VILNIUS UNIVERSITY

Rima Viliūnienė

THE EFFECTIVENESS OF THE TREATMENT OF PATIENTS WITH AFFECTIVE AND NEUROTIC DISORDERS IN THE PSYCHOTHERAPY DAY-CARE CENTRE: A LONGITUDINAL STUDY

Summary of Doctoral Dissertation

Biomedical sciences, Medicine (06B)

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VILNIAUS UNIVERSITETAS

Rima Viliūnienė

PACIENTŲ SU AFEKTINIAIS IR NEUROZINIAIS SUTRIKIMAIS GYDYMO PSICHOTERAPIJOS DIENOS STACIONARE EFEKTYVUMAS: LONGITUDINIS TYRIMAS

Daktaro disertacijos santrauka

Biomedicinos mokslai, medicina (06B)

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ABBREVIATIONS

PDC	–	Psychotherapy Day-care Centre
MHC	–	Mental Health Centre
QPASS	–	The Quick Psycho-Affective Symptoms Scan. Questionnaire for the evaluation of the severity of mental status.
CORE-OM	–	Clinical Outcomes for Routine Evaluation – Outcome Measure. Questionnaire for the evaluation of the level in psychological distress.
FMP	–	Fragebogenzur Messung der psychotherapiemotivation. Questionnaire for the evaluation of the Motivation for psychotherapy.
RSA	–	Resilience Scale for Adults. Questionnaire for measuring resilience**.**
GPI	–	Global psychopathology index
E.s.	–	Effect size
M	–	Mean
SD	–	Standard deviation
p	–	Level of significance

INTRODUCTION

Depression is one of the most common mental health disorders. Scientific literature reports that from 3 to 17 percent of the European population suffers from depressive disorders. Other sources report that depression and other mood and anxiety disorders affects about 20 percent of the population of developed countries. Depression risk for men is about 5 percent while for women - 10 percent. In Great Britain, from 5% to 10% of people are treated for depressive disorders. Dutch scientists carried out a large sample study and found that 67% of patients with depression at the same time also suffered from anxiety disorder, and 75% of depressed patients' life histories showed the presence of an earlier anxiety disorder. 63% of patients with anxiety disorders at the same time get depressed, and 81% of patients' life histories showed an earlier presence of depression. According to WHO depression is the third most significant factor in terms of the economic burden. According to the data from the year 2008 the disease also took third place in Europe. Is it predicted that by 2030 depression will become an illness causing the greatest economic burden, even ahead of ischemic heart disease.

There have been a lot of discussions on depression and anxiety disorder treatment in scientific literature. Many studies have been conducted assessing the pharmaceutical, combined (pharmaceutical and psychotherapeutic) and psychotherapeutical treatments effectiveness and comparing these techniques with each other. Extensive research, meta-analyzes and discussions which treatment – psychotherapy, pharmacotherapy or combination of both - leads to reach the best depression and anxiety disorders treatment results continues to this day. Many meta-analyzes concluded that combined treatment is more effective than psychotherapeutic or pharmacotherapeutic treatment alone.

Numerous studies have shown that stressful life events increase the probability of psychiatric symptoms and disorders. In studies of psychological resilience patients identified stressors (e.g., bereavement, chronic illness, experience of violence) which often coincides with stressors mentioned in studies of clinical depression. It was found that individuals who develop psychopathological symptoms are characterized by significantly lower resilience

than the rest. Increase of resilience is an important target in the treatment of depression, anxiety and stressful reactions. Resilience can be measured and it is related to general health status. Resilience is changeable and can be improved by treatment. Greater increased resilience corresponds to the greater general improvement of mental health. Resilience is positive mental health foundation. General resilience characteristics are more stable than psychiatric symptoms, so they may be particularly important in predicting psychological growth during the psychotherapy process, the risk of relapse and the patient's ability to cope with current and future challenges.

An adult patient consulting mental health specialists because of his/her depressive or anxiety disorders, as a rule, already has some experience of somatic treatment, which is usually associated with a passive role of the patient obeying the doctors' orders. This patient-physician relationship is typical and it is internalised during the long-term. This communication model is usually repeated and/or extended in contact with a psychiatrist for depression or anxiety disorder. The patient is prescribed medication, he/she might be sent to a psychologist, but is not enough to exactly follow the doctor's recommendations for the successful psychotherapeutic treatment. Positive and long-term psychotherapy treatment results are most likely when the patient himself is actively involved and contributing to change. Patients who approached psychotherapeutic help, who asked their therapists about medical services they can offer and actively formulated and reached therapeutic goals on their own initiative, received better results in therapy than those who behaved passively. The degree of patient's active participation in psychotherapy is one of the strongest precursors of the treatment results. On the other hand, lack of motivation is one of the most frequently mentioned reason in the literature of patients’ discontinuation of treatment, therapeutic non-compliance with the agreement, relapse and other negative psychotherapeutic treatment outcomes.

A psychotherapy Day-care Centre is a special, partial hospitalization programme, in-between hospitalization and outpatient treatment. Treatment in a psychotherapy Day-care Centre includes an intensive but short-term psychotherapy or combined help. From a clinical point of view, treatment in Day-care Centre compared with inpatient treatment has the following advantages: the patient experiences less dependence (strong need for support and help from others, maintaining self-esteem and handling daily life), and regression (a return to a less mature level of mental functioning, manifesting in emotions, thinking, behaviour), less stigmatisation. A Day-care Centre promotes personal patients' responsibility for their treatment and recovery, intensive psychotherapy work is combined with homework assignments, family involvement remains intact, social contacts are not interrupted. At the same time psychotherapeutic treatment in a Day-care Centre is more exhaustive and provides less support, protection, there are fewer possibilities for a retreat, provides less containment (a process which takes place in secure psychotherapeutic relationship where the patient is able to project different unacceptable to him and frightening feelings to the therapist who endures, „contains“ in himself these feelings, and returns them to the patient in a safe form, helping him/her solve his/her problems).

AIM OF THE STUDY

To estimate the effectiveness of treatment for patients with neurotic and affective disorders at the psychotherapy Day-care Centre, and establish the relationships and changes over time of sociodemographic factors, psychopathological symptoms, psychological distress, motivation for psychotherapeutic treatment and psychological resilience.

OBJECTIVES OF THE STUDY

1. Find and put in readiness for use methodologies relevant to assess manifestation of psychopathological symptoms, psychological distress, motivation for psychotherapy and psychological resilience.
2. To compare manifestation of psychopathological symptoms, psychological distress, motivation for psychotherapy and psychological resilience of patients with affective and neurotic disorders:
   a) at the beginning of the treatment in the PDC,
   b) after 6 weeks of treatment in the PDC,
   c) after 6 months follow-up.
3. To compare manifestation of psychopathological symptoms, psychological distress, motivation for psychotherapy and psychological resilience of patients treated with psychotherapy and combined treatment:
   a) at the beginning of the treatment in the PDC,
   b) after 6 weeks of treatment in the PDC,
   c) after 6 months follow-up.
4. To establish the relationships of patients' sociodemographic characteristics with the expression of psychopathological symptoms, psychological distress, motivation for psychotherapy and psychological resilience and to compare them:
   a) at the beginning of the treatment in the PDC,
   b) after 6 weeks of treatment in the PDC,
   c) after 6 months follow-up.
5. To evaluate the changes of psychopathological symptoms, psychological distress, motivation for psychotherapy and psychological resilience during the treatment and follow-up period.
6. To compare the manifestation of symptoms and psychological resilience of patients treated in the psychotherapy Day-care Centre and in Mental Health centres:
   a) at the beginning of the treatment,
   b) after 6 weeks of treatment.

NOVELTY OF THE STUDY

Four new questionnaires to assess patients' 1) motivation for psychotherapy, 2) expression of psychiatric symptoms, 3) results of psychotherapy, and 4) psychological resilience were prepared for use in Lithuania during this work.

In this study, for the first time, it was the intention to find out whether and how our patients' motivation for psychotherapy was related to their treatment results of a 6-week structured program in the psychotherapy Day-care Centre (PDC).

Scientific literature, discussing the changes and increase of psychological resilience, mainly deals with cognitive behaviour therapy and treatment or prevention of post-traumatic stress disorder. Data on psychodynamically oriented psychotherapy Day-care Centre treatment effect on psychological resilience of patients suffering from affective and neurotic disorders could not be found.

Also, according to the literature data available relationships of psychological resilience and motivation for psychotherapy and changes of these variables (motivation and resilience) during treatment and follow-up period have not yet been investigated in patients with affective and neurotic disorders.

DEFENDED STATEMENTS

1. Treatment in a psychotherapy Day-care Centre significantly improves the patient's mental state, diminishes distress and increases psychological resilience.
2. Mental state, distress, motivation for psychotherapy and psychological resilience are significantly related to sociodemographic factors.
3. No significant difference of treatment effect was found between the groups of patients with affective and neurotic disorders in the psychotherapy Day-care Centre.
4. Treatment outcomes for patients with affective and neurotic disorders in a psychotherapy Day-care Centre are better than for patients with the same disorders treated in Mental Health centres.

MATERIALS AND METHODS

STUDY SAMPLES

The **target** group consisted of patients with Neurotic and Mood (affective) disorders receiving treatment in the Vilnius Mental Health Centre Advisory Centre Psychotherapy Day-care Centre. Inclusion criteria for the research were as follows:

- Patient is undergoing treatment in the psychotherapy Day-care Centre,
- Patient is aged between 18 and 60 years,
- Patients is diagnosed with neurotic or affective disorder,
- Patient does not participate in any other study at the time of participation in this study,
- Patient agrees to participate in this study.

The sample size used to analyze the data was 95 patients. Age – from 18 to 60 years, mean age - 33.4 ± 10.4 years. The group consisted of 77 (81%) women and 18 (19%) men. Employed patients represented 54 (56.8%), students 20 (21.1%), and there were 21 (22.1%) unemployed persons. 65 (68.4%) of patients lived in the family and 30 (31.6%) lived alone. From the onset of symptoms to arrival in the PDC treatment for the 11 (11.6%) patients took less than a month, for 51 (53.7%) it took up to a year, and for 31 (32.6%) patients took more than one year. Two-thirds of study subjects (65 (68.4%)) were diagnosed with affective disorders (14 (21.5%) of them with the major depressive disorder, and 51 of them (78.5%) with recurrent depressive disorder). 30 (31.6%) patients were diagnosed with neurotic disorders, 15 (50%) of which - mixed anxiety and depressive disorder. While 81 (85.3%) patients were treated by combined treatment and only 14 (14.7%) were treated vy psychotherapy alone.

The **control**, treatment as usual (TAU), group consisted of patients undergoing treatment in PE Karoliniškių Clinic, PE Žirmūnų Mental Health Centre, PE Šeškinės Clinic, PE Vilnius University Hospital Santariškių Clinics Family Medicine Centre and Širvintų Mental Health Centre, Inc., and who agreed to participate in the study. The study participants' eligibility criteria:

- Patient is undergoing treatment in an outpatient mental health centre,
- Patient is aged between 18 and 60 years,
- Patients is diagnosed with neurotic or affective disorder and the doctor prescribed him/her a psychopharmacological treatment,
- Patient does not participate in any other study at the time of participation in this study,
- Patient agrees to participate in this study.

The sample size used to analyze the data was 30 patients. Age was from 18 to 60 years, mean age - 41.4 ± 11.9 years. The group consisted of 4 (13.3%) men and 26 (86.7%) women. Duration of disorders to starting the treatment in MHC for 5 (16.7%) patients was up to one month, while for 25 (83.3%) patients - up to one year. All of them were diagnosed with recurrent depressive disorder, and they all were treated psychopharmacologically.

The study began in October 2010, and was completed in July 2012. The research was conducted with the permission of the Lithuanian Bioethics Committee, permit No. 158200-10-237-056LP27 (6th Oct, 2010) and permit addendum No. 158200-237-TP1 (9th Sept, 2011).

The form of the informed personal consent was signed.

PROCESS OF THE STUDY

The study was longitudinal – it consisted of three evaluative stages.

Patients of target (PDC) group were tested three times:

1. At the beginning of treatment (T1).
2. At the end of treatment (T2).
3. After the follow-up period (T3) – six months after the end of the treatment in the PDC.

