VILNIUS UNIVERSITY

Ieva Povilaitienė

RELATIVES OF THE FIRST EPISODE PSYCHOSIS PATIENTS: THE RELATIONSHIP BETWEEN APPRAISAL OF ILLNESS SITUATION, SOCIAL SUPPORT, AND PSYCHOLOGICAL DISTRESS OVER TIME

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VILNIAUS UNIVERSITETAS

Ieva Povilaitienė

PIRMĄ PSICHOZĘ IŠGYVENUSIŲJŲ ARTIMIEJI: LIGOS SITUACIJOS VERTINIMO, SOCIALINĖS PARAMOS IR PSICHOLOGINĖS KANČIOS RYŠYS LAIKUI BĖGANT

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INTRODUCTION

Relevance of the topic. A World Health Report, summarizing the novelties of the field of mental health research and practice in 2001, announced the importance of looking at the origins of mental disorders and the care more broadly – it recommended switching between a single-sided medical model to a more diverse biopsychosocial model. These tendencies in research and practice have left the response to the explanation and treatment of psychotic disorders. A psychosis has been viewed as a chronic disease with a gradual person‘s regression for a long time, but in the last decade an attitude to psychosis has changed radically. It was determined that there are only 10 percent of patients with a psychosis resistant to treatment (Edwards et al., 1998). Thus, psychosis does not necessarily mean an inevitable decrease in patient’s functioning and disability. On the contrary, its outcomes are more diverse and optimistic rather than it was thought before.

The success of person‘s recovery from psychosis is closely related to a well-timed and effective care. Meanwhile, in reality this is not necessarily realizable. Often an initial treatment is rough, traumatizing, and encouraging alienation, and poor succession of further care determines patient‘s resistance to care (McGorry, 2004). Also, an effective treatment of early psychoses is impossible without psychological help provided to patients and their families. Patients, who are experiencing the first psychosis and their relatives benefit greatly from psychological help (Killackey, 2009; Gleeson et al., 2010).

Family is very close to the patient and its role is extremely important in patient’s clinical, emotional, and social recovery (Addington et al., 2005a). However, the psychosis of a family member is a challenge to the relatives which is difficult to cope with. In order the relatives to be helpful in the patient recovery, they themselves need to be able to cope with their reaction. An effective professional help can improve the abilities of relatives, but in order to provide an effective help, it is important to know what the relatives are experiencing; how these experiences undergo changes in the significant stages of recovery from psychosis; by what these experiences are enhanced or diminished; how relatives’ experiences are associated with different appraisals of illness situations; which aspects of the illness situation are most significant to psychological distress in different stages of recovery and etc.

Scientific novelty. Researchers began studying the first episode psychosis families more in the past decade. This is associated with empirical evidence that 2-5 years of recovery from psychosis is a "critical period", prognostically significant to the further functioning of a patient (Birchwood and McMillan, 1993). Thus, in this stage an effective participation of a family in a patient recovery process is extremely important. Until then the researchers focused on families of psychotic patients for a long time. The most important questions the researchers were trying to answer in the last decades were the following: What influence does the illness of a family member have on relatives? (e.g., Magliano et al., 2006; Laidlaw et al., 2002) How do relatives influence the recovery of a patient? (e.g., Kuipers et al., 2006; van Os et al., 2001) What help, which is provided, is effective to the relatives? (e.g., Jennes et al., 2006)

Our study belongs to a group of studies researching the influence of psychosis on relatives. For a long time, these kind of research studies were mostly dominated by a concept of a burden, that limited the possibilities of studies, because they focused on a patient as a basic resource of distress for relatives, did not allow to explain the variability of reactions of relatives of a patient with psychosis, and did not assume positive aspects of a caregiving experience. Szmukler et al. (1986) were the first to apply coping with stress model to explain the psychological and physical outcomes, associated with illness situation, of the relatives of patients diagnosed with psychosis. In an adapted model, a cognitive appraisal of situation is considered a mediating variable between an objective situation and the relatives' reaction to it. This model was tested empirically (Szmukler et al., 1996; Joyce et al., 2003) and was introduced into the sample of the first episode psychosis families (Addington et al., 2003, 2005b). According to research, relatives' appraisal of the illness situation is directly associated with their psychological distress; it can be more useful in predicting the distress of relatives than objective patient symptoms (Addington et al., 2003; Möller-Leimkühler, 2005) and the received social support by relatives is inversely related with psychological distress (Lee et al., 2000). Still, it is not clear how the appraisal of situation difficulty by relatives, received social support, and psychological distress are interrelated, and differ in important stages of the patient recovery from psychosis: if changes in the appraisal of illness situation during recovery from psychosis contribute to the changes of psychological distress or vice versa – the psychological distress influences changes in the appraisal of illness situation? Which

aspects of illness situation are most influential psychological distress in families in different stages of recovery from psychosis and does the importance of separate aspects of caregiving experience change? What role does a received social support by relatives play in this interplay over time, and does the nature of social support change depending on specifics of the illness or the stage of recovery? And the last unanswered question – Can we predict later psychological distress from the appraisal of the illness situation?

