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Features of Psychopharmacotherapy in Patients with Severe Mental Disorders

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ABSTRACT

Proper psychopharmacotherapy in mental disorders helps to improve the patient's quality of Education, Behavior and family relationships. At the same time, the recommended methods do not take into account the reasons for the violation of the patient's compatibility, which can reduce their effectiveness. The decrease in compliance levels in the treatment of patients allows for a better understanding of the causes and, on this basis, forms more focused and adapted programs for correcting health and drug compliance.

Introduction. Severe mental disorders that account for 14% of the global disease burden and 30% of the non-fatal disease burden, requiring sequential and long-term drug therapy, which is often difficult, mainly due to impaired adherence to treatment by patients[1-5]. The study of the causes and consequences of non-compliance with drugs prescribed by a doctor, as well as the search for ways to improve drug compliance in patients with severe mental disorders (TPR), has a history of almost thirty years, but does not lose its relevance. Many modern studies aimed at optimizing therapeutic care for patients with TPR and analyzing failures, showing the critical role of medical conformity disorder as part of" pseudo-bias " [6-9], making it difficult to assess the effects of the drugs used and leading to incomplete and unsatisfactory results of treatment. This is especially true because despite the presence of high-potency drugs with tolerance and safety, the prevalence of conformity disorders is depressed. Systematic review data, including 46 recent studies, confirmed that overall, 49% of patients with severe mental disorders did not follow the psychotropic drug regimen. Of these, failure to take psychotropic drugs for schizophrenia, underlying depressive disorder, and bipolar affective disorder accounted for 56%, 50%, and 44%, respectively [10-12].

Not using drugs increases the risk of exacerbation, reduces the effectiveness of treatment, or is prone to further therapy. Other consequences of incompatibility include re-hospitalization, low quality of life for patients, and negative psychosocial outcomes, increased comorbidity, wasted health resources, and increased suicide [13-19]. Existing problems with Noncomplaence necessitate the need for patients and health professionals to develop appropriate interventions to achieve the desired treatment goals. At the same time, the development of personalized interventions based on identifying the reasons for non-compliance with drug therapy in order to increase the effectiveness of patients and save health resources seems to be especially relevant.

The desire of a person to be healthy and not experience suffering due to the symptoms of the disease does not always lead to the fact that patients actively resort to the help of a doctor.

Leventhal's model of everyday meaning explains the patient's attitude towards the disease by the position of a "simple Scientist" [20]: here it is important the previous experience of the patient's social communication and the ideas adopted in society about the disease, the position of the immediate environment, as well as the personal experience of experiencing problems. The last factor proved to be the strongest predictor of the disease [21-25].

In turn, the patient's decision on treatment is a complex cognitive action in which subjective adaptation, fear of complications and the patient's ability to follow therapeutic recommendations play the most important role against the background of the disease [26-29]. In this case, the motivation to decide on treatment, according to the theory of self-determination, is associated with the participation of different places of the cause. In particular, it has been shown that the position of abstinence from help is not a simple contradiction to all variants of motivation to consent to therapy. The decision not to be treated often turns out to be independent and is not based on information from medical professionals. Thus, the refusal of treatment is associated with another external location of the cause. At the same time, consent to treatment is associated with autonomous and impersonal loci of the cause, that is, in patients it often occurs spontaneously to independently decide on health care [30]. This information is very important for patients with severe mental disorders, since the motivation to receive psychosocial support plays a special role in the entire psychiatric rehabilitation system [31-35]. Treatment motivation is one of the factors for choosing the duration of psychopharmacotherapy against relapse [36-41].

Within the framework of Myasishchev's theory of relations, the perception of the disease is also based, on the one hand, on the direct experience of the patient experiencing its symptoms, which determines the special importance of the concept in the case of mental disorders; on the other hand, it mediates the individual with the data of the results of external medical examinations [42-48]. This will cause significant tension to the doctor-patient relationship system if the instrumental methods of psychiatric examination are limited. The situation can be further complicated by the phenomenon of social stigmatization of the mentally ill. A mathematical model built on a large project to study the forecasts of the daily activities of patients with schizophrenia with the participation of more than 900 patients found that most of their personal, morbid and social factors are associated with the outcome of the disease, often indirectly. Mental disorganization, effective symptoms, severity of Abulia directly and indirectly determine the final level of work of patients. At the same time, emotional expression, patients 'cognitive level, and disease response strategies have only indirect effects by influencing social cognitions, patients' internal stigma, and their involvement in the rehabilitation system [49-53]. Thus, the motivation and compatibility of treatment, as well as a balanced attitude to the disease, supported by sufficient social skills, are the main parameters of the therapeutic process. These data are consistent with local studies on the characteristics of the clinic and the course of the disease in patients with schizophrenia [54-58].