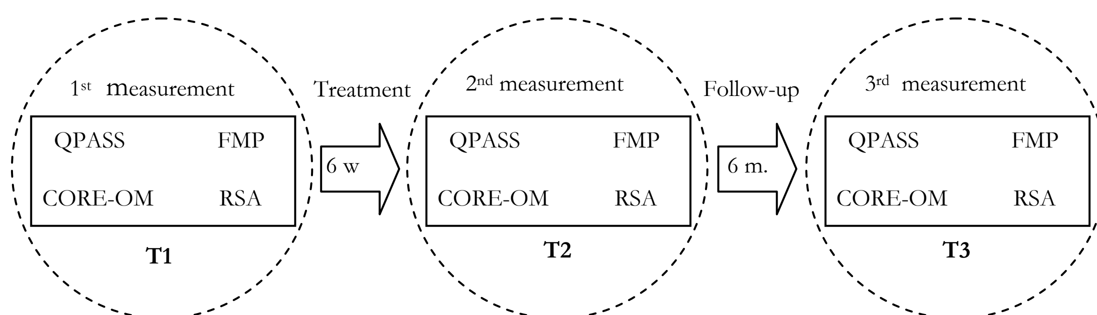

Chart 1. The target group research scheme

Patients of control group (MHC patients, TAU group) were tested two times:

1. First, T1 – at arrival to a routine visit to a psychiatrist,
2. Second, T2 – at arrival next visit to a psychiatrist (after ~7 weeks).

QPASS and RSA questionnaires were used.

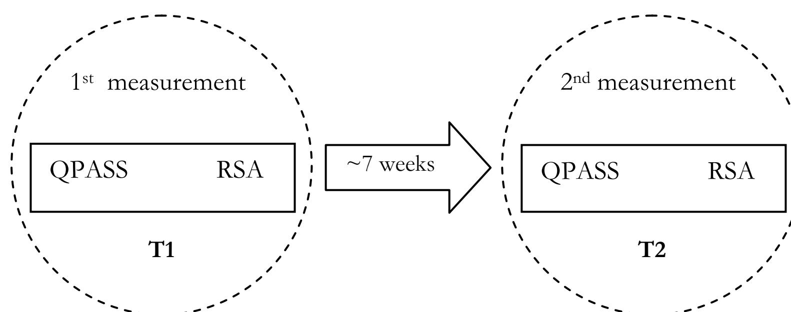

Chart 2. The control group research scheme

METHODOLOGY OF THE STUDY

Sociodemographic and the data of illness and treatment: age, sex, diagnosis, occupation, marital status, treatment history, medication use – was collected from the medical records of the patients.

The study used four questionnaires.

The severity of mental status was assessed using ***QPASS* (The Quick Psycho-Affective Symptoms Scan)**. It is a self-report instrument. Each of the 105 QPASS items is rated on a 5-point Likert scale, rating from 0 (not at all) to 4 (extremely). In this study, measuring the severity of symptoms expression, we used three (out of 8) scales of this instrument: Depression, Anxiety, Anger. Global psychopathology index GPI reflects the sum of ratings on all 105 items. The higher the GPI score, the more severe is the patient's mental state. The Cronbach's Alfa of QPASS for our sample ranged from 0.93 to 0.98.

The level of changes in **psychological distress** was measured using ***CORE-OM* (Clinical Outcomes for Routine Evaluation – Outcome Measure)**. This is an instrument designed to evaluate the effectiveness of psychotherapy.

The CORE-OM is composed of 34 items addressing domains of subjective well-being, problems/symptoms, functioning and risk (risk to self and risk to others). Items are scored on a five point scale from 0 (not at all) to 4 (all the time). Separate domains and the overall measure are problem scored (i.e. higher scores indicate more problems). The Cronbach's Alfa of CORE-OM for our sample ranged from 0.69 to 0.95.

The motivation for psychotherapy was evaluated using ***FMP* (Fragebogenzur Messung der psychotherapiemotivation)**. This German language questionnaire is used to measure patients' attitudes toward his or her illness and toward psychotherapy. It is composed of four subscales derived from the total pool of 47 items, and each item is rated on a 5-point scale (1 completely agree, 5 completely disagree). The four subscales are as follows: 1. Negative Illness Consequences; 2. Psychosocial Lay Etiology, measures the relative degree of psychosocial versus physical/somatic causal attribution of patients' symptoms. 3. Psychotherapeutic Treatment Expectations, assessing expectations about the functional value of physical (e.g., medication, surgery) versus psychotherapeutic treatment approaches to reduce one's complaints. 4. Openness to Psychotherapy, reflecting general attitudes toward and experience with psychotherapy. The sum of the scores of the all answers reflects the general motivation for psychotherapeutic treatment. The higher the total score, the more the patient is motivated towards the psychotherapeutic treatment. The Cronbach's Alfa of FMP for our sample ranged from 0.69 to 0.79.

We used ***RSA* (Resilience Scale for Adults)** for measuring **resilience.** The RSA is a 33 item self-report scale and applies a seven point semantic differential scale in which each item has a positive and a negative attribute at each end of the scale continuum. Scores vary between 33 and 231, with higher scores indicating higher levels of resilience. The scale consists of six factors, indicating intrapersonal and interpersonal protective factors presumed to facilitate to adaptation to psychosocial adversities: (1) Perception of self, (2) Planned future, (3) Social competence, (4) Structured style, (5) Family cohesion and (6) Social resources. The Cronbach's Alfa of RSA for our sample ranged from 0.70 to 0.92.

STATISTICAL ANALYSIS OF THE DATA

Collected data was analyzed using the SPSS 20 software package. Continuous data was tested for normal distribution by the Kolmogorov-Smirnov test. Student's t-test for independent samples was used to compare variables between the two groups (e.g., patients' groups receiving different treatment). Student pair sample test was used to determine the differences between the two measurement phases (e.g., the first and the second measurement). One factor analysis of the variance with stacked data (repeated measures ANOVA) was used to determine the differences among the three phases of measurement (e.g., the first, second and the third measurement). Two-factor analysis of the variance with the stacked data was used to assess whether the differences among the evaluated measurements can be critical to a single factor, e.g., belonging to one group or another. The Fisher's F-test was used to analyse variance. Post hoc (a posteriori) criterion indicates the differences between the groups in the analysis of variance. This paper used Bonferoni post hoc test. The use of the Student's t-test and the analysis of the variance was based on the exact p-value to determine the difference between the features of the statistical significance. The difference was considered statistically significant at 95 percent probability when $p \leq 0.05$, and at 99 percent probability, when $p \leq 0.01$.

Also, using Student's t-test was calculated effect size (Cohen's d), which is presented as a measure of the strength of the changes. It shows objective significance of the changes, how strong are the found differences and whether they are or are not random, but in fact exist. Cohen (1988) offered the interpretations of Cohen's d effect size: up to 0.2 – small, up to 0.5 – average, above 0.8 – a big strength. Performing the analysis of variance the effect size – eta squared was also calculated. It also shows the objective significance of changes. Cohen (1988) offered the interpretations of eta squared effect size: up to 0.01 – small, up to 0.06 – average, above 0.14 – a big strength. Correlations were used for the assessment of relationships. We applied Pearson's correlation to determine the relationship between the variables used for each phase or between the phases in the data analysis. To identify the relationship of all the variables with demographic variables of work, we used Pearson's correlation for interval data (e.g., age) and Spearman correlation for categorical data (e.g., education). Determination of the statistical significance of relationships was based on the exact p-value. Relationship strength was considered statistically significant at 95 percent probability when $p \leq 0.05$, and a 99 percent probability, when $p \leq 0.01$.

In order to determine the relationships between the expression of symptoms, motivation and resilience over time, we performed structural equation modelling with the Mplus 5.0 program. We tested a cross-lagged model, which estimates the relationship over time and at the same time serves to answer the question about changes over time and the direction of the variable relationship. The structural cross-lagged model was estimated by 3 model fit criteria: CFI, RMSEA, and TLI. CFI and TLI index values greater than 0,90 show that a model fits data adequately; values greater than 0,95 show a good fit of a model. RMSEA values lower than 0,08 represent a sufficient root mean square error of approximation; values lower than 0,05 show a good model fit to data. We estimated a model fit additionally using a χ^2 criterion, with a level of significance greater than 0,05.

RESULTS

TREATMENT EFFECTIVENESS

We discovered that during the six weeks of treatment at PDC and after the follow-up period the expression of psychopathological symptoms, distress, motivation for psychotherapy as well as psychological resilience of all the patients changed significantly.

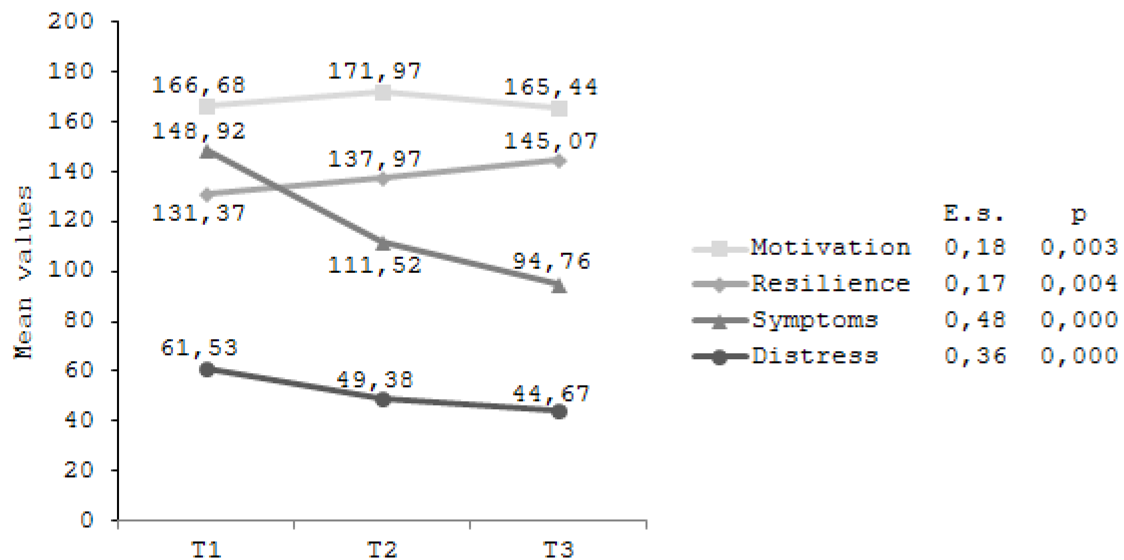

Figure 1. The changes of the general values of the scales over time (E.s.- effect size – eta squared)

CHANGES IN SYMPTOMS

In the process of the treatment in PDC all the investigated symptoms (depression, anxiety, anger, and general psychopathology) in patients significantly decreased, which persuasively showed that the treatment in PDC was effective. According to the research data, decline of symptoms continued and after the treatment in PDC – we observed that the symptoms significantly decreased further after the six months follow-up period.

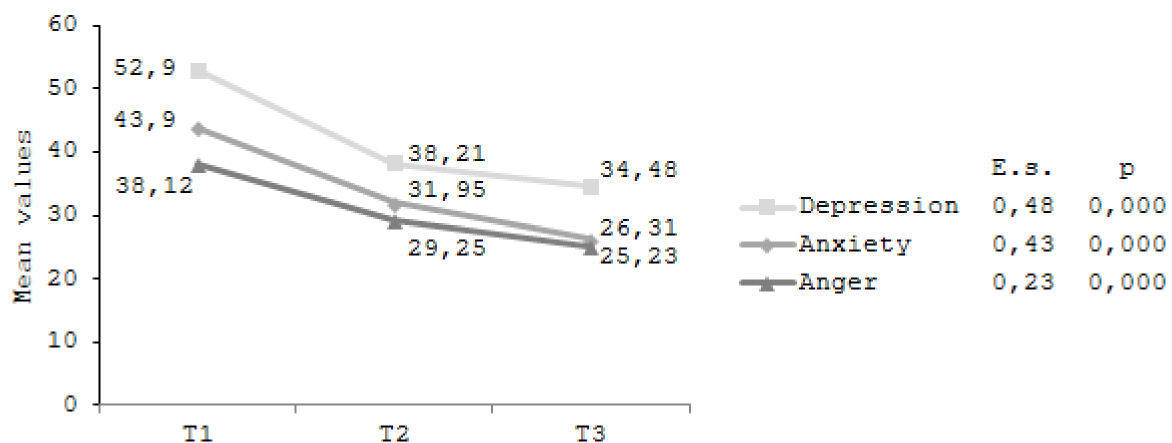

Figure 2. Changes in the expression of symptoms over time. (E.s.- effect size – eta squared)

Different changes in values of depression symptoms were observed for the patients treated only by psychotherapy – depression significantly reduced after the treatment, but after the six months follow-up period symptoms of depression slightly increased but did not reach the expression of the symptoms at the beginning of the treatment.

