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ASSESSMENT OF THE RELATIONSHIP OF THE DEGREE OF CONFORMITY IN PATIENTS WITH SCHIZOPHRENIA WITH CLINICAL FEATURES AND SOCIO-DEMOGRAPHIC FACTORS

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Abstract: Compliance in medicine is voluntary adherence to the prescribed treatment regimen of the patient. In the broad sense of the word, it means that the patient is committed to following all the doctor's instructions: daily routine, diet, exercise, proper medication. However, often compliance means that patients follow the drug therapy regimen.

Key words: Schizophrenia, socio-demographic factor, physical activity, personality.

Introduction. Patients ' adherence to the prescribed therapy regimen occurs in a variety of diseases. The WHO estimates that about half of patients with chronic diseases do not follow medical recommendations. Thus, noncomplaence is about 65% among patients with diabetes, and about 50% among patients with bronchial asthma and arterial hypertension [1-3].

Many researchers estimate that patients with somatic disorders have a higher rate of adherence to the therapy regimen than those with mental disorders, especially if long-term care treatments are needed. In the study of the problem of refusal of therapeutic cooperation for such a severe mental illness as schizophrenia, it becomes clear that there is a very high prevalence of noncomplaence, which, according to various estimates, is 10-90% (on average 50%). Among the most important causes of noncomplaence are the side effects of psychopharmacotherapy, the need to receive long-term supportive treatment, the complexity of the regimen of taking medications, the lack of criticism of its condition, the lack of information about the disease and prescribed treatment [4-9].

Understanding plays an important role in the patient's commitment to the prescribed therapy regimen. In modern psychiatry, the concept of " understanding "is used by patients to" realize" their own diseases, to adequately assess their own painful conditions in accordance with the conclusion of specialists [10].

Violation of the antipsychotic therapy regimen in schizophrenia is associated with an increased risk of developing recurrent exacerbations and exacerbation of chronic psychopathological symptoms [11]. The development of the disease, in turn, reduces the effectiveness of therapy due to the formation of resistant psychopathological formations: a violation of formal thinking, anhedonia, allogy, emotional flattening, motivation and a decrease in voluntary aspirations. According to modern concepts, these symptoms correspond to the concept of "negative symptoms". This prevents the patient from adequately assessing the pain of his condition and helps not to comply with medical recommendations. Thus, there is a formation of a vicious circle that determines the unfavorable course of schizophrenia [12-18].

Conditionally, the factors affecting compliance can be divided into 4 groups:

1. Factors related to the patient (his personality and the nature of the disease);
2. Factors associated with therapy (severity of side symptoms, frequent increase in drug intake, high cost of treatment);
3. Factors related to the doctor (lack of adequate therapeutic relationships, qualification of a specialist);
4. Factors related to the external environment (influence of socio-demographic factors).

The study of quality of life parameters in various psychiatric nosologies, in particular schizophrenia, is still relevant today. There are several disorders that are interconnected with this disease – psychopathological diseases (positive and negative symptoms) and disorders of social interactions. Schizophrenia has a lack of social skills that were initially present or lost due to illness, as a result of which there is a deterioration in role function, which is often interpreted as a manifestation of negative symptoms, but in fact it is not [19-24]. At the same time, patients with severe chronic mental disorders often find greater satisfaction in their material and social status, in the nature of their social interaction, which is explained by the fact that these patients do not want changes in their lives due to the needs reduced as a result of the disease [25-27].

In this regard, it seems relevant to study the role of various biological, clinical, socio-psychological factors that are important for the formation of the quality of life and social activities of people with mental disorders. One of the main biopsychosocial aspects that affect all measures of human life is the sexual factor [28].

Indeed, sexual dimorphism is one of the main evolutionary biological, social and medical problems. Taking into account gender (gender) factors (the similarity and difference of these terms will be discussed below) is currently becoming a standard in cultural, sociological, psychological, clinical research [29, 30].

