ПСИХОКОРРЕКЦИОННАЯ ПРОГРАММА ПОВЫШЕНИЯ КОМПЛАЕНСА ПРИ ПРОВЕДЕНИИ АНТИГИПЕРТЕНЗИВНОЙ ТЕРАПИИ: РАЗРАБОТКА И ОЦЕНКА ЭФФЕКТИВНОСТИ

Л.Е. Трачук, С.Г. Сахно, Н.В. Береза

Ключевые слова: психокоррекционная программа, комплаенс, антигипертензивная терапия, артериальная гипертензия.

Цель исследования: повышение комплаенса при проведении антигипертензивной терапии при помощи психокоррекционных мероприятий личностной направленности для пациентов с артериальной гипертензией.

Материалы и методы исследования. Исследование, направленное на разработку и внедрение психокоррекционной программы для повышения комплаенса проводилось в 2011–2013 гг. Всего обследовано 203 пациента с артериальной гипертензией, из них отобрано 150 пациентов с низким и средним комплаенсом: 77 – для основной группы (принимали участие в психокоррекционной программе и получали гипотензивную терапию) и 73 – для группы сравнения (получали только гипотензивную терапию).

Результаты и их обсуждение. Разработанная программа показала высокую эффективность – у пациентов из основной группы выявлено достоверное повышение комплаенса, увеличение интенсивности отношения к здоровью и уменьшение частоты гипертензивных кризов средней степени тяжести и тяжелых, в отличие от группы сравнения ($p<0,05$).

Выводы. Исследование результативности внедренной в комплексную курацию пациентов с артериальной гипертензией психокоррекционной программы свидетельствует об улучшении комплаентности и оптимизации контроля артериального давления, что значительно повышает эффективность лечения данного контингента больных.

PSYCHOCORRECTIVE PROGRAM TO IMPROVE THE COMPLIANCE WITH ANTIHYPERTENSIVE THERAPY: DEVELOPMENT AND EFFECTIVENESS

L.E. Trachuk, S.G. Sachno, N.V. Bereza

Key words: psychocorrective program, compliance, antihypertensive therapy, arterial hypertension.

Objective: to improve compliance with antihypertensive therapy with the help of psychocorrective program of personal direction for hypertensive patients.

Materials and methods. The research aimed at developing and implementing of psychocorrective program to improve compliance conducted in 2011-2013. The sample of 203 patients with hypertension was examine, of which we selected 150 patients with low and medium compliance: 77 – for the main group (participated in the program and receive antihypertensive therapy) and 73 - for the comparison group (received only antihypertensive therapy).

Results. Approved program showed its high efficiency in improving compliance, increasing the level of intensity of attitude to health and reducing the frequency of hypertensive crises in the main group of patients, unlike the comparison group ($p<0,05$).

Conclusions. The study of effectiveness of psychocorrective program embedded in a comprehensive curation of hypertensive patients indicates an improvement of compliance and optimizing blood pressure control, which greatly increases the efficiency of the treatment of these patients.

UDK 616.89-008:617.7-001.4

Ts. Abdryahimova

TYPES OF STRATEGIES FOR COPING WITH TRAUMATIC GENESIS BY PATIENTS WITH PARTIAL LOSS OF VISUAL PERCEPTION IN THE CONTEXT OF NONPSYCHOTIC MENTAL DISORDERS

Ukrainian Scientific and Research Institute of the Social and Forensic Psychiatry and Addictology of the Ministry of Health of Ukraine, Kyiv

Key words: partial vision loss of traumatic genesis, nonpsychotic mental disorders, coping strategies.

On the basis of clinical psychopathology and psycho-diagnostic survey 400 patients with partial loss of traumatic origin (PLTO) investigated the characteristics of their coping strategies. It was found out that patients with non-psychotic mental disorders (NMD) due to PLTO hold the prevalence of non-constructive coping strategies, namely, cognitive-destructive, aggressive and emotional conflict types, reflecting their negative role in the genesis of the NMD in these patients. In contrast to patients with NMD, people with no PLTO of NMD demonstrated the predominance of constructive coping strategies in the form of cognitive stimulation, behaviorally and emotionally-activity determined types, which in this case are defensive mechanism that prevents the development of NMD. The findings lead to the conclusion that there is an unused adaptive resource ofovercoming in patients with NMD, to revitalize which should be directed therapeutic effects in treatment of these patients.