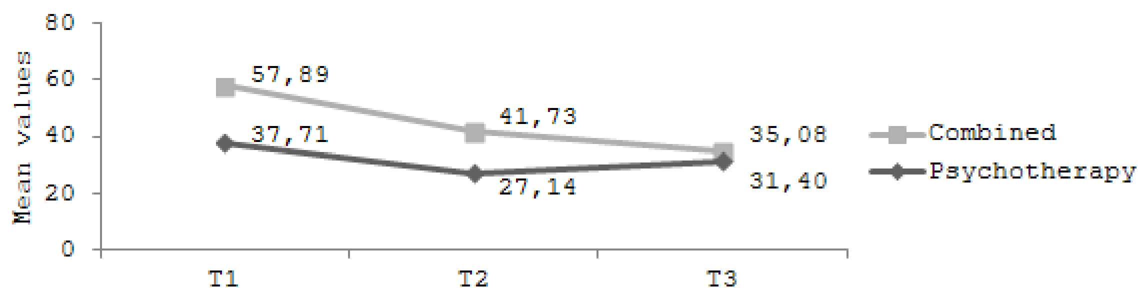

Figure 3. Changes in values of depression in differently treated patients

CHANGES IN PATIENTS' DISTRESS

During the treatment at PDC the patient's subjective sense of well-being significantly increased, values of problems and risk scales significantly decreased during that period. Functioning and overall subjective assessment of distress significantly also improved.

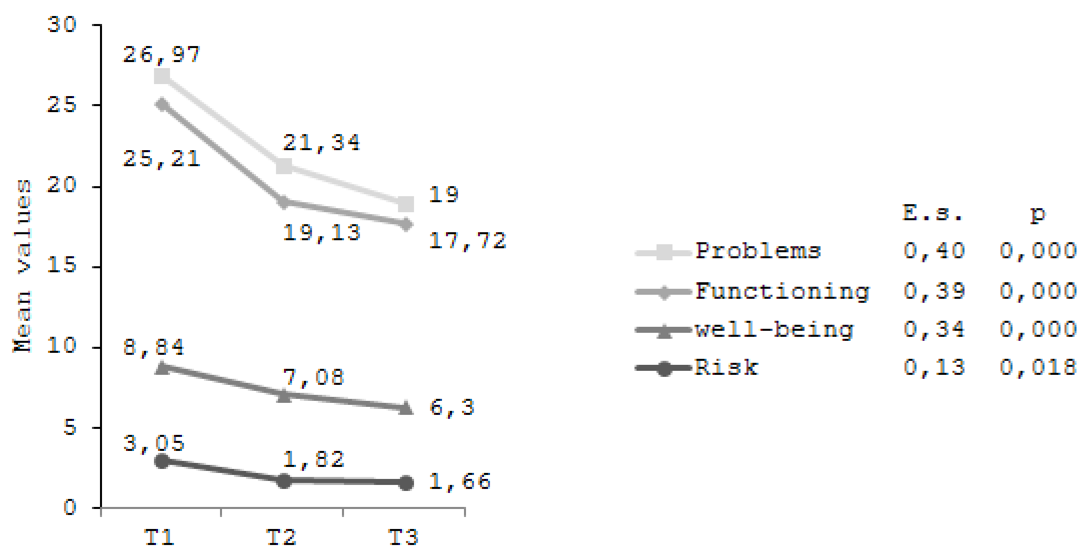

Figure 4. Changes in the expression of psychological distress variables. (E.s.- effect size – eta squared)

CHANGES IN MOTIVATION

During and after the treatment in PDC certain aspects of patients' motivation significantly changed. The degree of suffering (negative illness consequences) during treatment and in the follow-up period for all the patients significantly decreased. All the patients immediately after treatment were significantly more likely to assess their illness etiology as psychological. After the follow-up period patients' understanding of the etiology of their illness become more somatic. The patients' openness to psychotherapy significantly increased during treatment, and after the six months follow-up period openness decreased. General motivation for psychotherapy significantly increased during treatment and after the follow-up period it became lower than at the beginning of the treatment.

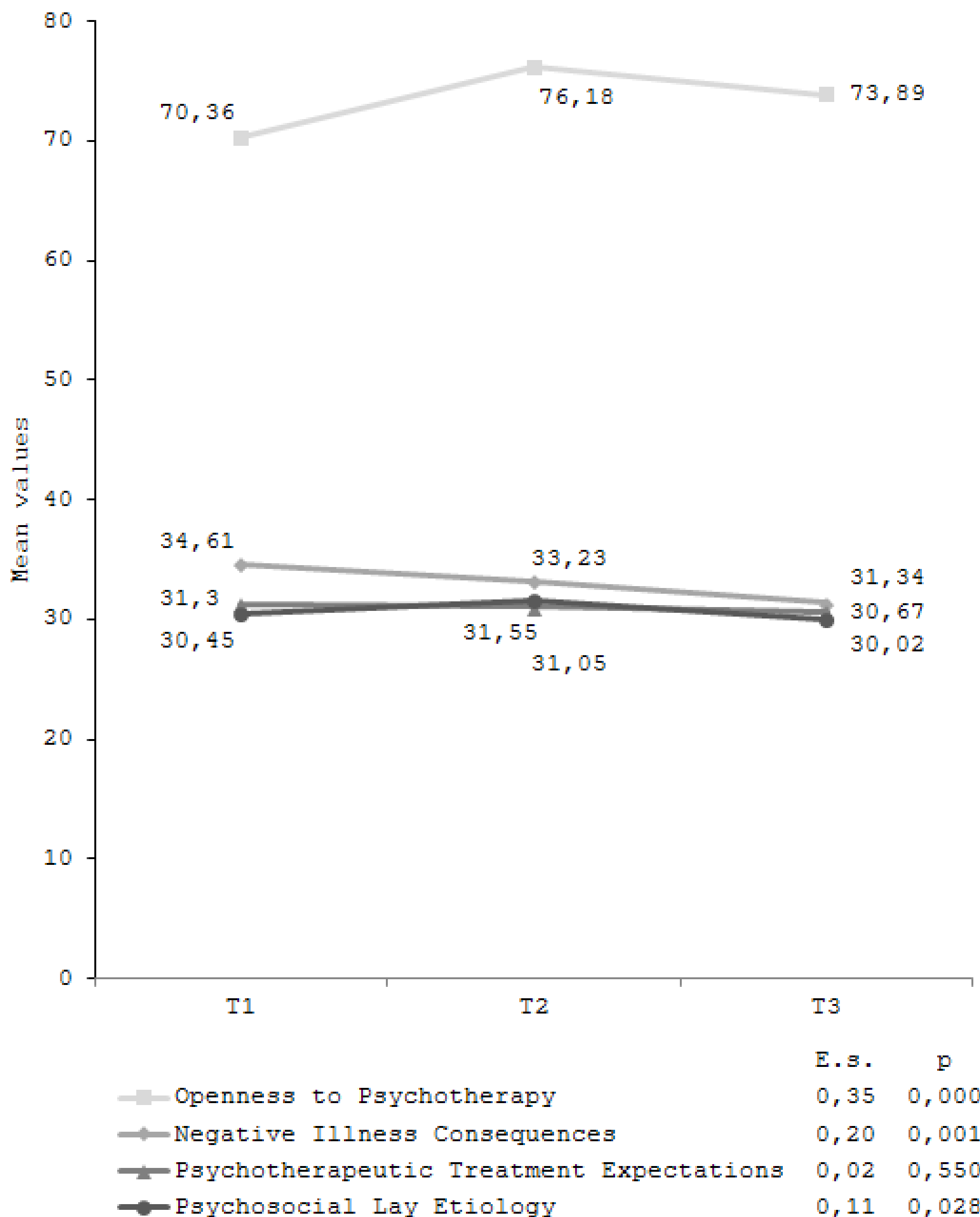

Figure 5. Changes of values of motivation variables. (E.s.- effect size – eta squared)

CHANGES IN PSYCHOLOGICAL RESILIENCE

During and after the treatment in PDC certain aspects of patients' psychological resilience also changed significantly. The overall psychological resilience significantly increased in all the groups during the treatment and the follow-up period. We found that planned future significantly improved and family cohesion significantly increased.

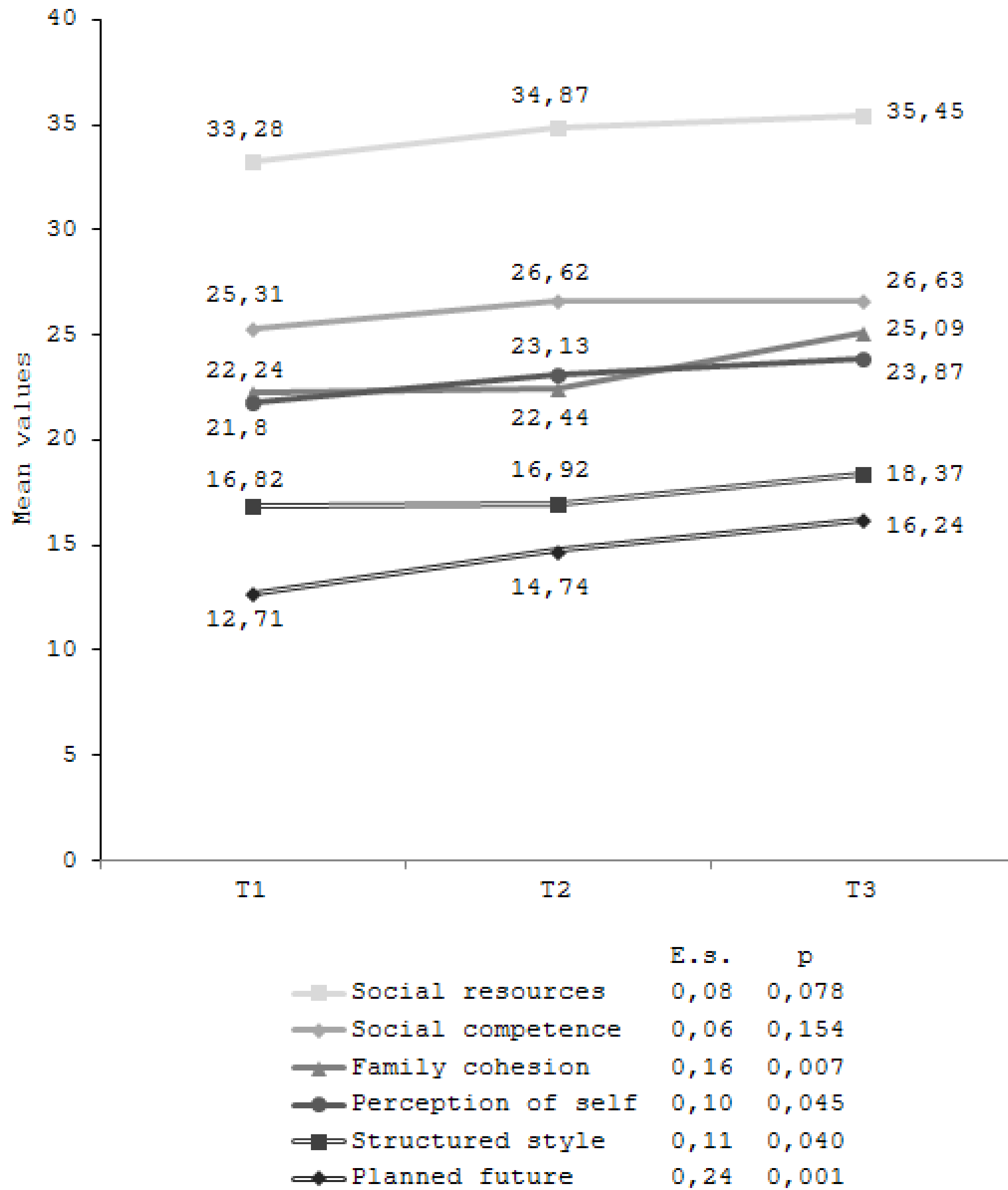

Figure 6. Changes of values of the resilience variables. (E.s.- effect size – eta squared)

RELATIONSHIP AND COMPARISONS OF THE DEMOGRAPHIC CHARACTERISTICS AND SYMPTOMS

We found that there is significant relationship among the sociodemographic characteristics and variables we investigated (expression of symptoms, distress, motivation and resilience).