The study of the role of gender differences in mental pathology is a valuable paradigm for understanding the interaction of biological and social factors associated not only with pathogenetic mechanisms, but also with therapeutic approaches [31]. All concepts that explain gender differences can be divided into two large categories: biological and social.

The biological approach follows from the fact that the differences between men and women are explained by genetic and hormonal factors, brain structure, innate properties of the Constitution, temperament, etc. According to this concept, the male sex plays a key role in change, while the female sex plays a key role in maintaining the population. According to this theory, the idea of evolution involves two inseparable opposite aspects – preservation and transformation. Both the system and the environment develop, but since the environment is always larger than the system, it determines the evolution of the system. In other words, two genders are two conjugate subsystems – conservative (female gender) and operational (male) [32-34]. The first moves away from the environment (degraded and positively affected) to preserve existing genetic information, and the second approaches the environment to obtain a new one, viz.plays the avant-garde role of evolution. This differentiation increases the overall stability of any system, so it is often found

among evolving, adaptive, Observer systems (regardless of their specific nature) – biological, social, technical, etc. Thus, the male sex, in comparison with the female, has a higher mutation rate, a higher reaction rate, higher aggression and curiosity, search, risky behavior and other qualities "close to the environment"are more active [35-38].

All of them purposefully lead the male sex around the distribution, giving him the priority of new environmental information. The broad norm of female sexual response gives it higher plasticity (flexibility) in ontogenesis than the male sex. This also applies to psychological characteristics [39].

In other words, women adapt to the situation, and men find a new solution and get out of it. The role of the avant – garde belongs to men in influencing some diseases, as well as social vices-alcoholism, smoking, drug addiction, gambling, crime, etc. V. A. According to geodacian theory, psychological and sexual role differences between men and women depend on the logic of evolution [40].

The purpose of the study: to assess the correlation between conformity levels, clinical manifestations and socio-demographic factors in patients with schizophrenia.

Materials and methods. 30 male and female patients diagnosed with schizophrenia were examined. All patients were treated in the inpatient departments of the State Center "Psychiatry". Among them: men-10, women-20. Age range: from 22 to 75 years old. According to the current classification, 22 patients were diagnosed with a "paranoid form of schizophrenia", 7 patients with a "simple form of schizophrenia", 1 patient with a "catatonic form of schizophrenia". 18 patients reported a continuous type of disease, 12 patients reported an episodic course type.

Clinical-catamnestic, survey "assessment of treatment and insight compliance," deficit disorder assessment protocol", methods of statistical analysis. Our study tried to assess the impact on compliance with the following factors: the severity of negative symptoms, the type of disease and some socio-demographic characteristics. A"deficit disorder assessment protocol" was used to assess the severity of negative symptoms. Assessment of the severity of negative symptomatology: limited exposure, decreased emotional range, poverty of speech, limitations of interests, decreased goal and decreased social movement were rated from 0 to 4 points, where the maximum value corresponded to the most pronounced deficit signs. Compliance assessment was carried out using the "compliance assessment and understanding" questionnaire on a scale of 0 to 22 points, where the maximum score corresponds to the maximum compliance weight.

Socio-demographic factors studied include: gender, age, level of education, the presence of a disability group, marital status, the presence of social support.

Research results. A negative high correlation was established between the degree of severity of negative symptoms and the degree of conformity ($p<0,001$). A negative high correlation was established between the severity of negative symptoms and the availability of Higher Education ($p<0,001$). A positive correlation was established between the degree of conformity and the availability of Higher Education ($R = 0,77$; $p<0,001$). In the group of patients with episodic flow type, the degree of conformity is much higher than in the group with constant flow Type.

