

PSYCHOLOGICAL PECULIARITIES OF SOCIAL ADAPTATION IN PARANOID SCHIZOPHRENIA

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Abstract. *The high prevalence of schizophrenia in combination with the progressive course of this disease leads to a gradual increase in the specific cognitive, emotional motivational and voluntary changes of the individual, a significant decrease in the social adaptation and quality of life of patients, and at the same time an insufficient study of psychological factors affecting the level of social adaptation in the initial*

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Introduction. Among the various forms of mental illness, schizophrenia rightfully occupies a special place, which is due not only to the peculiarities of clinical manifestations, but also to the high disability of patients (40%) and large economic costs for their treatment and rehabilitation. All this determines the undoubted social significance of this disease [1].

Despite efforts by health professionals and the social services and the public at large, issues related to social Labor rehabilitation (adaptation) of patients with schizophrenia remain one of the most important problems in modern psychiatry and continue to attract the attention of various professionals [2, 3].

The first psychotic episode of schizophrenia, as a rule, is an independent mental trauma and severe biological and social stress for the patient and those around him, affecting important aspects of his life, leading to deep inner experiences and in many ways marking his further life [4].

According to some authors, after the first psychotic episode in the pathogenesis of schizophrenia, in addition to endogens, reactive mechanisms also occupy a leading position [5]. In this regard, active psychological support of the patient in the form of psychotherapy and psychosocial therapy seems the most important [6].

In this regard, the first years of the disease are usually considered a "critical period", in which the most important changes occur in all areas of the patient's life [7]. Thus, the vast majority of patients have the ability to build interpersonal relationships, decreased interest in life, decreased self-esteem and desire for personal growth, loss of interest in previous hobbies and new types of activities [8].

According to the concept of psychopathological diathesis [9], a significant decrease in the personal resource was noted in the early stage of schizophrenia, which hinders successful social adaptation [10]. To date, the decline in social adaptation by Western psychiatrists is seen as one of the diagnostic criteria for schizophrenia [11]. According to some data, a decrease in social and psychological activity is observed in 14% of patients with schizophrenia [12, 13].

In most cases, it is associated with psychiatric hospitalization, prescribing drug therapy, stigmatization effects of diagnosis [14], decreased ability to work, family problems, emotional discomfort and other unwanted manifestations. According to [15] only 40% of patients maintain the same level of social activity after their first hospitalization.

The social adaptation of patients with schizophrenia, from the point of view of psychology, includes three components: coping, psychological protection and the internal appearance of the disease [16, 17] and depends not only on the specific nature of the disease and the therapy being carried out [18, 19], but also largely on supporting the patient's microsocial environment [20, 21].

Some gender characteristics of social adaptation of patients with schizophrenia. Thus, according to the author, the biological factor, which includes the duration of the disease, is a decisive factor for men. Also, the painful experiences of men feeling their inferiority associated with the presence of stigmatizing disease are characterized by the expectation of self-neglect by others, so they often prefer to avoid society and cling to themselves. In addition to the duration of the disease, the possibility of achieving social well-being is also important for women. However, in women, the reaction to the disease is often manifested by pronounced confusion, unstable emotional fluctuations, which often disrupt their behavior and reduce stress resistance [22-26].

Thus, for most patients diagnosed with schizophrenia, a decrease in labor and social adaptation is an urgent problem, which is primarily due to the emergence of difficulties in solving personal and interpersonal problems, i.e. problems with activities in society [27-30].

One of the main factors determining the social adaptation of the patient is a critical attitude to the disease and adequate compliance. As you know, despite the undoubted benefit of drug treatment, a low level of adherence to the prescription regimen is characteristic for people with mental disorders. The degree of conformity of patients with schizophrenia also depends on a number of factors. First of all, according to some authors, high compliance is associated with the patient's ability to realize the presence of mental illness with all psychopathological signs [31-35].

Other authors believe that for conformity, it is not the fact of realizing the existence of the disease that is more important, but the ability to recognize changes in its mental state in time, which helps to consent to therapy by the patient [36].

In turn, the ability to critically perceive and assess the symptoms of the disease in patients with schizophrenia largely depends on the premorbid personality characteristics of the patient. It has also been found that less violent psychotic symptoms can help increase the patient's ability to critically perceive their condition [37].

The purpose of the study: to study the characteristics of the cognitive sphere at the initial stage of paranoid schizophrenia, as well as personal characteristics, including the characteristics of the protective, stress management and nervous behavior of patients; to determine the prognostic significance of the studied individual-individual characteristics.

Research materials and methods. Patients with clinical diagnoses of "schizophrenia, paranoid form" defined according to diagnostic criteria of the F20.0 "paranoid schizophrenia" section of ICD-10 were selected to participate in the study. At the same time, the duration of the disease did not exceed 1 year from the moment the first psychotic episode began until an examination was carried out for each patient. In total, 80 patients between the ages of 18 and 39 (39 women, 41 men) were examined (median age 32 ± 6.23 years). The comparison group comprised 50 mentally healthy people (25 men, 25 women) between the ages of 20 and 40 (average age 29 ± 6.63 years).