According to the World Health Organization visual organ disorder is considered to be a permanent or temporary impairment of the sense of vision, lasting during significant time period, it restrains the capability of a person to fulfill one or several types of main activities and can be exacerbated by economic and social conditions [1].

Partial loss of visual perception caused by a trauma in adult age can be accompanied by emotional and social consequences, which influence both psychophysiological state of the individual and his interaction within a family and society; it also limits the life perspectives of a person (desired education, job placement, finding a partner etc.). As a result, acute stress reactions occur, followed by negative emotional stress, disablement awareness and finally by the development of the borderline mental disorder [2].

At the present moment patients with the partial loss of visual perception have high level of physical and intellectual ability to work, that is socially needed [1]. At the same time the important issue is to study how people with partial loss of visual perception overcome visual obstacles and to define specific nature of coping strategies.

Contemporary scientific researchers consider coping strategies to be the behavior that allows an individual to cope with stress or difficult situation by conscious actions in

Table 1. Structure of behavioral coping strategies in the patients

Type of coping behavior/ strategy	MG			CG		
	N	%	± m	N	%	± m
Cognitive coping strategies (n=200)						
Ignoring	36	6,0	2,4	6	1,0	1,0
Humility	33	5,5	2,3	9	1,5	1,2
Dissimulation	39	6,5	2,5	6	1,0	1,0
Self-control	6	1,0	1,0	51	8,5	2,8
Problem analysis	6	1,0	1,0	51	8,5	2,8
Relativity	9	1,5	1,2	6	1,0	1,0
Religiosity	18	3,0	1,7	9	1,5	1,2
Confusion	33	5,5	2,3	6	1,0	1,0
Adding sense	12	2,0	1,4	6	1,0	1,0
Detection of own importance	8	1,3	1,1	50	8,3	2,8
Emotion focused coping strategies (n=200)						
Protest	12	2,0	1,4	63	10,5	3,1
Emotional release	9	1,5	1,2	12	2,0	1,4
Emotional suppression	39	6,5	2,5	9	1,5	1,2
Optimism	6	1,0	1,0	66	11,0	3,1
Passive cooperation	9	1,5	1,2	12	2,0	1,4
Submission	39	6,5	2,5	12	2,0	1,4
Self-reproach	45	7,5	2,6	12	2,0	1,4
Aggression	41	6,8	2,5	14	2,3	1,5
Behavioral coping strategies (n=200)						
Distractibility	18	3,0	1,7	6	1,0	1,0
Altruism	18	3,0	1,7	60	10,0	3,0
Active digression	57	9,5	2,9	9	1,5	1,2
Compensation	18	3,0	1,7	3	0,5	0,7
Constructive activity	18	3,0	1,7	6	1,0	1,0
Digression	45	7,5	2,6	6	1,0	1,0
Collaboration	15	2,5	1,6	54	9,0	2,9
Appeal	11	1,8	1,3	56	9,3	2,9

ways appropriate to personal characteristics and situations. It is a conscious behavior aimed at the change of the situation (if the situation can be controlled), or adaptation to it (if the situation cannot be controlled). Lack of adequate coping strategies causes adverse effects on productivity, health and well-being of the individual [3–5].

Therefore, to study and single out the types of coping strategies among patients with partial loss of visual perception caused by trauma and to determine their role in the development of the borderline mental disorder among these patients, on condition that there is an informed consent in compliance with the principles of bioethics and ethics by random selecting after ophthalmic intervention and finding out amount and prediction of the loss of visual perception, screening test of 600 persons with partial loss of visual perception was conducted. All patients had an acute stress reaction.

During three months after hospital discharge while passing the Master of Science in Epidemiology and Biostatistics (MSEB) clinical and psychopathological examination of patients was conducted and as a result two study groups were defined: main group (MG) included 200 patients, who after traumatic events resulted in a partial loss of visual perception with the diagnosis of borderline mental disorder and control group (CG) consisted of 200 persons with the mental state, corresponding to «conventional norm.»

The following criteria were not included to the study: lack of informed consent, a history of mental and behavioral disorders or psychotic disorders at the moment of examination, the presence of evident somatic diseases that may affect the mental state of the patient.

Nosologic structure of the diagnosed borderline mental disorder was presented by mental and behavioral disorders of the cluster F43, reaction to stress and adaptive disorders with the domination of the mixed anxiety-depressive reaction F43.22 (97 persons, 48.5% of the MG), approximately one third of patients had prolonged depressive reaction F43.21 (44 persons, 22 % of the MG) adaptive disorder with prevalence of disorders of other emotions F43.23 (29 people, 14.5 % of the MG, 23 (11.5 %) patients had post-traumatic stress disorder F43.1 and 7 (3.5 %) patients had adaptive disorder with mixed emotions and behavior disorders F43.25.