Clinical-psychopathological analysis showed a predominance of both paranoid (40,5%) and affective-delusional (29%) syndromic forms of disease in the studied contingent. A persistent progredient or paroxysmal progredient type of schizophrenia has been reported in many patients (47 and 28% respectively). Low indicators of social activity and quality of life of patients were found. For example, 63 (31,5%) people had their own family, while only 52 (26%) lived with the parents of the patient. In more than half of the observations, family relations were very complex: unsustainable (65 people, 33,7%) and contradictory (22 people, 11,4%), neutral relations were recorded in 30 (15,5%) people. At the same time,

communication in 67 (33,6%) people is limited to the family environment. Despite the fact that the level of education of patients was much higher (57% of those with secondary special education, 4,5% of unfinished higher education and 19% of higher education), their labor status was significantly reduced. So, 161 people (80,5%) did not work and did not study; Of those examined, 138 (69%) had a mental health disability group, with many working patients engaged in unskilled labor. A household adjustment assessment found that 48% of patients could only do simple household chores, while 41% could only master light physical activity.

Despite the low material level of patients with schizophrenia (46% of patients had enough funds only for food), their living conditions were relatively satisfactory: most of the patients lived in their apartments (183 people, 91,5%). Assessing the subjective parameters of the quality of life of patients, it can be noted that in general they were more satisfied with the main areas of their life (mental and physical condition, physical and intellectual indicators, material condition, etc. During the study, four main options were identified for a combination of objective parameters of social adaptation and their subjective assessment by patients (subjective quality of life). False positive (patients rated their quality of life as good with sufficiently low objective parameters of social activity)-35% (70 people) and sufficiently negative options (with objectively high parameters of social activity, they rated the quality of life as bad) – 33% (66 people). In other cases, sufficiently positive (positive subjective assessment of the quality of life with positive objective parameters of social activity)-12% (24 people) and sufficiently negative (negative subjective assessment of the quality of life with low objective parameters of social activity) – 20% (40 people) were noted.variants. In terms of the degree of adherence to drugs and compliance with medical recommendations (compliance), patients are divided into three groups: high (27 people, 13,5%), moderate (88 people – 44%) and low (85 people, 42,5%) compliance. Catamnestic analysis and assessment of the objective parameters of the social activity of patients showed the predominance of a stable negative option (88 people, 47%). 54 (28,9%) patients reported a stable-positive variant, while 45 (24,1%) people reported a negative-dynamic variant with maladaptive and social shift events.

In patients with female and male schizophrenia (150 and 50 people), reliable differences in clinical parameters, objective indicators of social adaptation and subjective parameters of quality of life were identified. Clinical and psychopathological analyses have shown that men exhibit psychopatho-like manifestations (22 and 2,7%, respectively; $p<0,001$) as part of persistent low-progressive schizophrenia (18 and 7,3%, $p<0,05$, respectively), predisposition to aggressive behavior (38 and 15,3%, respectively) than women; $p<0,001$), substance abuse (38 and 2,0 respectively%; $p<0,001$). At the same time, hypochondriacal symptomatology was more characteristic of women than men when the paroxysmal-progredient form of schizophrenia prevailed (32,7 and 14% respectively; $p<0,05$) in the structure of Affective-delusional attacks (11,3 and 0% respectively; $p<0,05$).

Higher levels of social functioning and adaptation of female patients were found than men. Thus, often men were unmarried (44 and 27,3% respectively; $p<0,05$) and divorced (34 and 18,7% respectively; $p<0.05$), compared to women, most female patients were married (35,3 and 20% respectively; $p<0,05$).

Most often, males live with their parents (46 and 19,3% respectively; $p<0,001$) than females, while females live with their children (20,7 and 0% respectively; $p<0,001$). In addition, relationships in women's families were more consistent with their opinion compared to men (55,3% and 34% respectively; $p<0,05$). In an assessment of the status of labor, it was found that the majority of patients were male (38 people, 76%) and female (123 people, 82%) who were not engaged in professional activities and had a disability group in mental disorders (64 and 70,7%, respectively), but the type of labor among working women was very diverse. by men. It has often been found that women consider themselves to belong to the Christian faith and have good relations with the religious organization (69,3 and 46% respectively; $p<0,01$).