Longitudinal studies could be employed to answer these questions, but this kind of longitudinal studies involving relatives of the first psychosis patients are rarely conducted. Consequently, it encouraged us to contribute to this field of scientific research conducting a longitudinal study, which is directed to answering these questions controlling earlier measures of appraisal of the illness situation, social support, and psychological distress of the relatives.

The aim of the study is to determine the relationship between the appraisal of illness situation, social support, and psychological distress over time in the relatives of the first episode psychosis patients.

Objectives:

1. Determine the changes of relatives' appraisal of the illness situation, psychological distress, and received social support over time.
2. Determine the variable which are significant to relatives' psychological distress in different stages of patient recovery, and compare with the results that of repeated psychosis families.
3. Determine the prognostic value of relatives' appraisal of illness situation to their later psychological distress.
4. Evaluate the direction of the relationship between the relatives' appraisal of illness situation and their psychological distress over time.
5. Evaluate the importance of relatives' received social support to their psychological distress.

Practical implications. The results of this study, concerning the relationship between appraisal of illness situation, social support, and psychological distress in families over time, can be applied in clinical practice in order to provide a more purposeful and flexible care to the first episode psychosis families. Knowing that the appraisal of situation difficulty determines psychological distress and in order to lower

the later psychological distress of the relatives, first we should improve the appraisal of situation difficulty. Knowing the most important aspects of caregiving experience contributing to psychological distress in relatives in different stages, our response to the needs of families could be more purposeful and flexible. Application of the study results in practice could help the relatives cope with an unexpected crisis experience more effectively, and help in the recovery proves of a patient.

Defended statements:

1. Relatives perceive the first episode psychosis of a family member as most difficult and overwhelming experience in their lives.
2. Relatives reactions to the family member's first episode psychosis are specific to the stage of patient recovery:
   - The intensity of appraisal of illness situation and psychological distress in relatives differs in the stages of patient recovery;
   - The prognostic variables of relatives' psychological distress differ in the stages of patient recovery.
3. Later emotional state can be predicted from cognitive aspect rather than from the initial emotional state in the first episode psychosis families.
4. Received social support prevents the first episode psychosis families from psychological distress – social support is significant to their psychological distress either separately, or in a relationship with the appraisal of illness situation.

METHODS

Participants. Study participants – relatives of patients who were hospitalized for psychosis. Participant inclusion criteria: one or more relatives (parents, brothers or sisters, spouses) or a patient who was hospitalized for the first time; patient diagnosed with a psychotic spectrum disorder (F20-29, according to ICD-10) or an affective disorder with psychosis (F30.2, F31.2, F31.5, F32.3, according to ICD-10); patient younger than 40 years of age. Exclusion criteria: patient has been hospitalized before for other mental disorders; psychoactive substances or organic disorders induced patient's psychosis; patient's relatives are under-age.

Sample size used for data analysis – 30 relatives (63% parents, 26% brothers or sisters, 10% spouses). Age (M = 42,3) and gender (37% men, 63% women) of relatives. Age (M = 24,1) and gender (70% men, 30% women) of patients.

A comparison group was used in order to reach the second objective of our study. This group consisted of 36 relatives of repeated hospitalized patients with psychosis (of whom 58% were parents, 11% brothers or sisters, 11% spouses, 25% children, 5% other relatives). Age (M = 51,1) and gender (22% men, 78% women) of relatives. Patient age (M = 39,9), gender (47% men, 53% women), number of hospitalizations (M = 7,2), duration of illness in years (M = 10,3).

Study variables and methods. ***Appraisal of illness situation*** is a complex variable in our study, which includes situation's difficulty appraisal, coping efficacy appraisal, and different aspects of caregiving appraisal.

Appraisal of situation difficulty is measured with Crisis State Assessment Scale: Perceived psychological trauma subscale (CSAS-PPT; Lewis, 2005).

Appraisal of coping efficacy is measured with Crisis State Assessment Scale: Problems with coping efficacy subscale (CSAS-PCE; Lewis, 2005).