Relationship between the patients' sex and investigated variables

The group consisted of 77 (81%) women and 18 (19%) men. Women had significantly worse subjective well-being estimates (M=9.75, SD=3.48 women and M=7.83, SD=3.11 men, p=0.035), tendency to associate their illness with psychological reasons was significantly greater (women M=31.56, SD=3.95; men M=29.06, SD=5.43; p=0.027), also women had significantly higher overall ratings of motivation for psychotherapy (women M=170.05, SD=12.39; men M=163.44, SD=11.93; p=0.043) at the beginning of the treatment. Women had higher estimates of the illness etiology (women M=32.51, SD=4.39; men M=29.83, SD=7.06; p=0.043) and overall assessment of motivation for psychotherapy (women M=175.58, SD=14.01; men M=164.67, SD=18.11; p=0.006); they also had a significantly greater openness to psychotherapy (women M=77.40, SD=14.01; men M=72.33, SD=10.19; p=0.021) and social competence (women M=27.84, SD=8.00; men M=23.78, SD=6.60; p=0.048) than the men at the end of the treatment. Women's general openness to psychotherapy estimates were still higher compared with men (women M=75.27, SD=9.85; men M=69.14, SD=9.46; p=0.043) after the follow-up period.

Relationship between the patients' marital status and investigated variables

65 (68.4%) patients lived with their family and 30 (31.6%) lived alone. Individuals, who live with the family, had better psychological resilience. Starting the treatment in the PDC, patients living with the family had a significantly higher estimates of the family cohesion (with family M=24.78, SD=8.04; alone M=17.41, SD=8.76; p=0.0000), social resources (with family M=35.03, alone M=29.11, SD=8.06; p=0.001), structured style (with family M=17.57, SD=5.44; alone M=14.69, SD=5.25; p=0.014) subscales, and their overall psychological resilience was higher comparing it against single patients (with family 135.63, SD=24.43; alone 117.71, SD=25.26; p=0.001). After the treatment the patients living with the family had higher estimates of the family cohesion (with family M=24.22, SD=8.60; alone M=19.46, SD=8.50; p=0.010), and the planned future (with family M=15.15, SD=6.43; alone M=12.24, SD=8.50; p=0.042) subscales. Persons living with the family had higher estimates in family cohesion (with family M=26.84, SD=7.28; alone M=22.08, SD=10.17; p=0.036) and social resources subscales (with family M=37.50, SD=7.43; alone M=32.58, SD=9.70; p=0.028). However those living alone had higher estimates of expectations of psychotherapy (with family M=29.58, SD=3.89; alone M=35.52, SD=3.87; p=0.006) after the follow-up period.

Relationship between the patients' activity and investigated variables

54 (56.8%) employed, 20 (21.1%) students and 21 (22.1%) unemployed persons were in the target group. We found that the expression of certain variables was significantly

related to the activity of the subjects before the treatment. The employed persons had the highest overall motivation for psychotherapy (employed M=172.07, SD= 12.39; unemployed M=165.00, SD=11.77; students M=162.28, SD=10.40; p=0.004), they were more likely to understand their illness etiology psychologically (employed M=32.26, SD=3.94; unemployed M=29.74, SD=4.54; students M=28.72, SD=4.25; p=0.003), and their estimates of openness to psychotherapy were highest (employed M=73.21, SD=7.29; unemployed M=68.42, SD=4.96; students M=68.44, SD=6.66; p=0.005) at the beginning of the treatment. Students had the lowest estimates of their well-being, that means the best well- being (employed M=9.81, SD=3.47; unemployed M=10.05, SD=3.14; students M=9.38, SD=3.48; p=0.013), and also had the best planned future (employed M=11.53, SD=6.83; unemployed M=9.11, SD=4.22; students M=15.06, SD=5.24; p=0.016). Unemployed individuals rated the worst their well-being (employed M=6.84, unemployed M=9.16, SD=3.29; students M=5.83, SD=3.65; p=0.012) and functioning (employed M=18.84, SD=7.10; unemployed M=23.95, SD=8.58; students M=15.83, SD=7.78; p = 0.005), as well as their estimates of planned future were the lowest (employed M=14.40, SD=6.02; unemployed M=10.00, SD=6.06; students M=17.44, SD=7.42; p=0.002) after the treatment. No differences were found between the groups after the follow-up period.

Relationship between the patient age and investigated variables

Expression of the certain variables had a relationship with age. The results of our study showed that the older the person was, the more he/she was motivated for psychotherapy and experienced better family cohesion before the treatment. We found that estimates of separate symptoms - depression, anxiety, anger – and overall estimate of psychopathological symptoms remained significantly higher for the older persons, they also had more problems and worse recognition of their well-being after the treatment. The older person was, the smaller was his/her expectations of the psychotherapy and the worse was his/her planned future after the treatment. Expectations of psychotherapy still remained smaller half a year after the treatment.

Table 1. Relationship between the age of the patients with variables throughout the study period

VARIABLES	***MEASUREMENT***		
	T1	**T2**	**T3**
SYMPTOMS			
Depression	0,05	0,32**	0,10
Anxiety	0,09	0,23*	0,13
Anger	0,03	0,30**	0,01
Total	0,04	0,32**	0,06
DISTRESS			
Well-being	0,08	0,21*	0,07
Problems	0,15	0,27**	0,06
Functioning	0,04	0,14	0,09
Risk	-0,08	-0,08	0,05
Total	0,09	0,22*	0,07
MOTIVATION			
Suffering	0,15	0,20	0,22
Etiology	0,08	0,05	-0,12
Expectations	-0,15	-0,21*	-0,32*
Openness	0,24*	0,09	-0,11
Total	0,17	0,10	-0,08

VARIABLES	*MEASUREMENT*		
RESILIENCE			
Perception of self	-0.06	-0,13	-0,07
Planned future	-0,19	-0,25*	-0,25
Social competence	0,06	0,01	-0,01
Family cohesion	0,39***	0,16	0,13
Social resources	0,19	-0,01	0,01
Structured style	0,11	0,01	0,07
Total	0,20	-0,01	0,03

Note. ** $p < 0,01$; * $p < 0,05$. T1 – first measurement, T2 – second measurement, T3 – third measurement.

THE DIFFERENCES BETWEEN THE PATIENTS WITH AFFECTIVE AND NEUROTIC DISORDERS

Significant differences were found between individuals with affective and neurotic disorders, evaluating manifestation of psychopathological symptoms, distress, motivation for psychotherapy and psychological resilience.

Individuals who have been diagnosed with affective disorders, exhibited poorer mental status and lower resilience - they stressed depressive symptoms significantly more (affective M=58.55, SD=18.78; neurotic M=47.93, SD=19.73; p=0.016), had a higher risk scale scores (affective M=0.63, SD=0.62; neurotic M=0.36, SD=0.41; p=0.032), evaluated lower their well-being (affective M=9.98, SD=3.48; neurotic M=8.47, SD=3.11; p=0.050), their perception of self was worse (affective M=19.98, SD=5.23; neurotic M=22.48, SD=5.27; p=0.041) as well as their planned future (affective M=9.62, SD=5.56; neurotic M=14.69, SD=5.78; p=0.000) than in the group of patients with neurotic disorders at the beginning of the treatment. The patients' with affective disorders estimates of depression remained higher (affective M=45.29, SD=21.41; neurotic M=30.03, SD=15.21; p=0.000), and future planning skills worse (affective M=11.98, SD=6.01; neurotic M=16.63, SD=6.87; p=0.002) compared with patients who suffered from neurotic disorders, but those with affective disorders became more open to psychotherapy (affective M=78.41, SD=7.55; neurotic M=72.57, SD=9.25; p=0.002) and distinguished for higher overall motivation (affective M=177.14, SD=13.03; neurotic M=167.33, 17.73; p=0.004) at the end of the six week treatment in PDC. The condition of patients with affective disorders still remained worse compared to patients with the group of neurotic disorders: estimates of depression further remained higher (affective M=39.95, SD=23.17; neurotic M=27.56, SD=14.64; p=0.043), estimates of anxiety relatively increased (affective M=31.68, SD=21.33; neurotic M=19.50, SD=14.41; p=0.033), and naturally, the suffering they experienced was higher (affective M=32.82, SD=6.95; neurotic M=29.00, SD=3.91; p=0.035), and they evaluated subjectively worse their well-being (affective M=7.45, SD=4.13; neurotic M=4.67, SD=2.74; p=0.012) six months after the treatment in PDC. Estimates of functioning (affective M=19.68, SD=8.40; neurotic M=14.94, SD=7.42; p=0.046), and general distress (affective M=50.89, SD=25.11; neurotic M=35.72, SD=17.18; p=0.024) were higher of the affective disorders patients' group than the group of neurotic patients who testified to worse functioning and distress. Individuals with affective disorders did not plan their future so well as sufferers from neurotic disorders (affective M=13.95, SD=7.37; neurotic M=20.50, SD=3.41; p=0.001).

THE DIFFERENCES BETWEEN PSYCHOTHERAPY AND COMBINED TREATMENT GROUPS

Significant differences were found between the groups of patients who were treated by psychotherapy versus combined treatment evaluating manifestation of psychopathological symptoms, distress, motivation for psychotherapy and psychological resilience.

Patients who were treated only by psychotherapy were characterised by a better mental condition - they had less pronounced symptoms of depression, anxiety and anger, and also they had a lower overall symptoms score at the beginning of the treatment.

Table 2. Mean estimates of symptoms at the beginning of treatment and their comparison

	Psychotherapy		Combined			
Scale	**Mean**	**SD**	**Mean**	**SD**	**t**	**p**
Depression T1	37,71	17,09	57,89	18,37	3,83	**0,000**
Anxiety T1	36,43	19,45	50,15	21,61	2,22	**0,029**
Anger T1	28,29	15,42	41,04	18,59	2,42	**0,017**
GPI T1	119,50	49,92	166,67	57,83	2,87	**0,005**

Note. Mean – mean, SD – standard deviation, t – Student's t-test.

Patients from the psychotherapy treatment group better perceived themselves (psychotherapy M=25.43, SD=4.50; combined M=20.27, SD=5.36; p=0.001) and subjectively better assessed their well-being, had fewer problems, and their overall distress estimates were lower than the combined treatment group.

Table 3. Mean estimates of psychological distress at the beginning of treatment and their comparison

	Psychotherapy		Combined			
Scale	**Mean**	**SD**	**Mean**	**SD**	**t**	**p**
Well-being T1	6,93	2,43	9,81	3,47	2,98	**0,004**
Problems T1	22,57	8,73	29,95	8,92	2,86	**0,005**
Functioning T1	22,93	8,41	27,64	8,55	1,91	0,060
Risk T1	2,07	2,40	3,37	3,58	1,31	0,194
Total T1	51,86	18,48	68,06	20,61	2,75	**0,007**

Note. Mean – mean, SD – standard deviation, t – Student's t-test.

Patients treated only by psychotherapy had lower motivation for psychotherapy – they experienced smaller suffering caused by illness, were less likely to link the origin of their illness with psychological factors, and had a lower overall evaluation of motivation for psychotherapy, compared with the patients treated with the combined method.

Table 4. Mean estimates of motivation for psychotherapy at the beginning of treatment and their comparison

	Psychotherapy		Combined			
Scale	**Mean**	**SD**	**Mean**	**SD**	**t**	**p**
Suffering T1	31,00	5,19	36,01	5,32	3,27	**0,002**
Etiology T1	28,79	5,04	31,48	4,12	2,18	**0,031**
Expectations T1	31,71	3,52	30,99	4,09	-0,63	0,533
Openness T1	68,07	6,92	71,92	7,02	1,89	0,061
Total T1	159,57	11,79	170,40	12,01	3,12	**0,002**

Note. Mean – mean, SD – standard deviation, t – Student's t-test.