In men, complete satisfaction with the basic parameters of quality of life was determined significantly more often, with low objective indicators of social adaptation (17 people, 34%). In women, the reverse trend was observed-high indicators of social adaptation with subjective dissatisfaction with the main parameters of quality of life (58 people, 38,7%).

The study showed that a more favorable course of the disease, increased attention to health (lack of bad habits, a high degree of coherence), social adaptation of women in comparison with men due to good family relationships (a stable positive option in 34% of observations). In male patients, social disruption (a negative-dynamic option in 56% of cases) is mainly associated with a less favorable course of the disease (which is mainly due to low compliance and irregular medication intake), a significant decrease in family and professional levels.

In addition, the parameters of the quality of life and social adaptation of patients in different groups of the population were studied, taking into account the gender factor. The grouping of clinical material by habitat factor is determined by such characteristics of rural patients as the distance of rural settlements from the places of medical care, poor state of transport communication, poorly developed social infrastructure in the village, as well as the influence of these factors on the social activities of patients. Patients were divided into urban and rural populations (141 (70,5%) and 59 (29,5%), respectively). Clinical features of urban patients were found to be psychopatho-like disorders (9,9 and 1,7%, respectively; $p<0,05$) and low progressive course of disease (12,8 and 3,4%, respectively; $p<0,05$) compared to rural patients. Rural populations have frequently encountered a recurrent type of disease (3,4 and 0%, $p<0,05$, respectively) in the severity of psychopathological disorders compared to urban populations.

An analysis of a set of social factors found that rural patients were more likely to live with their families (35,5 and 29,8% respectively) and spouses and children (16,3 and 23,7% respectively), while urban residents were single in more observations and lived with their parents (29,1 and 18,6% respectively).). The employment status of urban and rural patients was characterized by a significant decrease: many had a disability group for mental illness (72,3 and 61%, respectively) and did not work (80,8 and 79,7%, respectively), and more than half of working patients were employed in unskilled labor (7,1 and 8,7%, respectively). Rural patients had better rates of domestic adaptation, and more active forms of rest were observed than urban ones: daily walks (54,2 and 32,6% respectively; $p<0,01$), jobs typical of rural areas. The material situation of the rural population was low compared to the urban population and their level of conformity was low. A subjective assessment of the quality of life of rural patients was found to be much more appropriate than urban residents.

According to the age factor, patients were divided into young (18-35 years old – 47 people, 23,5%), mature (36-55 years old – 105 people, 52,5%) and involutional (56 years old and above – 48 people, 24%) patients. For young patients, the dominance of Affective-delusional symptoms (46,8% and 24,8% respectively; $p<0,01$) with clinically similar psychopathic behavior, aggression towards those around them (32,5 and 16,2% respectively; $p<0,05$), pronounced asociality (47,5 and 29,5%, $p<0.05$) was reliable. They were found to have low social levels (often compared to average age patients in a populated apartment – 10 and 1,0% respectively; $p<0,05$) and family compatibility (80,8% of young patients were unmarried and 63,8% - lived with their parents, often with troubled family relationships). In young patients, a false positive subjective assessment of quality of life was often found (21 people, 44,7%). In middle-aged patients, a continuous progressive course of the disease (82,9% and 62,5, respectively), in which paranoid symptoms (43,8%) prevail; $p<0,01$) has been reported significantly more frequently compared to younger patients.

These patients found higher levels of social and family adaptation than patients of other ages. Among middle-aged patients, married people are more common than younger patients (38,1 and 12,5%, respectively; $p<0,01$), who live more with their spouses and children (24,8% -7,5%, respectively; $p<0,05$).

Subjective assessment of the quality of life of this group of patients has been found to be more appropriate than other age groups. In older people, the clinical picture was dominated by clear deficit symptoms, affective flattening. The study found low objective indicators of social adaptation of such patients. At the time of the study, these patients were widowed, and compared to older patients (41.7 and 8.6% respectively; p<0.001), their free time was characterized by passivity and monotony, they lacked social and self-service skills. In addition, often such patients needed care compared to their relatives in full service, mature age patients (4,2 and 0% respectively; p<0,05). The financial situation of most elderly patients was defined as much more severe, becoming ill more often than older patients (14,6 and 3,8%, respectively; p<0,05) and starving (8,3 and 0%, respectively; p<0,01). Elderly patients often found satisfaction with the subjective quality of life against the background of the worst objective indicators (18 people, 37,5%).