Appraisal of negative caregiving:

- *appraisal of difficult behaviours* is measured with Experience of Caregiving Inventory: Difficult behaviours subscale (ECI-DB; Szmukler, 1996);
- *appraisal of negative symptoms* is measured with Experience of Caregiving Inventory: Negative symptoms subscale (ECI-NS; Szmukler, 1996);
- *appraisal of stigma* is measured with Experience of Caregiving Inventory: Stigma subscale (ECI-S; Szmukler, 1996);
- *appraisal of problems with services* is measured with Experience of Caregiving Inventory: Problems with services subscale (ECI-PS; Szmukler, 1996);
- *appraisal of effects on family* is measured with Experience of Caregiving Inventory: Effects on family subscale (ECI-EF; Szmukler, 1996);
- *appraisal of dependency* is measured with Experience of Caregiving Inventory: Dependency subscale (ECI-D; Szmukler, 1996);
- *appraisal of loss* is measured with Experience of Caregiving Inventory: Loss subscale (ECI-L; Szmukler, 1996);

Positive caregiving appraisal:

- *good relationship with patient* is measured with Experience of Caregiving Inventory: Good aspects of relationship subscale (ECI-GR; Szmukler et al., 1996);
- *positive personal experience* is measured with Experience of Caregiving Inventory: positive personal experience subscale (ECI-PPE; Szmukler et al., 1996).

Social support was measured with Crisis Support Scale (CSS; Joseph, 1999).

Psychological distress was measured with Hospital Anxiety and Depression Scale (HADS; Zigmont and Snaith, 1983).

Sociodemographic variables were measured with Questionnaire of social demographic data.

Study procedure. The study was continuous; it consisted of three evaluative stages. First, relatives were questioned during the first week of patient hospitalization. They were repeatedly questioned after three and nine months. Relatives were questioned on individual basis. 41% of the study sample dropped out during the course of study. 51 respondents were questioned at Time 1, 37 of them at Time 2, and 30 – at Time 3. In order to determine if study variables and demographic characteristics of the respondents could contribute to drop out from the study, logistical regression analysis was used. The results indicate that situation difficulty (Exp(B) = 1,24, p = 0,63), negative caregiver experience (Exp(B) = 0,99, p = 0,60), positive caregiver experience (Exp(B) = 0,95, p = 0,16), experienced psychological distress (Exp(B) = 0,87, p = 0,11), social support (Exp(B) = 0,97, p = 0,24), age (Exp(B) = 1,06, p = 0,29), gender (Exp(B) = 1,68, p = 0,53), education (Exp(B) = 0,89, p = 0,90), marital status (Exp(B) = 0,36, p = 0,24) or relationship to a patient (Exp(B) = 0,11, p = 0,11) did not contribute to the drop out. Only coping efficacy level of significance was $p<0,05$. Therefore, patient relatives who took part in one or more stages of study similarly perceive situation difficulty, caregiving experience, experience psychological distress, and demonstrate similar demographic characteristics. Yet there is a 2,5 times greater tendency to drop out of study for those who feel ineffective in coping with situation. There is a possibility that those who drop out feel ineffective in coping with situation.

Data analysis. The data was analyzed using SPSS 15.0 and MPLUS 6 programs. The following SPSS analysis methods were employed:

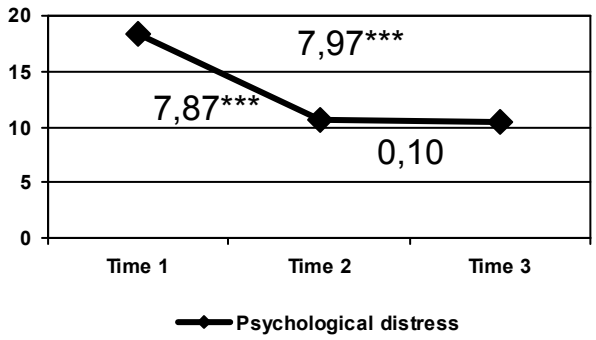
- Logistic Regression was used to determine if the study variables and demographic characteristics of study participants could contribute to drop out;
- Repeated Measures Anova was used to determine the differences between stages of measurement;
- Pearson correlations and Multiple Linear Regression were used in every stage of the study to determine the relationship between caregiving experience and psychological distress.
- Pearson (for scale data) and Spearman (for ordinal data) correlations were used to determine the relationship between psychological distress and sociodemographic variables.
- In order to determine the interaction of social support and appraisal of illness situation in predicting psychological distress, we performed a Multiple Linear Regression with the interaction of two variables. B coefficients were used to compute 4 coordinates in a plane: high in support and high negativity of illness situation; high in support and low in negativity; low in support and high in negativity; low in support and low in negativity. Connecting the dots in a plane, two lines were drawn to represent the interaction of variables in predicting psychological distress.