Patients who were treated only by psychotherapy, after it, had less pronounced depression symptoms (psychotherapy M=27.14, SD=12.06; combined M=41.73, SD=20.85; p=0.013) and anger (psychotherapy M=23.79, SD=14.07; combined M=34.30, SD=17.54; p=0.036) not only compared with their condition at the beginning of treatment, but also compared them with patients who received combined treatment. Also the group of patients who received psychotherapy understood the etiology of the illness as more somatic (psychotherapy M=28.57, SD=7.73; combined M=32.57, SD=4.25; p=0.005), they became less open to psychotherapy (psychotherapy M=70.57, SD=11.71; combined M=77.46, SD=7.35; p=0.004), and had a lower overall motivation than the combined treatment group (psychotherapy M=161.21, SD=19.08; combined M=175.64, SD=13.69; p=0.001). Patients treated by psychotherapy were better in planned future compared with the combined treatment group (psychotherapy M=20.70, SD=4.37; combined M=15.69, SD=7.34; p=0.008) after the follow-up period.

RELATIONSHIPS BETWEEN VARIABLES

We analyzed the relationships between the variables. The results showed that all the investigated parameters were interrelated at the beginning of treatment.

Table 5. General relationships between the scales at the first measurement (beginning of the treatment)

	O. Symptoms	O. Motivation	O. Distress	O. Resilience
O. Symptoms	1			
O. Motivation	0,55***	1		
O. Distress	0,83***	0,54***	1	
O. Resilience	-0,37***	-0,31**	-0,56***	1

Note. *** P <0.001, ** p <0.01, * p <0.05. O. Symptoms - the total symptom score, O. Motivation - overall assessment of motivation, O. Distress - overall assessment of distress, O. Resilience – overall psychological resilience rating.

The only one relationship changed – there were no more correlation between motivation for psychotherapy and psychological resilience after the treatment.

Table 6. General relationships between the scales at the second measurement (after treatment)

	O. Symptoms	O. Motivation	O. Distress	O. Resilience
O. Symptoms	1			
O. Motivation	0,36***	1		
O. Distress	0,83***	0,31**	1	
O. Resilience	-0,50***	-0,13	-0,62***	1

Note. *** P <0.001, ** p <0.01, * p <0.05. O. Symptoms - overall symptom score, O. Motivation - overall assessment of motivation, O. Distress - overall assessment of distress, O. Resilience – overall psychological resilience rating.

Motivation for psychotherapy already was related with the symptoms only, but had no relationship with the subjectively evaluated distress or psychological resilience after six months of treatment.

Table 7. General relationships between the scales at the third measurement (follow-up)

	O. Symptoms	O. Motivation	O. Distress	O. Resilience
O. Symptoms	1			
O. Motivation	0,32*	1		
O. Distress	0,93***	0,22	1	
O. Resilience	-0,46***	0,01	-0,59***	1

Note. *** P <0.001, ** p <0.01, * p <0.05. O. Symptoms - overall symptom score, O. Motivation - overall assessment of motivation, O. Distress - overall assessment of distress, O. Resilience – overall psychological resilience rating.

RELATIONSHIP BETWEEN MOTIVATION FOR PSYCHOTHERAPY AND EXPRESSION OF SYMPTOMS OVER TIME

In order to determine the relationship between motivation for psychotherapy and expression of symptoms over time, when the pre-existing relationship between them are controlled, we tested the model presented in Figure 7. We controlled the gender and age effects in each of the 13 tested models evaluating the relationships between motivation for psychotherapy and symptoms expression. Indicators of tested models' appropriateness were ideal for the data ($\chi^2 = 0.00$, $p = 0.00$, $df = 0$, CFI = 1.00, TLI = 1.00, RMSEA = 0.00). When the degree of freedom was zero (df), models always fitted the data. Models' results are presented in Table 8. In Table 8 the first four columns show that both the symptoms and the separate aspects of motivation for psychotherapy remains relatively stable over time (e.g., standardized depression autoregressive coefficients for all models ranged from 0.42 to 0.52).

The results indicated that the initial symptoms' assessment led to predict subsequent symptoms' evaluation values. Similarly, initial measurements of the motivation for psychotherapy allowed prediction of subsequent motivation for psychotherapy evaluation values with the exception of openness between the second and third measurement.

A cross-lagged analysis of preliminary data helped not only to assess stability of the expression of symptoms and motivation for psychotherapy, but also to answer the question about the relationship direction - whether the expression of symptoms determines the motivation for psychotherapy or motivation for psychotherapy determines manifestation of symptoms over time. The results show that only one aspect of motivation (Negative Illness conequences/suffering) determines changes of symptoms (anxiety) after treatment. However, other aspects of motivation for psychotherapy did not determine the expression of symptoms over time.

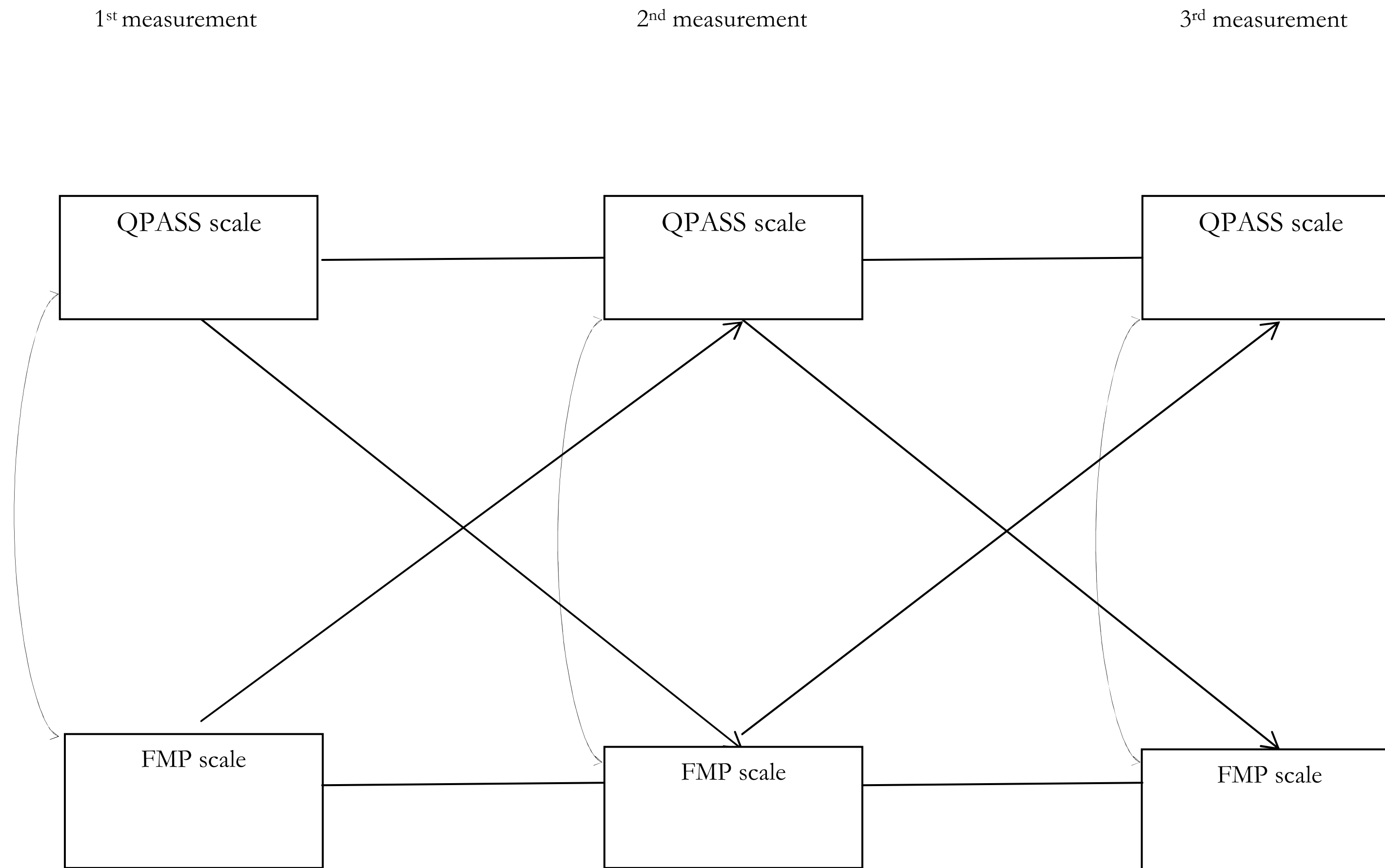

Figure 7. The conceptual testing model between the expression of the symptoms and motivation for psychotherapy

Table 8. Standardized models' coefficients evaluated using cross-lagged analysis

	Stability				**Direction**			
Model	Qpass T1 – Qpass T2	Qpass T2 – Qpass T3	Mot T1 – Mot T2	Mot T2 – Mot T3	Mot T1 – Qpass T2	Mot T2 – Qpass T3	Qpass T1 – Mot T2	Qpass T2 – Mot T3
Dep – Suf	0,42***	0,51***	0,43***	0,37***	0,09	0,08	0,29***	0,11
Dep – Etio	0,46***	0,51***	0,43***	0,31**	0,04	0,11	0,22*	0,14
Dep – Exp	0,47***	0,52***	0,39***	0,47***	0,07	0,01	0,18*	0,10
Dep – Ope	0,47***	0,53***	0,35***	0,14	-0,01	0,04	0,11	0,11
Anx – Suf	0,53***	0,32**	0,53***	0,60***	0,05	0,33*	0,14	-0,21
Anx – Etio	0,56***	0,35**	0,39***	0,30*	-0,01	-0,04	0,32*	0,04
Anx – Exp	0,56***	0,35**	0,39***	0,45***	0,08	0,08	0,30**	0,04
Anx – Ope	0,56***	0,37**	0,34***	0,14	-0,01	0,06	0,12	0,01
Ang – Suf	0,48***	0,25*	0,53***	0,55***	0,08	0,12	0,13	-0,14
Ang – Etio	0,51***	0,27*	0,44***	0,27*	-0,01	0,10	0,18*	0,05
Ang – Exp	0,52***	0,24*	0,36***	0,49***	-0,01	0,14	0,21*	0,06
Ang – Ope	0,52***	0,34**	0,36***	0,13	-0,03	0,24	0,08	0,02
Total – Total	0,53***	0,37**	0,38***	0,09	0,03	0,16	0,31***	0,04

Note. *** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$. Qpass T1 - Qpass T2 stability of separate questionnaire scales (depression, anxiety, anger, and general psychopathology) - how the first measurement can predict the second measurement, and Qpass T2 - Qpass T3 stability of separate questionnaire scales - how the second measurement can predict the third measurement, Mot T1 - Mot T2 stability of motivation for psychotherapy scales (suffering, etiology, expectations, openness) - how the first measurement can predict a second measurement, and Mot T2 – Mot T3 stability of motivation for psychotherapy scales - how the second measurement can predict the third measurement: Mot T1 - Qpass T2 how separate scales of motivation questionnaire at the first measurement predicts the symptoms at the second measurement, and Mot T2 - Qpass T3 how separate scales of motivation questionnaire at the second measurement predicts the symptoms at the third measurement; Qpass T1 – Mot T2 how symptoms at the first measurement predicts motivation for psychotherapy at the second measurement, and Qpass T2 – Mot T3 how symptoms at the second measurement predicts motivation for psychotherapy at the third measurement. Each model has only two variables - one of Qpass questionnaire, and the other of Motivation for psychotherapy questionnaire, and stability of these two variables and their ability to predict one another were evaluated in this model. Dep - Depression, Anx - anxiety, Ang – anger, Suf - suffering, Etio - etiology, Exp – expectations, Ope – openness.

The results also showed that the expression of symptoms might determine aspects of motivation for psychotherapy over time. Depressive symptoms might determine the experience of suffering ($\beta = 0.29$, $p < 0.001$) when previous experience of suffering was controlled. The more depressive symptoms patients had before treatment, the more they suffered during treatment. Depression, anxiety and anger determined the etiology of the illness and the general expectations of psychotherapy. The more of the symptoms patients had and the more they were pronounced at the beginning of treatment, the more psychologically patients understood their illness etiology and their expectations for psychotherapy continued to grow during treatment. Comparing patients who received only psychotherapy and combined treatment, we found that openness for psychotherapy immediately after treatment could predict depressive symptoms a half-year after the treatment in patients who had been treated by psychotherapy ($\beta = 0.55$, $p < 0.001$). This relationship was positive, which indicates a higher openness to psychotherapy of those patients at the end of the treatment determined higher depressive symptoms a half-year after the treatment.