A comparative analysis of patients living in urban and rural areas, as well as different age groups, taking into account the sexual factor, identified trends similar to the general sample of patients in clinical characteristics, subjective assessment of the quality of life and objective parameters of social activity. The study showed that a more favorable course of the disease (paroxysmal with impressive supplements), increased attention to their health (lack of bad habits, high level of compliance), social adaptation of women living in the city due to good family relationships (often women) (a stable negative option in 51,9% of observations). in marriage, they have a different family composition and got along well with their relatives). In urban male patients, a negative-dynamic variant of social adaptation (51,4%) occurs significantly more often due to an unfavorable course of the disease (which often has a constant course with psychopathic-like symptoms complicated by alcoholism), a significant decrease in family and professional level. A comparative analysis of patients of male and female villagers found a stable-positive variant of social adaptation (36,4%) for women, and a negative – dynamic (66,7%) for men. An analysis of the clinical characteristics of rural patients found that cognitive deception, behavioral aggression, formal thought disorder, and addiction to women were frequent in men.

While high adaptation rates in rural women are associated with increased attention to their health and family adaptation, low adaptation rates in rural men are associated with a decrease in professional labor in addition to clinical factors (almost no one is permanently employed). The group of patients with a stable positive adjustment option is made up of 36-55 years old (46,5%), mostly women with secondary special education (88%) (46,5%), and symptomatic individuals similar to neurosis among these patients were found to be much higher compared to patients with a stable negative option (17,2 and 17,5%). 3,2% respectively; p<0,01). In the clinical picture of the disease, these patients often have depressive-hypochondrial symptom complexes within the framework of paroxysmal paranoid schizophrenia. Professional matching of patient data was better than other groups: 15,5 percent of patients were employed in unskilled labor, 10,3 percent were employees, 3,4 percent were entrepreneurs, and 5,1 percent were other professional groups. In comparison to patients with a stable negative variant of social adaptation among these patients (9 and 3,2%, p<0,01, respectively), individuals who worked without skill reduction were reliably dominant. Adaptive psychosocial factors of this group of patients include the fact that 39,6% of patients are married, and 46,5% of them are on good terms with relatives. Most often, patients with a stable positive variant of social adaptation were the head of the family, the main breadwinner, whose opinion was decisive in comparison with patients with a stable negative variant of social adaptation (13,8 and 4,2%, p<0,05, respectively). In these patients, compared to patients with a stable negative option different social circles are significantly more frequent. The finances of most of these patients were found to be satisfactory compared to patients with a stable negative option (58,6 and 34% respectively; p<0,01). Patients with a stable positive social adjustment had significantly higher follow-up compatibility compared to patients with a consistent negative option (25,9 and 9,6%, respectively; p<0,01). Most patients with a stable positive variant of social adaptation have found a false negative subjective assessment of the quality of life (27,6%). A comparative analysis, taking into account the sexual factor, did not identify significant differences in the

clinical manifestations of the disease and the level of social activity of men and women. At the same time, it was found that in the female sample, stable social adaptation is mainly associated with family factors, and in men-with Occupational Employment factors.

Conclusions. Assessing the correlation between the degree of conformity, severity of negative symptoms, and educational attainment in patients with schizophrenia allows the following conclusions to be drawn. The degree of compliance is negatively associated with the severity of negative symptoms. The degree of negative symptoms is negatively associated with the level of Education. The degree of compliance is positively correlated with the level of Education. In the course of the study, no relationship between the degree of conformity and age and gender was found. The level of coherence in a group with an episodic type of schizophrenia course is much higher than in a constant flow type.

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