In order to determine the relationships between situation difficulty, coping efficacy, caregiving experience, social support and psychological distress over time, we performed structural equation modeling with Mplus 6.0 program (Muthen and Muthen, 1998-2000). We tested a cross-lagged model, which estimates the relationship over time and at the same time lets answer the question about changes over time and the direction of the variable relationship (Curan, 2000). 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 (Bentler and Bonett, 1980); values greater than 0,95 show a good fit of a model (Hu and Bentler, 1998). 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 (Browne and Cudeck, 1993). We estimated a model fit additionally using a χ^2 criterion, with a level of significance greater than 0,05.

RESULTS

Intensity and change in psychological distress. Data representing mean estimates of psychological distress in families and their comparison are presented in Figure 1. As we can see in the figure, family experience the most intense psychological distress in an acute crisis (Time 1), and it is least intense in the late stage of recovery (Time 3). Statistically significant differences were found between Time 1 and Time 2, Time 1 and Time 3 measures of psychological distress. Consequently, family of the first episode psychosis patients experience highest psychological distress in an acute crisis, but it lowers in intensity during the early stage of recovery and remains similar in the late stage of recovery.



*** $p < 0{,}001$

Figure 1. Mean difference of psychological distress in different moments in time (Bonferroni criterion)

In our study psychological distress is a complex variable, encompassing the estimates of anxiety and depression. Our study results show that in an acute crisis (Time 1) 60 percent of the families fall into a risk group of an anxiety disorder and 50 percent of the families fall into the risk group of a depressive disorder (Figure 2). However, in the early and late stage of recovery (Time 2 and Time 3) anxiety level of the families reduces significantly and only one third of families fall into the risk group of an anxiety disorder. In this stage level of depression in families decreases significantly – in the early

and late stage of recovery (Time 2 and Time 3) one fifth of families fall into the risk group of a depressive disorder.

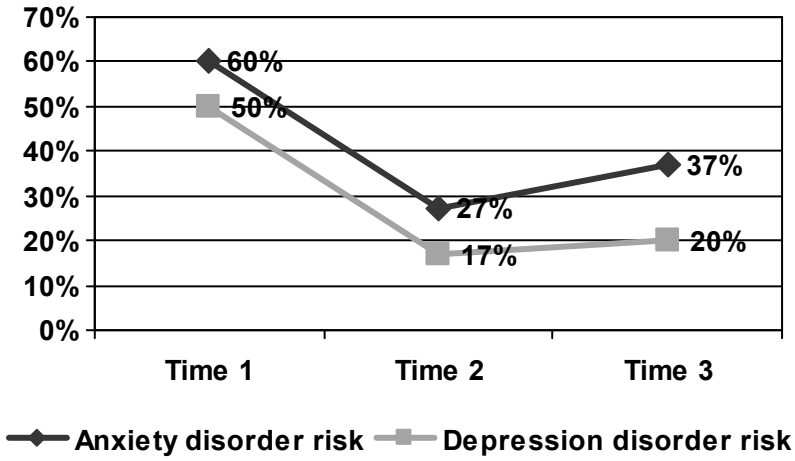
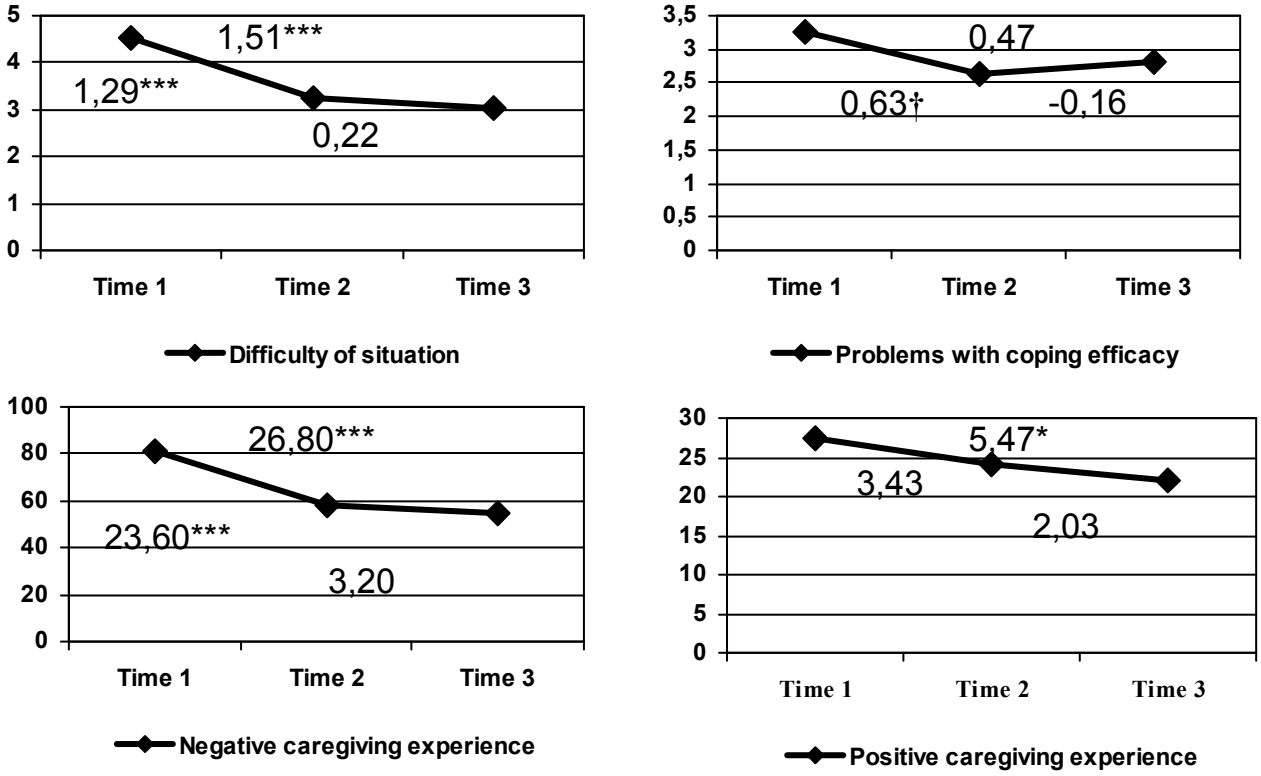