RELATIONSHIP BETWEEN PSYCHOLOGICAL RESILIENCE AND EXPRESSION OF SYMPTOMS OVER TIME

In order to determine the relationship between psychological resilience and the expression of symptoms over time, when pre-existing relationships between them were controlled, we tested the model presented in Figure 8. We controlled the gender and age effects in all of the 19 tested models assessing the relationships between psychological resilience and expression of the symptoms. Indicators of the tested models' appropriateness were ideal for the data ($\chi^2 = 0.00$, $p = 0.00$, $df = 0$, CFI = 1.00, TLI = 1.00, RMSEA = 0.00). When the degree of freedom was zero (df), models always fitted the data. The models' results are presented in Table 9. The results of models, presented in the first four columns of the Table 9 show that both the separate symptoms and the separate aspects of psychological resilience remained relatively stable over time. Separate components of psychological resilience were relatively stable between the two measurements, which suggested that previous psychological resilience of the person determined subsequent psychological resilience. The results indicate that the initial symptom assessment allows prediction of subsequent symptoms' score values. Only one aspect of the resilience (planned future) determines changes of symptoms (anger) after treatment.

The better planned future was immediately after treatment, the lower estimates of anger were half a year after treatment. However, other aspects of psychological resilience did not determine the expression of symptoms over time.

The results indicated that the expression of symptoms, or to be more specific anger, could determine structured style between the first and the second measurements. The higher were the estimates of the patients' symptoms of anger, the worse was their structured style during treatment. None of the other symptoms determined psychological resilience over time.

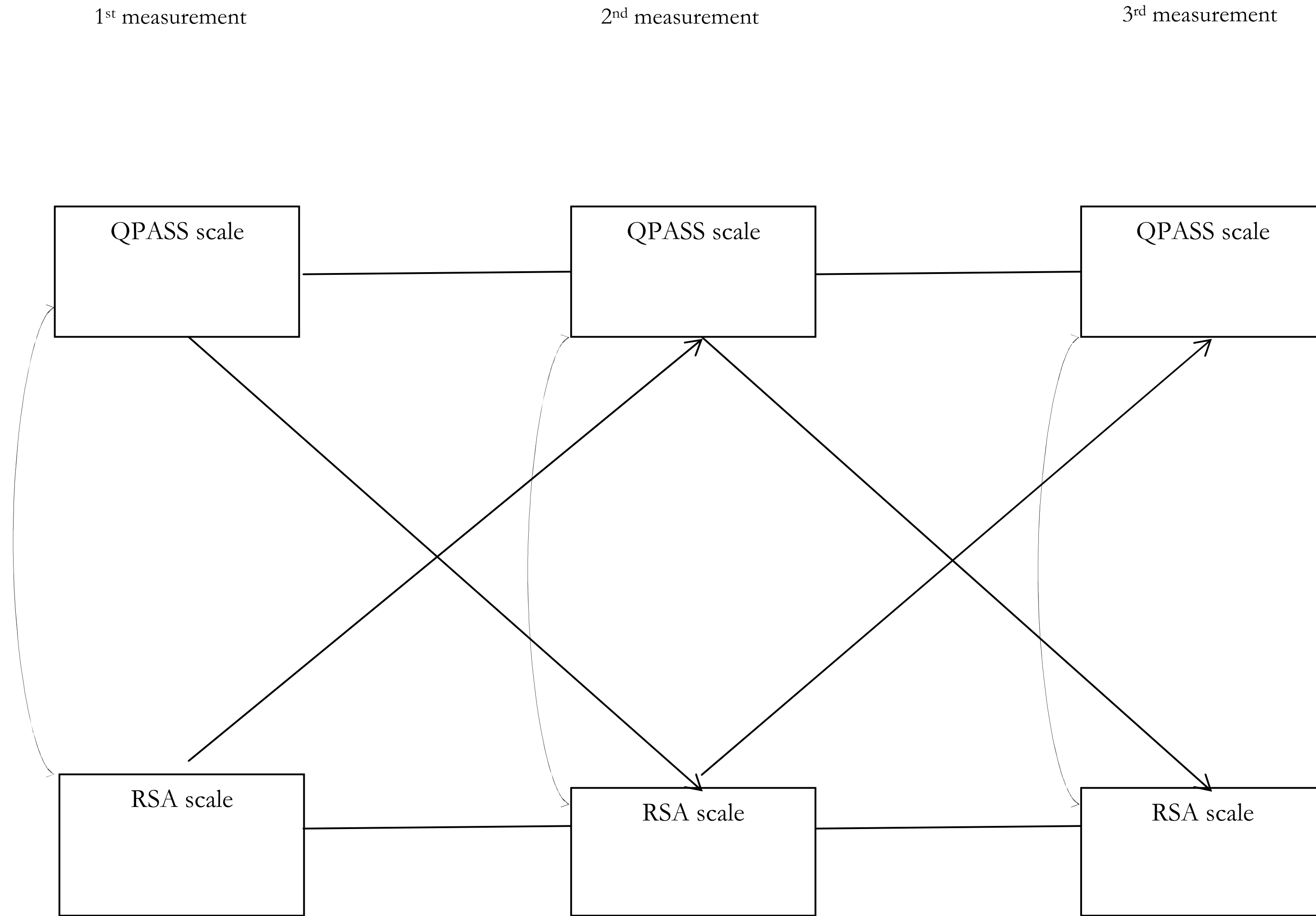

Figure 8. The conceptual testing model between the expression of the symptoms and psychological resilience

Table 9. Standardized models' coefficients evaluated using cross-lagged analysis

	Stability				Direction			
Model	Qpass T1 – Qpass T2	Qpass T2 – Qpass T3	RSA T1 – RSA T2	RSA T2 – RSA T3	RSA T1 – Qpass T2	RSA T2 – Qpass T3	Qpass T1 – RSA T2	Qpass T2 – RSA T3
Dep - Perself	0,42***	0,55***	0,61***	0,34**	-0,12	0,06	-0,05	-0,20
Dep - Future	0,48***	0,42***	0,57***	0,60***	0,01	-0,18	0,01	0,08
Dep - Soccom	0,48***	0,48***	0,77***	0,54***	0,05	-0,14	0,01	-0,03
Dep - Struc	0,47***	0,54***	0,65***	0,40***	-0,01	0,09	0,16	-0,05
Dep - Fam	0,44***	0,57***	0,81***	0,51***	-0,11	0,17	0,01	0,01
Dep - Socres	0,47***	0,56***	0,73***	0,40**	-0,01	0,11	-0,02	-0,03
Anx - Perself	0,55***	0,35**	0,65***	0,44***	-0,01	-0,03	0,03	-0,07
Anx - Future	0,56***	0,26*	0,60***	0,57***	0,01	-0,20	0,00	0,05
Anx - Soccom	0,56***	0,33**	0,78***	0,57***	0,06	-0,06	-0,02	0,01
Anx - Struc	0,55***	0,38**	0,62***	0,43***	-0,08	0,10	0,12	0,01
Anx - Fam	0,54***	0,37**	0,82***	0,50***	-0,09	0,06	0,04	0,05
Anx - Socres	0,55***	0,36**	0,74***	0,41**	-0,03	0,04	0,01	-0,01
Ang - Perself	0,48***	0,20	0,67***	0,43***	-0,09	-0,18	0,08	-0,11
Ang - Future	0,50***	0,04	0,58***	0,57***	-0,07	-0,48**	0,04	0,00
Ang - Soccom	0,52***	0,30*	0,78***	0,61***	0,07	0,02	-0,05	0,11
Ang - Struc	0,52***	0,32*	0,64***	0,43***	0,04	0,09	-0,16*	0,01
Ang - Fam	0,49***	0,33*	0,83***	0,54***	-0,09	0,08	0,03	0,10
Ang - Socres	0,51***	0,20	0,75***	0,43**	-0,01	-0,20	0,03	0,02
Total - Total	0,54***	0,36*	0,67***	0,61***	-0,01	-0,06	0,04	0,06

Note. *** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$. Qpass T1- Qpass T2 – stability of separate questionnaire scales (depression, anxiety, anger, and general psychopathology) (how the first measurement can predict the second measurement), Qpass T2- Qpass T3 - stability of separate questionnaire scales (how the second measurement can predict the third measurement), RSA T1- RSA T2 – stability of psychological resilience scales (perception of self, planned future, social competence, structured style, family cohesion, social resources) (how the first measurement can predict the second measurement), and RSA T2- RSA T3 - stability of psychological resilience scales (how the second measurement can predict the third measurement); RSA T1- Qpass T2 - how separate scales of psychological resilience at the first measurement predict the symptoms at the second measurement, and RSA T2- Qpass T3 - how separate scales of psychological resilience at the second measurement predict symptoms in the third measurement; Qpass T1-Re T2 - how symptoms at the first measurement predict psychological resilience at the second measurement, and Qpass T2- Re T3 - how symptoms at the second measurement predict psychological resilience at the third measurement. Each model had only two variables - one from Qpass questionnaire and another from RSA questionnaire, and stability of these two variables and their ability to predict one another were evaluated in this model. Dep - Depression, Anx - anxiety, Ang - anger, Perself – perception of self, Future – planned future, Soccom - social competence, Struc - structured style, Fam - family cohesion, Socres - social resources.

COMPARISON OF THE TREATMENT EFFECTIVENESS BETWEEN THE TARGET AND CONTROL GROUPS

Anxiety and overall psychopathology symptoms estimates were significantly higher for the group of patients treated in PDC, they also were characterized by a lower perception of self, smaller family cohesion, worse social resources, inferior structured style and lower rating of overall psychological resilience compared to MHC patients at the beginning of the treatment. In summary, MHC patients suffered from significantly fewer symptoms and their psychological resilience was significantly higher.

Both PDC and MHC patients had significantly less depression, anxiety, anger, and overall psychopathological symptoms after the treatment. It was observed during the study that the treatment process significantly improved perception of self, planned future, increased social competence, and increased overall evaluation of psychological resilience. It should be noted that both PDC and MHC patients have improved exactly the same psychological resilience components.

The obtained results showed that patients of our research treated in PDC and MHC evaluating expression of symptoms and psychological resilience differed at the beginning of the treatment. During the treatment, all patients' symptoms significantly reduced, and certain psychological resilience components significantly increased.