Clinical-Psychological, experimental-psychological and statistical research methods were used.

The clinical and psychological method involves obtaining an expert assessment of the level of social adaptation on the scale we have developed.

The experimental-psychological method involved the implementation of the following psychodiagnostic methods: pathopsychological tests: "Shulte tables", "10 words", "fourth supplement", "comparison of concepts" (Bleicher V. M., 2006); methods for diagnosing cognitive style characteristics: the "included numbers" technique (Gottschaldt K. B., 1926), the technique of "verbal-color interference" (Stroop J. R., 1992), the "comparison of similar pictures" technique (Kagan J., 1966), the "free sorting" technique (Gardner R. W. et al., 1959) V. A. In the Kolgi modification (Kolga V. A., 1986); "Lifestyle Index" methods have been used to determine the characteristics of an individual's protective and stress-coping behaviors (Wasserman L. I. etc., 2005) and "behavioral strategies" (Wasserman L. I. etc., 2009); to determine the characteristics of despair response - the despair response test (Rosenzweig S., 1945; Yanshin P. V., 2004); a multilevel "flexibility" questionnaire for studying personality traits (Maklakov A. G., Chermyanin S. V., 1993), socio-psychological adaptation questionnaire (Osnitsky A. K., 2004).

Statistical processing of the resulting data was carried out using a Russified version of the IBM SPSS Statistics package. Separate primary descriptive statistical descriptions (mean arithmetic, dispersion, mean square deviation, asymmetry and excess indicators) have been calculated for the comparison group and the experimental group; on the basis of these data, normal and asymmetrically distributed variables are highlighted.

Variables whose distribution is not unusual are included in a multi-regression analysis procedure performed separately for the comparison group and the experimental group. At the same time, the indicator "expert assessment of the level of social adaptation" was identified as a dependent variable. Significance levels $P < 0,001$; $p < 0,01$; $p < 0,05$ were taken into account.

Research results and their discussion. According to multiple regression analysis, the most important thing to achieve an acceptable level of social adjustment in mental health conditions is high concentration (β -coefficient: (-0,330); $p < 0,01$), "distance retention" (0,332; $p < 0,01$), and high levels of emotional comfort (socio-psychological adjustment technique) (0,243; $p < 0,05$).

It is known that the struggle strategy in the form of moving away from a stressful situation involves trying to overcome negative experiences associated with the problem by subjectively reducing its importance and the level of emotional attraction to it. Obviously, in this way, a person tries to prevent the development of strong emotional reactions to despair and maintain the state of emotional comfort to the level noted before the appearance of a stressful situation. Maintaining self-control and emotional balance in problem situations allows a person to use cognitive, including attentive, processes as a resource to cope with a stressful situation.

In the early stage of Paranoid schizophrenia, the formation of satisfactory levels of social adaptation is most significantly influenced by the following individual psychological characteristics: high yield of memorization (β -coefficient: 0,294; $p < 0,001$), cognitive style characteristics: utility (-0,448; $p < 0,001$), high accuracy of Information Analysis (-0,211; $p < 0,01$), latitude equivalence range (-0,343; $p < 0,001$) - "switching" mpz activity (0,169; $p < 0,05$) and "reactive formations" (0,410; $p < 0,001$), in the form of a positive reassessment of the problem

situation (0,146; $p < 0,05$), as well as behavioral predisposition in the form of extrapunitive (0,158; $p < 0,05$), intrapunitive (0,527; $p < 0,001$), and need-resistant frustration response (0,443; $p < 0,001$).

The greatest contribution to the decline in social adaptation in chronic mental illness (paranoid schizophrenia) conditions was noted for the high severity of personality traits assessed by the hypochondria scale (β -coefficient: (-0,242); $p < 0,01$), hysteria (-0,534; $p < 0,001$), excitability (-0,441; $p < 0,001$), and paranoia (-0,368); $p < 0,001$), as well as "regression" mpz intensity (-0,802; $p < 0,001$), high predisposition to the type of prevention of coping behavior (-0,178; $p < 0,01$ $p < 0,01$), and object-dominant frustration response (-0,293; $p < 0,001$).

In this regard, E. L. Korobova's data note that the most favorable for successful social adaptation of patients with a long – term illness (from 1 to 15 years, on average 10,74 years), which is a simple and paranoid form of schizophrenia, is the dependence on the mobile log, flexibility of cognitive control and cognitive-methodological features of reflectivity. According to other authors, usefulness in prolonged schizophrenia is associated with a high level of social adaptation of patients. Our study, conducted at an early stage of Paranoid schizophrenia, has a positive effect on the success of social adaptation of cognitive style characteristics, for example: utility, high accuracy of Information Analysis, breadth of equivalence range.

Conclusions. It should be noted that the data obtained in our study on the prognostic significance of a number of psychological characteristics in relation to the likelihood of maintaining a satisfactory level of social adaptation in paranoid schizophrenia allows us to determine the expansion of the set of methods of protection and stress coping as tasks of psychocorrectional work, as well as the response to.

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