Figure 2. Families with the risk of an anxiety or depressive disorder

Therefore, the study results show that the first episode psychosis of a family member causes a considerable psychological distress. In an acute psychiatric crisis the anxiety and depression estimates of more than a half of the families is an evidence of a potential anxiety or depressive disorder. Yet in the early stage of recovery the estimates of psychological distress reduce significantly and remain similar in the later stage of recovery. It may be that the greatest changes in the experience of psychological distress in families take place when the patient shifts from the acute stage to the early stage of recovery.

Changes in appraisal of illness situation. In our study the appraisal of illness situation encompasses the appraisal of situation difficulty, coping efficacy and disease-related stressors or caregiving. ***Appraisal of situation difficulty.*** Families were asked to rate the difficulty of a situation in the scale from 1 to 10, which is associated with the disease of their relative in comparison to their most difficult life events – 70% of families the first episode psychosis of a relative in an acute stage indicated as one of the most difficult life events in comparison to the other life events (median is 9, mode is 9 and 10, mean is 8,3). We measured the appraisal of situation difficulty in families with CSAS-PPT (Figure 3) and obtained that families appraise the situation as the most difficult in the acute crisis stage (Time 1), and the situation is appraised as the least

difficult in the late stage of recovery (Time 3). Statistically significant differences were found between Time 1 and Time 2, Time 1 and Time 3 measures of the appraisal of situation difficulty measures. Consequently, the appraisal of situation difficulty in families is the most difficult in the stage of acute crisis, but the situation difficulty decreases in the early stage of recovery and remains similar in the late stage of recovery.



† $p < 0,1$, * $p < 0,05$, *** $p < 0,001$

Figure 3. Mean differences of the appraisal of situation difficulty, coping efficacy, negative and positive caregiving experience in different moments in time (Bonferroni criterion)

Appraisal of coping efficacy. The appraisal of coping efficacy in relatives is fairly stable over time. The variation of difficulties in coping efficacy seen in Figure 3 are only a statistical tendency. ***Appraisal of negative caregiving experience.*** As we can see in Figure 3, the caregiving experience is appraised by families as the most negative in a stage of acute crisis (Time 1), and it is least negative in the stage of late recovery (Time 3). Statistically significant differences were found between Time 1 and Time 2, Time 1 and Time 3 measures of negative caregiving experience. Hence, according to the

families, the caregiving experience is the most negative in the stage of acute crisis, but its negativity reduces in the early stage of recovery and remains similar in the late stage of recovery. ***Appraisal of positive caregiving experience.*** The caregiving experience in families is appraised as the most positive in the stage of acute crisis (Time 1), and it is least positive in the late stage of recovery (Time 3) (Figure 3). Statistically significant differences were found between Time 1 and Time 3 measures of positive caregiving experience in relatives. However, there were no statistically significant differences between Time 1 and Time 2, Time 2 and Time 3 measures. This means that the appraisal of positive caregiving experience in families changes significantly in the late stage of recovery. Consequently, the caregiving experience is the most positive in the stage of acute crisis, but the positivity reduces gradually and it becomes significantly lower in the late stage of recovery.

