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Rehabilitation of Patients with Schizophrenia at Different Stages of the Course of the Disease

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Abstract: Schizophrenia is characterized by the development of: psychosis (loss of contact with reality), hallucinations (false sensations), delusional states (false beliefs), disorganized speech and behavior, affective dullness (narrowing of the range of emotions), cognitive deficits (impaired logical thinking and problem solving), loss working capacity and social activity. The cause is unknown, but a large role is given to genetic and environmental factors. Symptoms most often develop during adolescence and adolescence.

Although the specific cause and mechanism of development of schizophrenia is unknown, the disease has a biological basis, as evidenced by

- Changes in brain structure (eg, enlargement of the cerebral ventricles, thinning of the cerebral cortex, reduction in the size of the anterior hippocampus and other parts of the brain)
- Neurochemical changes, especially changes in markers indicating impaired dopamine and glutamate transmission
- Newly identified genetic risk factors

Some scientists believe that schizophrenia occurs more often in people with a susceptible nervous system, and that the onset, remission, and recurrence of symptoms are the result of an interaction between internal and external stressors.

Categories of symptoms in schizophrenia

Symptoms are divided into the following groups:

- Positive: Hallucinations and delusions
- Negative: Decreased or loss of normal function and emotional response
- Disorganized: Spasmodic thinking and bizarre behavior
- Cognitive: Decreased memory, ability to analyze information, and solve problems

The patient may have symptoms from one or two categories.

positive symptomsin turn are divided into:

- delusional states
- hallucinations

Delusions are erroneous beliefs that the patient adheres to, despite the presence of obvious contradictory facts. There are several types of bullshit:

- Persecutory delusions: Patients believe they have been tormented, stalked, deceived, or followed.
- False Relationships: Patients believe that passages from books, newspapers, song lyrics, or other environmental cues are directed at them.
- Delusions of detached thinking or imposed thinking: patients believe that others can read their thoughts, that their thoughts are being transmitted to others, or that their own thoughts and impulses are being imposed from outside

The delusions in schizophrenia are usually bizarre—that is, clearly not derived from the experience of ordinary life situations (for example, the belief that someone took out the patient's internal organs without leaving scars).

Hallucinations are sensory experiences that are not perceived by other people. They can be auditory, visual, olfactory, gustatory, tactile, but auditory hallucinations are the most common. Patients may hear voices commenting on their behavior, talking to each other, criticizing or making offensive comments about the patient. Delusions and hallucinations can be very annoying to patients.

Negative symptoms (defects) include:

- Dull affect: the patient's face is motionless, with poor eye contact and lack of expression.
- Poverty of speech: the patient speaks little and gives short answers to questions, giving the impression of inner emptiness
- Anhedonia: Lack of interest in any kind of activity and increased erratic, fussy activity.
- Asocial: Lack of interest in relationships with others.

Negative symptoms often reduce the patient's motivation and sense of need to achieve a goal.

Disorganized symptoms which can be considered as positive symptoms include

- Thinking disorders
- Abnormal Behavior

The patient's thinking is disorganized, characterized by incoherent, aimless speech, he quickly moves from one topic to another. Speech can range from mildly disorganized to completely incoherent and unintelligible. Bizarre behavior can be manifested by childishness, agitation, lack of hygiene, sloppy appearance. Catatonia is an extreme degree of behavioral disorder in which the patient may assume a forced rigid posture and resist attempts to move him or engage in aimless and unstimulated motor activity.

cognitive deficitincludes violations in the following areas:

- Attention Functions
- Processing speeds
- Working and declarative memory
- abstract thinking
- Problem Solving Ability
- Understanding Social Interaction

The patient's thinking may be inflexible, there is a decrease in the ability to solve problems, understand the point of view of others and learn from one's own experience. The severity of cognitive impairment is a major factor leading to disability.

Rehabilitation and supportive group activities

Psychological and vocational rehabilitation groups help many patients return to work, normal life, take care of themselves, manage the household; build relationships with other people.

Of particular value may be the maintenance of employment, during which patients are in a competitive environment and are provided with a coach in the workplace to facilitate adaptation to work. After a while, the psychologist begins to act only as a safety net to solve problems or communicate with employers.

Support programs allow many patients with schizophrenia to successfully integrate into modern society. Although most of them can live on their own, some patients require constant supervision by a psychologist. Special programs provide an individual level of control over such patients: from round-the-clock monitoring to periodic home visits. Programs like these help to ensure that the patient can live independently while being careful enough to minimize the chances of relapse and hospitalization. Community-based self-confidence treatment programs provide services in the patient's home or other location, and are based on a high level of staff-patient interaction; treatment teams directly provide all or almost all of the services required for treatment.

Hospitalization or crisis care in an alternative hospital may be required during severe flare-ups. If the patient poses a danger to himself or others, the question of involuntary hospitalization is raised. Despite rehabilitation activities and group sessions, only a relatively small number of patients (especially those with severe cognitive deficits and poor response to medication) require long-term maintenance treatment.

Some patients benefit from cognitive reclamation therapy. This therapy is intended to improve neurocognitive function (eg, attention, working memory, executive performance) and to teach or re-educate patients how to solve problems. Such therapy may improve the functioning of patients.

Psychotherapy

The goal of psychotherapy for schizophrenia is to develop a constructive relationship between patients, their family members, and the doctor so that patients can learn to manage their disease state, take medication on time, and cope with stress more effectively.

Although individual psychotherapy in combination with drug therapy is quite common, there are no uniform methodological recommendations. The most effective psychotherapy seems to be one that begins with a consideration of the patient's basic social needs, provides support and educates the patient about the nature of his illness, promotes the development of adaptive responses, and is based on empathy and understanding of the essence of schizophrenia. Many patients need psychological support to make it easier for them to adapt to a new life with schizophrenia, which can significantly limit activity.

In addition to individual psychotherapy, cognitive behavioral therapy for schizophrenia has improved significantly in recent years. For example, this therapy, given individually or in a group, may focus on ways to reduce the intensity of delusional thoughts.

If the patient lives with a family, then family group sessions are very effective in reducing the risk of relapse. Support and advocacy groups such as the National Alliance for the Mentally Ill are often helpful to families.

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