Coping strategies were studied using technique of psychological diagnosis of coping behavior of E. Heim [6] and as a result on the basis of generalization and qualitative and quantitative analysis of clinical- psychopathological and psychodiagnostic studies they were divided into types in terms of the borderline mental disorder by these persons.

Results of the study of the coping behavior structure among examined patients are represented in the table1, which shows that in the MG among cognitive coping strategies ignoring 36 (6,0±2,4 %), humility 33 (5,5±2,3 %),

Table 2. Adaptation types of behavioral coping strategies in the patients

Type of coping behavior/ strategy	MG (n=200)			CG (n=200)		
	N	%	± m	N	%	± m
Cognitive						
Self-control	6	3,0	1,7	51	25,5	4,4
Problem analysis	6	3,0	1,7	51	25,5	4,4
Detection of own importance	8	4,0	2,0	50	25,0	4,3
Emotional						
Protest	12	6,0	2,4	63	31,5	4,6
Optimism	6	3,0	1,7	66	33,0	4,7
Behavioral						
Altruism	18	9,0	2,9	60	30,0	4,6
Collaboration	15	7,5	2,6	54	27,0	4,4
Appeal	11	5,5	2,3	56	28,0	4,5

Note: – number of patients with adaptation type of coping behavior and their part in total sample.

Table 3. Relative adaptation types of coping strategies in the patients

Type of coping behavior/ strategy	MG (n=200)			CG (n=200)		
	N	%	± m	N	%	± m
Cognitive						
Relativity	9	4,5	2,1	6	3,0	1,7
Religiosity	18	9,0	2,9	9	4,5	2,1
Adding sense	12	6,0	2,4	6	3,0	1,7
Emotional						
Emotional release	9	4,5	2,1	12	6,0	2,4
Passive cooperative	9	4,5	2,1	12	6,0	2,4
Behavioral						
Distractibility	18	9,0	2,9	6	3,0	1,7
Compensation	18	9,0	2,9	3	1,5	1,2
Constructive activity	18	9,0	2,9	6	3,0	1,7

Note: – number of patients with adaptation type of coping behavior and their part in total sample.

Table 4. Non-adaptation types of coping strategies in the patients

Type of coping behavior/ strategy	MG (n=200)			CG (n=200)		
	N	%	± m	N	%	± m
Cognitive						
Ignoring	36	18,0	3,8	6	3,0	1,7
Submission	33	16,5	3,7	9	4,5	2,1
Dissimulation	39	19,5	4,0	6	3,0	1,7
Confusion	33	16,5	3,7	6	3,0	1,7
Emotional						
Emotional suppression	39	19,5	4,0	9	4,5	2,1
Humility	39	19,5	4,0	12	6,0	2,4
Self-reproach	45	22,5	4,2	12	6,0	2,4
Aggression	41	20,5	4,0	14	7,0	2,6
Behavioral						
Active digression	57	28,5	4,5	9	4,5	2,1
Digression	45	22,5	4,2	6	3,0	1,7

Note: – number of patients with adaptation type of coping behavior and their part in total sample.

dissimulation 39 (6.5±2,5 %), confusion 33 (5,5±2,3 %) prevailed. And in the CG, respectively, maintaining composure 51 (8,5±2,8 %), problematic analysis 51 (8,5±2,8 %), setting own values 50 (8,3±2,8 %) (p ≤0,05). Among the emotional coping strategies by patients of the MG the suppression of emotions 39 (6,5±2,5 %), submission 39 (6,5±2,5 %), self-blame 45 (7,5±2,6 %), aggressiveness 41 (6,8±2,5 %) prevailed. In turn in the CG respectively protest 63 (10,5±3,1 %), optimism 66 (11,0±3,1 %) (p ≤0,05) prevailed. Among behavioral coping strategies in patients of the MG the active avoidance 57 (9,5±2,9%), digression 45 (7,5±2,6 %) were prevalent, in the CG, respectively altruism 60 (10,0±3,0 %), cooperation 54 (9,0±2,9 %), treatment 56 (9,3±2,9 %) (p ≤0,05).