In summarizing the results of changes in illness situation in families, it can be stated that most families appraise the first episode psychosis of a family member as one of the most difficult events in their lives. It was determined that the negative appraisal of illness situation reduces over time – the appraisal of situation difficulty and negative caregiving experience reduces significantly in the early stage of recovery (Time 2), only the appraisal of difficulties in coping efficacy remains stable. The appraisal of positive caregiving experience reduces in the late stage of recovery (Time 3). It is true to say that the appraisal of illness situation in relatives changes over time.

Relationship between appraisal of individual aspects of caregiving experience and psychological distress over time. Data representing estimates of correlation coefficients of psychological distress and appraisal of individual caregiving aspects in first and repeated episode psychosis families are presented in Table 1. As we can see in the table, the appraisal of individual caregiving experience and psychological distress are directly related – the more negatively relatives appraise negative variables of caregiving, the more intense is their psychological distress in either stages of study.

Table 1. Relationship of caregiving experience and psychological distress in different moments in time

	First episode psychosis families			
	Acute crisis stage	**Early recovery stage**	**Late recovery stage**	**Repeated psychosis families**
	Psychological distress	Psychological distress	Psychological distress	Psychological distress
Negative caregiving experience:	0,59**	0,70***	0,77***	0,56***
Difficult behaviours	0,35	0,35	0,65***	0,45**
Negative symptoms	0,42*	0,62**	0,71***	0,40*
Stigma	0,24	0,74***	0,77***	0,66***
Problems with services	0,53**	0,67***	0,55***	0,31
Effects on family	0,32	0,68***	0,70***	0,41*
Dependency	0,67***	0,60***	0,65***	0,38*
Loss	0,53**	0,59***	0,79***	0,22
Positive caregiving experience:	0,23	0,29	0,30	0,07
Positive personal experience	0,35†	0,37*	0,39*	0,17
Good aspects of relationship	0,01	0,12	0,12	0,11

† $p < 0,1$, * $p < 0,05$, ** $p < 0,01$, *** $p < 0,001$

To estimate which of these seven caregiving aspects are most significant to the psychological distress in the first episode psychosis families in different stages of patient recovery, we performed a cross-sectional regression. Only those aspects of caregiving experience which were related to psychological distress were included in each stage regression analysis. The results were also compared to those of the families of a repeated psychosis patient (N=36). Figure 4 shows the results of all 4 regressions.

As we can see in the figure, psychological distress in families is most related to these aspects of caregiving experience: stigma, loss, dependency, and problems with services. The relationship between psychological distress and these variables changes over time. In an acute stage (Time 1) experience of dependency ($\beta = 0,48$, $p < 0,01$; $R^2 = 0,56$) and problems with services ($\beta = 0,27$, $p < 0,1$; $R^2 = 0,56$) are most significant to psychological distress in families. The importance of stigma to psychological distress ($\beta = 0,37$, $p < 0,1$; $R^2 = 0,62$) emerges in the early stage of recovery (Time 2). Stigma remains the most significant to the psychological distress in the late stage of recovery (Time 3) ($\beta = 0,41$, $p < 0,05$; $R^2 = 0,71$) and in the sample of the repeated psychosis

families (β = 0,51, p < 0,01; R^2 = 0,46). The importance of a loss variable to psychological distress (β = 0,50, p < 0,1; R^2 = 0,71) emerges in the late stage of recovery (Time 3).