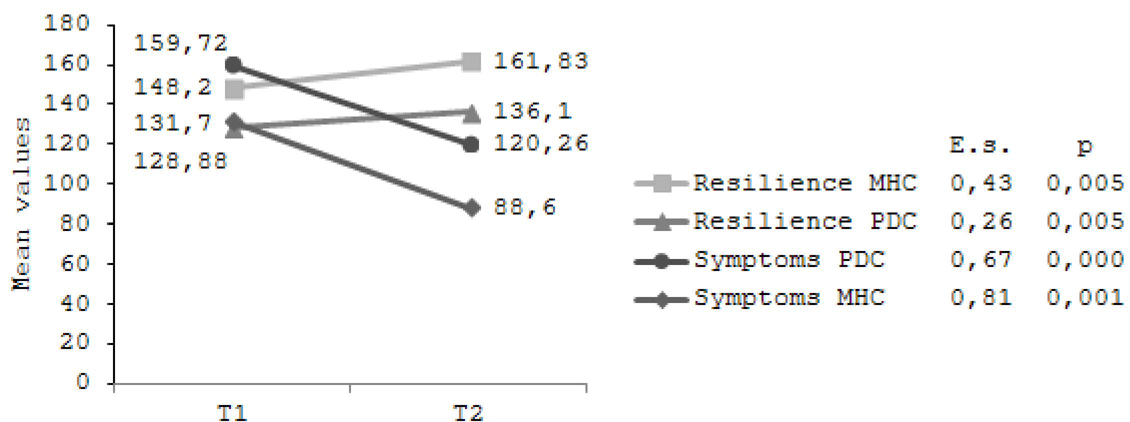

Figure 9. Changes of symptoms and resilience for PDC and MHC patients. (E.s.- effect size – Cohen's d)

CONCLUSIONS

1. We found that the expression of the studied variables (psychopathological symptoms, distress, motivation for psychotherapy and psychological resilience) significantly changed during and after the treatment.
    1.1. All of the symptoms decreased, which suggests that the treatment in PDC was effective.
    1.2. Distress of the patients decreased.
    1.3. Overall motivation, as well as the experience of suffering the illness, etiology, and openness to psychotherapy had changed.
    1.4. Overall resilience, perception of self, planned future, family cohesion and structured style had improved.
2. We established that significant relationships were between the sociodemographic characteristics and studied variables.
    2.1. Particular variable estimates of women differed significantly from those of men: women significantly poorer assessed their well-being, etiology of illness connected more with psychological reasons, and had a higher overall motivation for psychotherapy at the beginning and after the treatment. At the end of treatment, women stood out with bigger openness to psychotherapy and higher social competence. Estimates of women's openness to psychotherapy remained higher at the end of observation period.
    2.2. Persons living with the family stood out with the better psychological resilience.
    2.3. Employed persons had the highest overall motivation for psychotherapy at the beginning of treatment. Students had the best planned future and they had the highest estimates of their future and well-being. After the treatment unemployed persons estimated their well-being and functioning as worse and stood out with the worst future planning.
    2.4. The older a person was, the more motivated he/she was for psychotherapy and experienced the more cohesive family before the treatment. After the treatment significantly higher scores of the symptoms, lower well-being scores, lower expectations for psychotherapy, and worse planned future persisted for older persons.
3. Significant differences were established between the patients with affective and neurotic disorders.
   Group of patients with affective disorders was characterized by poorer mental condition and a lower resilience throughout the all study period.
4. Significant differences were established between the patients treated by psychotherapy and combined treatment.
   Patients treated only by psychotherapy were characterized by a better mental condition and lower motivation for psychotherapy at the beginning of the treatment and after it. After follow-up their planned future was significantly higher.
5. We found that patients of target (PDC) and control (MHC) groups differed significantly at the beginning of the treatment: MHC patients suffered from significantly fewer symptoms and their psychological resilience was significantly higher. All of the symptoms significantly decreased for patients in both groups during treatment, while the particular components of psychological resilience significantly improved.

PRACTICAL RECOMMENDATIONS

1. Routine clinical outcome measurement instrument (Outcome Measure CORE-OM) according to the results of its validation process is recommended for daily use for psychologists and psychotherapists working in all chains who wish to assess the effectiveness of their work and the progress the patients achieved.
2. Resilience scale for adults (Resilience Scale for Adults, RSA), on the basis of its reliability results, is recommended for use in evaluating the psychological resilience of the patients and its changes.
3. The results indicate that improvement of condition reached during psychotherapeutic treatment partially regressed during the follow-up period (some of the patients developed increased depressive symptoms, their openness to psychotherapy decreased, their illness was taken to understand more somatic). The only possible explanation of this process is that this phenomenon may be associated with a too short duration of treatment in the PDC, because newly discovered and/or learned subjects not keep up with to become a stable part of the personality structure because of a lack of time for practicing. A longer duration of treatment in PDC is required - we see that symptomatic changes are achieved, but they lack of stability due to insufficient time to establish new patterns of behaviour.

CURRICULUM VITAE

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EDUCATION

1990 – 1997 Doctor of Medicine degree from Faculty of Medicine, Vilnius University
1997 – 2002 Psychiatry residency at Clinic of Psychiatry, Faculty of Medicine, Vilnius University
1998 – 2004 Studies of Individual psychodynamic psychotherapy at Faculty of Medicine, Vilnius University
2008 – 2010 Studies of Psychoanalytic psychotherapy training programme for teachers
Since 2008 PhD student at Clinic of Psychiatry, Faculty of Medicine, Vilnius University

PROFESSIONAL EXPERIENCE

1997 – 2002 Resident doctor at Clinic of Psychiatry, Faculty of Medicine, Vilnius University
1997 – 1998 Psychiatrist at Vilnius Clinical Psychotherapeutic Centre
1998 – 2010 Psychiatrist psychotherapist at Vilnius Mental Health Centre
2007 – 2008 Psychotherapist at Medical Diagnostic Centre
2007 – 2010 Psychiatrist psychotherapist at Vilnius Psychotherapy Study Centre
Since 2009 Psychiatrist psychotherapist at Old town Psychiatry and Psychotherapy Centre

PEDAGOGICAL ACTIVITIES

Since 2002 assistant at Clinic of Psychiatry, Faculty of Medicine, Vilnius University
Since 2007 Teacher at Individual Psychodynamic Psychotherapy Training programme and a member of training committee, Vilnius university
2008 – 2011 Teacher at Group Psychodynamic Psychotherapy Training programme, Vilnius University

MEMBERSHIPS IN SOCIETIES

Lithuanian Society of Psychoanalysis (LPaD)
Lithuanian Psychiatric Association (LPA)
Society for Psychotherapy Research (SPR)

DISERTACIJOS SANTRAUKA

SANTRUMPOS

PDS	– Psichoterapijos dienos stacionaras
PSC	– Psichikos sveikatos centras
QPASS	– The Quick Psycho-Affective Symptoms Scan, Psichoemocinių simptomų anketa. Psichinės būklės sunkumui įvertinti naudota anketa.
CORE-OM	– Clinical Outcomes for Routine Evaluation – Outcome Measure, Klinikinių rezultatų vertinimo anketa. Naudojome matuoti pacientų išgyvenamą psichologinį distresą.
FMP	– Fragebogenzur Messung der Psychotherapiemotivation, Motyvacijos psichoterapijai anketa. Matavome pacientų motyvaciją psichoterapiniam gydymuisi.
RSA	– Resilience Scale for Adults, Suaugusiųjų atsparumo skalė. Psichologiniam atsparumui matuoti naudota anketa.

DARBO TIKSLAS

Nustatyti psichoterapijos dienos stacionaro pacientų, sergančių neuroziniais bei afektiniais sutrikimais, gydymo efektyvumą bei sociodemografinių veiksnių, psichopatologinių simptomų, psichologinio distreso, motyvacijos psichoterapiniam gydymuisi ir psichologinio atsparumo ryšius bei pokyčius laikui bėgant.

DARBO UŽDAVINIAI

1. Atrinkti ir parengti naudojimui metodikas, tinkamas įvertinti psichopatologinių simptomų išreikštumą, psichologinį distresą, motyvaciją psichoterapiniam gydymuisi ir psichologinį atsparumą.
2. Palyginti pacientų su afektiniais ir neurozinias sutrikimais psichopatologinių simptomų išreikštumą, psichologinį distresą, motyvaciją psichoterapiniam gydymuisi ir psichologinį atsparumą:
   a) gydymo PDS pradžioje,
   b) po 6 savaičių gydymosi PDS,
   c) praėjus 6 mėnesiams po gydymosi PDS.
3. Palyginti pacientų, kuriems taikytas psichoterapinis bei kombinuotas gydymas psichopatologinių simptomų išreikštumą, psichologinį distresą, motyvaciją psichoterapiniam gydymuisi ir psichologinį atsparumą:
   a) gydymo pradžioje,
   b) po 6 savaičių gydymosi PDS,
   c) praėjus 6 mėnesiams po gydymosi PDS.
4. Nustatyti pacientų sociodemografinių charakteristikų ryšį su psichopatologinių simptomų išreikštumu, psichologiniu distresu, motyvacija psichoterapiniam gydymuisi ir psichologiniu atsparumu ir palyginti juos:
   a) gydymo pradžioje,
   b) po 6 savaičių gydymosi PDS,
   c) praėjus 6 mėnesiams po gydymosi PDS.

5. Įvertinti simptomų, psichologinio distreso, motyvacijos psichoterapiniam gydymui ir psichologinio atsparumo pokyčius gydymo metu ir stebėjimo laikotarpiu.
6. Palyginti psichoterapiniame dienos stacionare ir psichikos sveikatos centre gydytų pacientų simptomų išreikštumą ir psichologinį atsparumą:
   a) gydymo pradžioje,
   b) po 6 savaičių gydymosi.

DARBO NAUJUMAS

Šio darbo metu buvo parengtos naudoti Lietuvoje keturios naujos anketos, skirtos įvertinti pacientų: 1) motyvaciją psichoterapiniam gydymuisi; 2) psichiatrinių simptomų išreikštumą; 3) psichoterapijos rezultatus ir 4) psichologinį atsparumą.

Šiame darbe pirmąsyk siekta išsiaiškinti, ar ir kaip pacientų motyvacija psichoterapiniam gydymuisi susijusi su gydymosi rezultatais struktūruota 6 savaičių trukmės programa psichoterapijos dienos stacionare (PDS).

Mokslinėje literatūroje, aptariant psichologinio atsparumo pokyčius, jo didinimą, dažniausiai kalbama apie kognityvinę elgesio terapiją ir potrauminio streso sutrikimo gydymą ar jo prevenciją. Duomenų apie psichodinamiškai orientuoto gydymo psichoterapijos dienos stacionare poveikį pacientų, kenčiančių nuo afektinių ir neurozinių sutrikimų, psichologiniam atsparumui rasti nepavyko.

Taip pat, mums žinomais literatūros duomenimis iki šiol nebuvo tyrinėtos pacientų su afektiniais bei neuroziniais sutrikimais psichologinio atsparumo bei motyvacijos gydytis psichoterapiškai tarpusavio sąsajos bei šių kintamųjų (motyvacijos ir atsparumo) pokyčiai gydymo metu ir stebėjimo laikotarpiu.

GINAMIEJI TEIGINIAI

1. Gydymasis psichoterapiname dienos stacionare statistiškai reikšmingai gerina pacientų psichinę būklę, mažiną distresą ir didina psichologinį atsparumą.
2. Psichinė būklė, distresas, motyvacija psichoterapiniam gydymuisi ir psichologinis atsparumas yra reikšmingai susiję su sociodemografiniais veiksniais.
3. Afektinių ir neurozinių sutrikimų pacientų grupėms gydymosi psichoterapiniame dienos stacionare efektas patikimai nesiskiria.
4. Pacientų su afektiniais ir neuroziniais sutrikimais gydymo rezultatai psichoterapijos dienos stacionare yra geresni nei pacientų su tais pačiais sutrikimais, gydytų psichikos sveikatos centruose.

TYRIMO MEDŽIAGA IR METODIKA

Darbas atliktas 2008 – 2012 Vilniaus universiteto Psichiatrijos klinikoje. Tyrimui atlikti buvo gautas Lietuvos bioetikos komiteto leidimas Nr. 158200-10-237-056LP27 (2010-10-06) bei leidimo papildymas Nr. 158200-237-PP1 (2011-02-09).

TIRIAMIEJI

Pagrindinę grupę sudarė Vilniaus miesto psichikos sveikatos centro Konsultacinio centro psichoterapiniame dienos stacionare besigydantys pacientai su afektiniais ir neuroziniais sutrikimais. Duomenims analizuoti naudotos imties dydis – 95 pacientai. Amžius – nuo 18 iki 60 metų; amžiaus vidurkis – 33.4 ±10.4 metai. Grupėje buvo 77 (81%) moterys ir 18 (19%) vyrų. Dirbančiųjų buvo 54 (56.8%), 20 (21.1%) moksleivių/studentų ir 21 (22.1%) nedirbantis asmuo. Su šeima gyveno 65 (68.4%), o 30 (31.6%) pacientų gyveno vieni. Nuo simptomų pasireiškimo pradžios iki atvykimo gydytis į PDS 11 (11.6%) pacientų truko mažiau nei mėnesį, 51 (53.7%) užtruko iki metų, o net 31 (32.6%) pacientui užėmė daugiau nei metus. Dviems trečdaliams tiriamųjų (65 (68.4%)) buvo diagnozuoti afektiniai sutrikimai (14 (21.5%) depresijos epizodas, o 51 (78.5%) – pasikartojantis depresinis sutrikimas). Neuroziniai sutrikimai diagnozuoti 30 (31.6%) pacientų, iš jų 15 (50%) – mišrus nerimo ir depresinis sutrikimas. Net 81 (85.3%) pacientas gydėsi kombinuotu būdu (combined treatment), ir tik 14 (14.7%) psychotherapeutic treatment.