Differential analysis of the structure of coping behavior in the patients allowed finding the regularity of dividing behavior of patients of different groups depending on their adaptation level. The results of studying division of adaptation types of coping behavior are provided in the table 2, which shows that among the patients with coping behavior prevailed the patients of the CG, especially according to cognitive component: Self-control – MG – 6 (3.0 %), CG – 51 (25.5 %), Problem analysis – MG – 6 (3.0 %), CG – 51 (25.55), Detection of own importance – MG 8 (4.0 %), CG – 50% (25.0 %); according to emotional component: Protest – MG – 12 (6.0 %), CG – 63 (31.5 %), Optimism – MG – 6 (3.0 %), CG – 66 (33.0 %); according to behavior component: Altruism – MG – 18 (9.0 %), CG – 60 (30.0 %), Collaboration – MG – 15 (7.5 %), CG – 54 (27.0 %), Appeal – MG – 11 (5.5 %), CG – 56 (28.0 %) (p≤0,05).

Studying division of relative adaptation types of coping behavior proved their similar representation among the patients with partial loss of visual perception of traumatic genesis and significant differences in some types (table 3). Among cognitive coping strategies there have been found some differences in religiosity between patients from different groups: (in the patients from the MG – 18 (9.0 %), CG – 9 (4.5 %)), among behavioral strategies – in Distractibility – 18 (9.0 %) MG, 6 (3.0 %) CG, Compensation – 18 (9.0 %) MG, 3 (1.5 %) CG and Constructive activity – 18 (9.0 %) MG, 6 (3.0 %) CG (p≤0,05). In whole relative adaptation coping strategies have been used by the patients of the MG more often than by the patients of the CG, which shows that patients with borderline mental disease keep adaptation capabilities but have limitations in use.

Analysis of division of non-adaptation types of coping behavior revealed their prevalence in all types of cognitive, emotional and behavioral components, i.e. ignoring, submission, dissimulation, confusion, emotional suppression, self-reproach, aggression, active digression, digression in the patients of the MG (p≤0,05) (Table 4).

Consequently, according to the results of research differentiation of the coping strategies in the patients of different groups have been specified: patients of the CG applied constructive strategies, and patients of the MG – non constructive types (p≤0.05).

Based on analysis and general conclusion we have singled out types of coping strategies characteristic for the patients.

The following types of constructive behavior have been characteristic for the patients of the CG:

- *Cognitive stimulation type*, which is characterized by the orientation on stress coping by means of cognitive analysis and choosing way of its coping;

- *Behavior-activity type*, the main feature of which was self-orientation on problem solving activities with the desire to rely on oneself and refusal from the help of other people;
- *Emotional-decisive type*, where patients in the process of choosing constructive coping strategy have feeling of guilt to the relatives for their «weakness», fear of being a burden to others and a desire to demonstrate their own abilities.

Among the patients of the MG with non-constructive behavior, the following types have been singled out:

- *Cognitive-destructive*, in which cognitive processing of information of individual led to realizing their inability and helplessness, which caused intrapersonal neurotic;
- *Aggressive conflict*, in which patients felt resentment against the unfairness of fate, anger and aggression towards others, resting responsibility on the others for what happened to them, which was accompanied by a refusal to adapt to new conditions of life with distinct demonstration of conflict behavior;
- *Emotional-disadaptive type*, which is characterized by impulsivity and amplitude of negative emotional and behavioral reactions beginning from the demonstration of vigorous activity with evident negative emotional experience to the complete inaction and spontaneous desire to avoid solving any problem.

Thus, it can be noted that among the patients with borderline mental disorder as a result of partial loss of visual perception non-constructive coping strategies prevail, namely, cognitive-destructive, aggressive-conflict and emotional-disadaptive types, indicating on their negative role in the genesis of the borderline mental disorders of these patients. In contrast to the patients with borderline mental disorder, people with partial loss of visual perception caused by trauma without borderline mental disorder showed no preference to constructive coping strategies as cognitive-stimulation, behavioral-activity and emotional-decisive types, which in this case serve as a defensive mechanism for the development of borderline mental disorder. Meanwhile, the results allow drawing a conclusion concerning existence of unused adaptation of coping resources in the patients of the MG, which should be activated by means of psychotherapeutic influence in the process of combination treatment of the present category of patients.