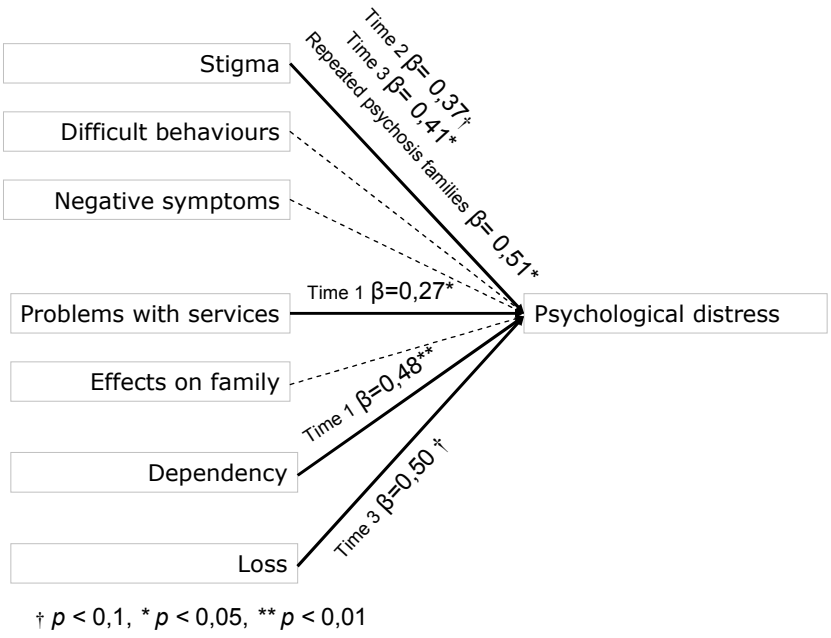


Figure 4. The results of four regression analyses in different moments in time

Relationship between appraisal of illness situation and psychological distress over time. ***Relationship of appraisal of situation difficulty and psychological distress over time.*** In order to test the relationship of psychological distress and appraisal of situation difficulty, when controling earlier relationships between of them, we tested a cross-lagged model of these variables (Figure 5). Goodness of fit estimates show that a sufficient model fit to data (χ^2 = 4,36, kai p = 0,36; RMSEA = 0,06; TLI = 0,99; CFI = 0,99). Model results show that the appraisal of the situation difficulty in the first episode psychosis families remains fairly stable over time (standardized autoregression coefficients 0,60 and 0,77), but psychological distress is not stable between Time 1 and Time 2 (standardized autoregression coefficient 0,05), and moderately stable between Time 2 and Time 3 (standardized autoregression coefficient 0,58).

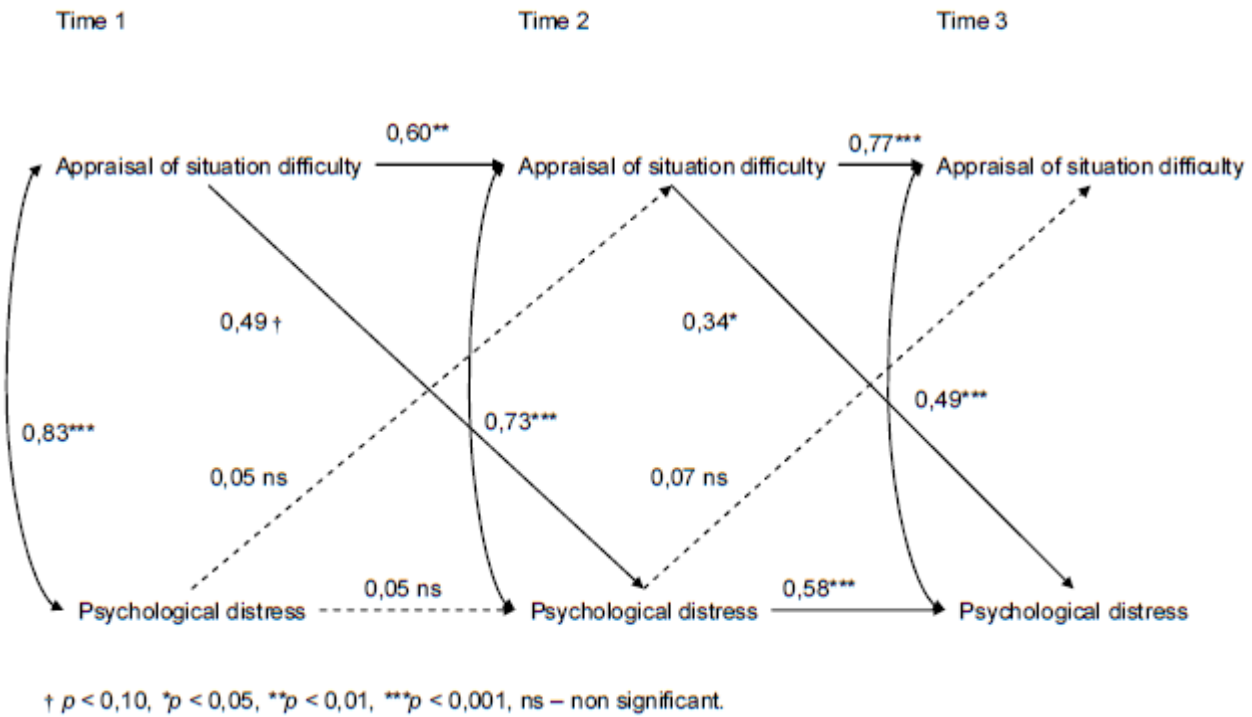
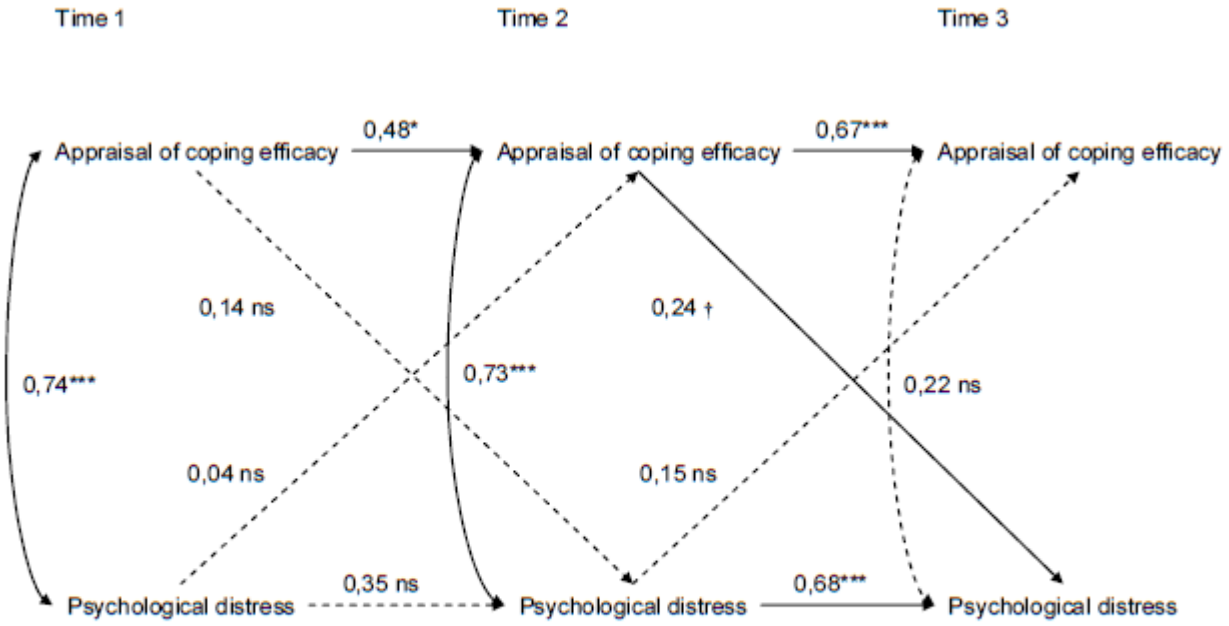