The purpose of the study: The purpose of this work was to typologize patients on indicators of violation of drug compliance.

Research material and methods: To achieve this goal, patients between the ages of 18 and 70 received inpatient treatment in the integrated pharmaco-psychotherapy unit of patients with mental disorders. Of these, 36,4% were male and 63,6% were female. The duration of the disease m (x) is 90.19 months, σ – 95,98 months., the number of decompensations M (x) 3,82, σ -3,39. According to the diagnostic criteria of ICD-10, those examined belonged to the headings of F2 - 320 people and F3 - 106 patients. The drug compliance scale (SHMC) was used to assess

the degree and structure of drug compliance. Statistical methods have been used: Varimax multi-regression and factor method and Cluster analysis with steingaus (ksrednix) method, as well as Bayesian Classification method. A threshold of statistical significance $p<0,05$ was set for all tests.

Results and discussions: to solve the classification problem, the classification of the initial set of patients with different conformity characteristics into classes (clusters) was carried out, and on this basis, a typology of conformity was created among patients with severe mental disorders. Generalized properties of drug compliance (latent factors) have been used for the typology of patients in accordance with the types of violations of adherence to drug therapy.

In accordance with the interpretation of hidden factors, it is possible to give a meaningful description of the formed clusters: – Cluster 1 (129 patients)-these are insufficiently active and poorly motivated patients with a low incidence of the disease. Their low motivation for treatment comes from the subjective lack of pressure from suffering. For this category of patients, there is a high risk of refusing drug treatment: "I feel better and there is no reason to take medication."

The problematic aspect of compliance with drug treatment of this group of patients is confirmed by low indicators of the total score of SHMC, as well as subcal: "reaction factors to medical treatment", "factors related to the immediate environment" and "factors related to the doctor".patients belonging to other clusters. This group of patients can be described as "active opponents of treatment", since the severity of the disease is low and the level of activity is sufficient, they react negatively to medical treatment, do not adequately support loved ones in pharmacotherapy and resist the establishment of therapeutic relationships.

- Cluster 2 (140 patients) are patients with moderate motivation, the most noticeable decrease in activity and a high incidence of the disease. For this group of patients, there is no clear psychological resistance to medical treatment, in general, they feel a desire to improve their condition, because they feel discomfort due to painful manifestations. Obstacles to their compatibility are, first of all, the severity of psychopathological symptoms, in particular, symptoms such as "blurred effect" and "violation of abstract thinking", which impair the patient's willingness and ability to take medications. Among these patients, there is the lowest rate of "patient-related factors" subscale, while the values of the indicators of other subscales and the total score of SHMC occupy an average position when comparing the indicators of patients with clusters 1 and 3.

Thus, patients belonging to cluster 2 can be classified as" conformably unstable " because their ratio to medical treatment is better than that of the previous group of patients. They support the immediate environment, which is a satisfactory indicator of therapeutic alliance, but their resources are weakened by morbid (the lowest of the"patient-related factors" sub-schools), which disrupts appropriate behavior.

- Cluster 3 (157 patients) - patients with high motivation to treatment, high activity levels and moderate severity of the disease. This compliance profile allows patients to use the effects of psychopharmacotherapy in the presence of pain pressure due to the acute nature of the disease. In patients belonging to cluster 3, the averages of all small and total SCHMK scores were found to be much higher compared to the other two clusters. Based on the data obtained, this group of patients can be described as "actively consistent", since they react positively to medical treatment and have a sufficient level of activity, trying to get rid of existing symptoms by supporting the therapeutic alliance and supporting loved ones.

Conclusion: in the literature, various interventions are proposed aimed at improving the commitment of patients with drug therapy: educational, behavioral, family and technological, each of which requires the use of resources. At the same time, the recommended methods do not

take into account the reasons for the violation of patient compatibility, which can reduce their effectiveness. Isolated clusters of patients make it possible to better understand the reasons for the decrease in the level of adherence to treatment, and on this basis form more focused and personalized programs for correcting drug adherence in accordance with modern trends in the personalization and saving of health resources.

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