Kontrolinę grupę, sudarė pacientai, besigydantys VšĮ Karoliniškių poliklinikos, VšĮ Žirmūnų psichikos sveikatos centro, VšĮ Šeškinės poliklinikos, VšĮ VU ligoninės Santariškių klinikos šeimos medicinos centro ir UAB Širvintų psichikos sveikatos centruose ir sutikę dalyvauti tyrime. Duomenims analizuoti naudotos imties dydis – 30 pacientų. Amžius – nuo 18 iki 60 metų; amžiaus vidurkis – 41.4±11.9 m. Grupę sudarė 4 (13.3%) vyrai ir 26 (86.7%) moterys. Ligos tukmė iki gydymosi PSC pradžios 5 (16.7%) pacientams buvo iki mėnesio, o 25 (83.3%) pacientams – iki metų. Visiems diagnozuotas pasikartojantis depresinis sutrikimas ir jie gydyti psichofarmakoterapiškai.

TYRIMO EIGA

Tyrimas buvo longitudinis, sudarytas iš trijų etapų:

Pagrindinės grupės pacientai buvo testuoti triskart:

1. Gydymo pradžioje (T1).
2. Gydymo pabaigoje (T2).
3. Pakartotinis matavimas (T3) – praėjus šešiems mėnesiams po gydymosi PDS pabaigos.

Kontrolinės grupės pacientai buvo tirti dukart:

1. Pirmas matavimas, T1 – atvykus įprastinio vizito pas psichiatrą.
2. Antras matavimas, T2 – atvykus sekančio vizito pas psichiatrą (po ~1,5 mėnesio). Naudotos QPASS ir RSA anketos.

TYRIMO METODIKA

Iš ligos istorijų buvo surinkti pacientų sociodemografiniai bei sirgimo ir gydymosi duomenys: amžius, lytis, diagnozė, užimtumas, šeiminė padėtis, gydymosi istorija, medikamentų vartojimas. Tyrime buvo panaudotos 4 anketos.

Psichinės būklės sunkumas vertintas Psichoemocinių simptomų anketa (The Quick Psycho-Affective Symptoms Scan – QPASS). Šiame tyrime naudojome tris (iš 8) šios anketos skales: depresijos, nerimo bei pykčio. Anketą sudaro 105 klausimai ir teiginai; pacientui reikia pažymėti tiksliausiai jo būseną per pastarąsias septynias dienas, įskaitant ir tyrimo dieną, nusakantį atsakymą. Vertinama Likerto skale nuo 0 (niekada) iki 4 (nuolat).

Skalių įverčiai lygūs jų klausimų įverčių sumai. Bendras psichopatologijos įvertis - BPI – tai visų klausimų įverčių suma. Kuo aukštesnis BPI įvertis, tuo labiau pacientas sutrikęs.

Motyvacija psichoterapiniam gydymui matuota Motyvacijos psichoterapijai anketa (Fragebogenzur Messung der Psychotherapiemotivation – FMP). Anketoje išskiriamos keturios skalės: Kančios. 2. Etiologijos. 3. Psichoterapinio gydymo lūkesčių. 4. Atvirumo psichoterapijai. Anketą sudaro 47 teiginai; pacientui reikia pažymėti labiausiai su jo nuomone ar patirtimi sutampantį atsakymą. Vertinama Likerto skale nuo 1 (visiškai sutinku) iki 5 (visiškai nesutinku). Skalių įverčiai lygūs jų klausimų įverčių sumai. Visų šios anketos klausimų įverčių suma atspindi bendrą motyvaciją psichoterapiniam gydymuisi. Kuo aukštesnis bendras įvertis, tuo labiau pacientas motyvuotas gydytis psichoterapiškai.

Klinikinių rezultatų vertinimo anketa (Clinical Outcomes for Routine Evaluation – Outcome Measure CORE-OM) Tai psichoterapijos veiksmingumui vertinti skirtas instrumentas, matuojantis psichologinio distreso lygį. CORE-OM anketa matuoja šiuos patiriamo distreso kintamuosius: Subjektyvią gerovę. 2. Problemas/simptomus. 3. Funkcionavimą. 4. Riziką. Anketą sudaro 34 teiginai; pacientui reikia pažymėti tiksliausiai jo būseną per paskutines septynias dienas nusakantį atsakymą. Vertinama Likerto skale nuo 0 (nė karto) iki 4 (dažniausiai arba nuolat). Skalių įverčiai lygūs jų klausimų įverčių sumai. Visų šios anketos klausimų įverčių suma atspindi bendrą psichologinio distreso lygį. Kuo aukštesnis bendras įvertis, tuo labiau pacientas išgyvena didesnį distresą.

Psichologiniam atsparumui matuoti naudota Suaugusiųjų atsparumo skalė (Resilience Scale for Adults – RSA). Skalė apima šešis atsparumo faktorius: Savęs suvokimas; 2. Ateities planavimas; 3. Struktūravimo stilius 4. Socialinė kompetencija 5. Šeimos sutelktumas 6. Socialiniai ištekliai. Anketą sudaro 33 klausimai ir teiginai; pacientui reikia pažymėti tiksliausiai jo įprastinę arba paskutiniojo mėnesio savijautą nusakantį atsakymą. Vertinama Likerto skale nuo 1 iki 7. Skalių įverčiai lygūs jų klausimų įverčių sumai. Bendras psichologinio atsparumo įvertis – tai visų klausimų įverčių suma. Kuo aukštesnis bedras įvertis, tuo didesniu psichologiniu atsparumu pasižymi pacientas.

IŠVADOS

1. Nustatėme, kad gydymo metu ir po jo tirtų kintamųjų (psichopatologinių simptomų, distreso, motyvacijos psichoterapiniam gydymuisi ir psichologinio atsparumo) išreikštumas statistiškai reikšmingai kito.
   1.1. Visi simptomai sumažėjo, kas leidžia teigti, kad gydymas PDS yra efektyvus.
   1.2. Sumažėjo pacientų distresas.
   1.3. Bendra motyvacija, taip pat ligos kančios patyrimas, etiologija ir atvirumas psichoterapijai pakito.
   1.4. Pagerėjo bendras atsparumas, savęs suvokimas, ateities planavimas, šeimos sutelktumas ir struktūravimo stilius.
2. Nustatėme, kad tarp sociodemografinių charakteristikų ir tirtų kintamųjų yra reikšmingos sąsajos.
   2.1. Moterų atskirų kintamųjų įverčiai reikšmingai skiriasi nuo vyrų: moterys gydymo pradžioje ir po jo reikšmingai prasčiau vertino savo gerovę, ligos etiologiją labiau siejo su psichologinėmis priežastimis ir pasižymėjo aukštesne bendra motyvacija psichoterapijai. Gydymo pabaigoje moterys išsiskyrė didesniu atvirumu psichoterapijai ir aukštesne socialine kompetencija. Stebėjimo laikotarpio gale moterų atvirumo psichoterapijai įverčiai ir toliau išliko aukštesni.
   2.2. Su šeima gyvenantys asmenys išsiskyrė geresniu psichologiniu atsparumu.

2.3. Dirbantys asmenys gydymo pradžioje pasižymi didžiausia bendra motyvacija psichoterapiniam gydymuisi. Moksleiviai/studentai pasižymi geriausiu ateities planavimu ir geriausiai vertina savo ateitį ir gerovę. Nedirbantys asmenys po gydymo savo gerovę ir funkcionavimą vertino prasčiausiai bei išsiskyrė prasčiausiu ateities planavimu.
2.4. Kuo vyresnis asmuo, tuo jis labiau motyvuotas psichoterapijai ir patiria didesnį šeimos sutelktumą iki gydymo. Po gydymo vyresniems asmenims išlieka reikšmingai aukštesni simptomų įvertinimai bei prastesnė savijauta ir mažesni lūkesčiai psichoterapijai bei silpnesnis ateities planavimas.

3. Nustatyti reikšmingi skirtumai tarp pacientų su afektiniais ir neuroziniais sutrikimais.
   Afektinių sutrikimų grupės pacientai viso tyrimo laikotarpiu pasižymėjo blogesne psichine būkle ir žemesniu atsparumu.
4. Nustatyti reikšmingi skirtumai tarp psichoterapiniu ir kombinuotu būdu besigydžiusių pacientų.
   Pacientai, gydęsi vien psichoterapiškai, gydymo pradžioje ir po jo pasižymėjo geresne psichine būkle ir žemesne motyvacija psichoterapijai. After follow-up jų ateities planavimas buvo reikšmingai aukštesnis.
5. Nustatėme, kad gydymo pradžioje statistiškai reikšmingai skyrėsi pagrindinės (PDS) ir kontrolinės (PSC) pacientai: PSC pacientus vargino ženkliai mažiau simptomų ir jų psichologinis atsparumas buvo reikšmingai didesnis. Gydymo metu abiejų grupių pacientams visi simptomai statistiškai reikšmingai sumažėjo, o atskiri psichologinio atsparumo komponentai statistiškai reikšmingai pagerėjo.

PRAKTINĖS REKOMENDACIJOS

Klinikinių rezultatų vertinimo anketa (Clinical Outcomes for Routine Evaluation – Outcome Measure CORE-OM), remiantis jos validizacijos proceso rezultatais, rekomenduojama kasdieniam naudojimui visose grandyse dirbantiems psichologams ir psichoterapeutams, kurie nori įvertinti savo darbo efektyvumą bei pacientų pasiektą progresą.

Atsparumo skalė suaugusiems (Resiliense Scale for Adults, RSA), remiantis jos patikimumo rezultatus, rekomenduojama naudoti pacientų psichologinio atsparumo ir jo pokyčių įvertinimui.

Gauti rezultatai rodo, kad psichoterapinio gydymo metu pasiektas būsenos pagerėjimas stebėjimo laikotarpio metu dalinai regresuoja (daliai pacientų sustiprėja depresijos simptomai, mažėja atvirumas psichoterapijai, savo susirgimas imamas suprasti labiau somatiškai). Vienintelis galimas šio proceso paaiškinimas – šis fenomenas gali būti susijęs su per trumpa gydymosi PDS trukme, nes naujai atrasti ir/ar išmokti dalykai nespėja tapti stabilia asmenybės struktūros dalimi dėl laiko praktikavimuisi stokos. Reikalinga ilgesnė gydymo trukmė PDS – matome, kad simptominiai pokyčiai pasiekiami, bet jų stabilumas nepakankamas, nes nepakanka laiko įsitvirtinti naujiems elgesio modeliams.

GYVENIMO APRAŠYMAS

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IŠSILAVINIMAS

1990 – 1997 Medicinos gydytojos studijos Vilniaus universiteto Medicinos fakultete
1997 – 2002 Psichiatrijos rezidentūra VU MF Psichiatrijos Klinikoje
1998 – 2004 Individualiosios psichodinaminės psichoterapijos studijos VU MF
2008 – 2010 Studijos Psichoanalitinės psichoterapijos mokytojų mokymo programoje
Nuo 2008 Doktorantė VU MF Psichiatrijos klinikoje

PROFESINĖ PATIRTIS

1997 – 2002 Gydytoja rezidentė Vilniaus universiteto Psichiatrijos Klinikoje
1997 – 1998 Psichiatrė Vilniaus m. klinikiniame psichoterapijos centre
1998 – 2010 Psichiatrė psichoterapeutė Vilniaus psichikos sveikatos centre
2007 – 2008 Psichoterapeutė Medicinos diagnostikos centre
2007 – 2010 Psichiatrė psichoterapeutė Vilniaus psichoterapijos studijų centre
nuo 2009 Psichiatrė psichoterapeutė Senamiesčio psichiatrijos ir psichoterapijos centre

PEDAGOGINĖ VEIKLA

nuo 2002 Asistentė VU MF Psichiatrijos klinikoje
nuo 2007 Mokytoja VU MF Individualios psichodinaminės psichoterapijos mokymo programoje bei mokymo komiteto narė
2008 – 2011 Mokytoja VU MF Grupinės psichodinaminės psichoterapijos mokymo programoje

NARYSTĖ DRAUGIJOSE

Lietuvos psichoanalizės draugija
Lietuvos psichiatrų asociacija
Society for psychotherapy research