospital, as well as with the All – Russian public organization of people with disabilities due to mental disorders and their families "new opportunities" - all this made it possible to include a wider range of events (exhibitions, concerts, festivals) in the rehabilitation process.

Thus, the minimum wage is included in all branches of the organization of psychiatric care (hospital, day hospital, HDPE). This makes it possible to implement the principle of continuity of rehabilitation Actions, allows you to turn employees and support all units with personnel and various types of rehabilitation. At the same time, the department is at the stage of formation and further development.

While rehabilitation is important for various contingents of the mentally ill, it is revealed that Segod day is inadequate, especially when it comes to patients with schizophrenia and schizophrenia spectrum disorders. Specificity of rehabilitation in psychiatric practice, reflection of new approaches to the rehabilitation process, taking into account the biopsychosocial nature of mental disorders, a special approach to patients with the first episode, patients who are not yet disabled, patients with long – term disability experience-all this is reflected in the broad literature and requires translation into practice.

Modern psychosocial therapy and rehabilitation (including cognitive) is based on data obtained in studies on the dynamics of the clinical picture characteristics of patients and the possibility of influencing them using psychosocial influences. There are data on the effectiveness of certain rehabilitation effects at different stages of the disease and at different stages of psychiatric care. A wide range of literature on this problem, including local literature, shows that this psychosocial, including cognitive therapy and rehabilitation on related modules – is currently becoming the main content of the work of specialists in medical and rehabilitation departments. Among these modules is the rehabilitation motivation formation module, which is very important because it tends to disappear as the motivation for rehabilitation during illness and the patient's disability continues. Social and communication skills modules, cognitive remediation modules, etc. are also important. This work, as a rule, is carried out by medical psychologists and psychotherapists. It is this work that aims to restore social competence, cognitive activity, providing an opportunity for the patient to become a conscious and active participant in the rehabilitation process aimed at integration into society.

In the work on the development of the medical and rehabilitation department, we rely on the fact that most modern meta-analyses note some advantages over the rest of cognitive, learning-based approaches.

In accordance with the new organizational model and in the procedure for mastering new forms of rehabilitation work, new forms of psychosocial rehabilitation are also included in the procedure for providing assistance. The tasks of the diagnostic Department are expanded by introducing methods for detecting cognitive impairments (neurocognitive and Social) into an experimental psychological study. Training and mastering of techniques is carried out in cooperation with specialists from the Institute of psychiatry. The tasks of the Rehabilitation Unit are also expanded through the introduction of new modules: the formation and increase of compliance (motivation for correct and long-term acceptance of therapy), the recognition of the

initial (signal) signs of starting exacerbations, meta-cognitive training, social and communication skills, rehabilitation motivation.

Each module is headed by a specialist: psychiatrist, psychotherapist, medical psychologist, etc.in the future, it is planned to create 5 modules that will work continuously, for each of which 2 specialists will answer and thus provide an interchange. The approximate sequence of modules that patients with schizophrenia and schizophrenia spectrum disorders undergo is as follows: from motivation to rehabilitation – to metacognitive training, and then to "medical" psycho – educational modules: formation and increase compliance, recognition of the first signs of exacerbations, prevention of repeated hospitalization. Thus, consistent problem solving is ensured. The first task of rehabilitation within the framework of the medical and rehabilitation department is the task of restoring the cognitive functions of the patient. The second task is to restore the social roles of the patient, encouraging him to adapt at a different, higher level. At the same time, modules are not replaced by employment therapy, but are wisely combined with it. Therefore, as a third task, it is planned to combine work on modules with other rehabilitation activities such as employment therapy izo Studio, Music Studio, etc.

At a new level of activity and quality of life, the patient himself already gives more impetus to circle work and other forms of immersion in the social sphere (for example, visiting a music and Fine Arts Studio). This allows you to generalize the skills and abilities acquired in psychosocial modules. It is important to assess whether skills have been preserved by monitoring the performance of patients in modules and other rehabilitation activities. If the recovered skills are lost, the patient will again work on the modules.

Conclusions. The results of practical confirmation of the module for the formation of rehabilitation motivation-confirm the legitimacy of the claim that the motivational processes of patients with schizophrenia are flexible and dynamic in modular working conditions and respond to certain "keys" or stimuli included in the group training format. The optimal combination of external and internal motivational factors allows their mutual strengthening effect – in terms of the continuity of rehabilitation actions and the active involvement of patients in psychosocial rehabilitation measures of the medical and Rehabilitation Department.

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