References

1. *Vision-Specific Distress and Depressive Symptoms in People with Vision Impairment / G. Rees, H. W. Tee, M. Marella [et al.] // Invest. Ophthalmol. Vis. Sci. – June 2010. – Vol. 51. – № 6. – P. 2891 – 2896.*
2. *Абдряхімова Ц. Б. Роль копінг-поведінки в розвитку непсихотичних психічних розладів у осіб з частковою втратою зору травматичного ґенезу / Ц. Б. Абдряхімова // Український вісник психоневрології. – 2013. – № 2. – С. 68 – 72.*
3. *Залуцкий И. Л. Проблема копинг-поведения в работах отечественных и зарубежных исследователей / И. Л. Залуцкий, Л. М. Махнач // Онкологический журнал. – 2009. – Т. 3, № 3 (11). – С. 81 – 87.*
4. *Иванова Е. А. Психологические факторы преодоления жизненных трудностей инвалидами по зрению: автореф. дисс. … канд. психол. наук: 19.00.10 / Е. А. Иванова. – Учреждение Российской академии образования «Институт коррекционной педагогики». – Москва, 2010. – 22 с.*
5. *Карвасарский Б. Д. Клиническая психология: Учебник для вузов. 4-е изд. / Б. Д. Карвасарский. – СПб-Питер, 2011. – 864 с.*
6. *Совладающий интеллект: человек в сложной жизненной ситуации / А. В. Либина. – М.: Эксмо, 2008. – 400 с.*

ТИПОЛОГИЯ СТРАТЕГИЙ ПРЕОДОЛЕНИЯ У ЛИЦ С ЧАСТИЧНОЙ ПОТЕРЕЙ ЗРЕНИЯ ТРАВМАТИЧЕСКОГО ГЕНЕЗА В АСПЕКТЕ РАЗВИТИЯ У НИХ НЕПСИХОТИЧЕСКИХ ПСИХИЧЕСКИХ РАССТРОЙСТВ

Ц.Б. Абдряхимова

Ключевые слова: частичная потеря зрения травматического генеза, непсихотические психические расстройства, стратегии преодоления.

На основе клинико-психопатологического и психодиагностического обследования 400 больных с частичной потерей зрения травматического генеза (ЧПЗТГ) исследованы особенности их стратегий преодоления. Установлено, что у лиц с непсихотическими психическими расстройствами (НПР) вследствие ЧПЗТГ имеет место превалирование неконструктивных стратегий преодоления, а именно, когнитивно-деструктивного, агрессивно-конфликтного и эмоционально-дезадаптивного типов, что свидетельствует об их негативной роли в генезе НПР у этих больных. В отличие от пациентов с НПР, лица с ЧПЗТГ без НПР демонстрировали преобладание конструктивных стратегий преодоления в виде когнитивно-стимулирующего, поведенчески-деятельностного и эмоционально-решительного типов, которые в данном случае становятся дефензивным механизмом, препятствующим развитию НПР. Полученные данные позволяют сделать вывод о наличии неиспользованного адаптивного ресурса преодоления у пациентов с НПР, на активизацию которого должны быть направлены психотерапевтические воздействия в комплексном лечении данной категории пациентов.

ТИПОЛОГІЯ СТРАТЕГІЙ ПОДОЛАННЯ В ОСІБ З ЧАСТКОВОЮ ВТРАТОЮ ЗОРУ ТРАВМАТИЧНОГО ГЕНЕЗУ В АСПЕКТІ РОЗВИТКУ У НИХ НЕПСИХОТИЧНИХ ПСИХІЧНИХ РОЗЛАДІВ

Ц.Б. Абдряхімова

Ключові слова: часткова втрата зору травматичного генезу, непсихотичні психічні розлади, стратегії подолання.

На основі клініко-психопатологічного та психодіагностичного обстеження 400 хворих з частковою втратою зору травматичного генезу (ЧПЗТГ) досліджено особливості їх стратегій подолання. Встановлено, що в осіб з непсихотичними психічними розладами (НПР) внаслідок ЧПЗТГ має місце превалювання неконструктивних стратегій подолання, а саме когнітивно-деструктивного, агресивно-конфліктного і емоційно-дезадаптивного типів, що свідчить про їх негативну роль у генезі НПР у цих хворих. На відміну від пацієнтів з НПР, особи з ЧПЗТГ без НПР демонстрували переважання конструктивних стратегій подолання у вигляді когнітивно-стимулюючого, поведінково-діяльнісного та емоційно-рішучого типів, які в даному випадку стають дефензивним механізмом, що перешкоджає розвитку НПР. Отримані дані дозволяють зробити висновок про наявність невикористаного адаптивного ресурсу подолання у пацієнтів з НПР, на активізацію якого повинні бути спрямовані психотерапевтичні дії в комплексному лікуванні даної категорії пацієнтів.