Figure 5. Appraisal of situation difficulty and psychological distress – cross-lagged model results

Relationships between separate measurements were the most important in this model; that is, a path from appraisal of situation difficulty to psychological distress and a path from psychological distress to appraisal of situation difficulty. The results show that psychological distress in the first episode psychosis families cannot predict the appraisal of situation difficulty when controlled for all model relationships. However, the results indicate that the appraisal of situation difficulty predicts psychological distress, when controlled for all model relationships. This supports an assumption that psychological distress is caused not by situation itself, but a subjective appraisal of situation. The more participants consider the situation as a difficult one, the more they experience psychological distress over time.

Since psychological distress in families is associated with the family member gender, relationship, and living together with a patient, the cross-lagged model was tested taking into account each of these variables. The earlier relationships of the model did not change when controlled for gender, relationship, and living together with a patient; the appraisal of situation difficulty prognostic value increased partially; and additionally, it was estimated that these variables are most significant to psychological distress in the stage of acute crisis. Living together with a patient can be greatly significant to appraisal of situation difficulty in an acute crisis.

Relationship of appraisal of coping efficacy and psychological distress over time. When we tested a cross-lagged model of coping efficacy and psychological distress, the results showed that a model has a good fit to data (χ^2 = 5,30, kai p = 0,26; RMSEA = 0,10; TLI = 0,96; CFI = 0,99). Model results show (Figure 6) that appraisal of coping efficacy remains fairly stable over time (standardized autoregression coefficients 0,48 and 0,67), but psychological distress is not stable between Time 1 and Time 2, and is moderately stable between Time 2 and Time 3 (standardized autoregression coefficient 0,68). In this model also there were important relationships between measurements; that is, a path from appraisal of coping efficacy to psychological distress, and a path from psychological distress to appraisal of coping efficacy. The results show that psychological distress cannot predict the appraisal of situation difficulty, when controlled for all model relationships. However, the results show that appraisal of situation difficulty in part can predict an experienced psychological distress, when controlled for all model relationships. This supports an assumption that the stress is



†$p < 0,10$, *$p < 0,05$, **$p < 0,01$, ***$p < 0,001$, ns – non significant.

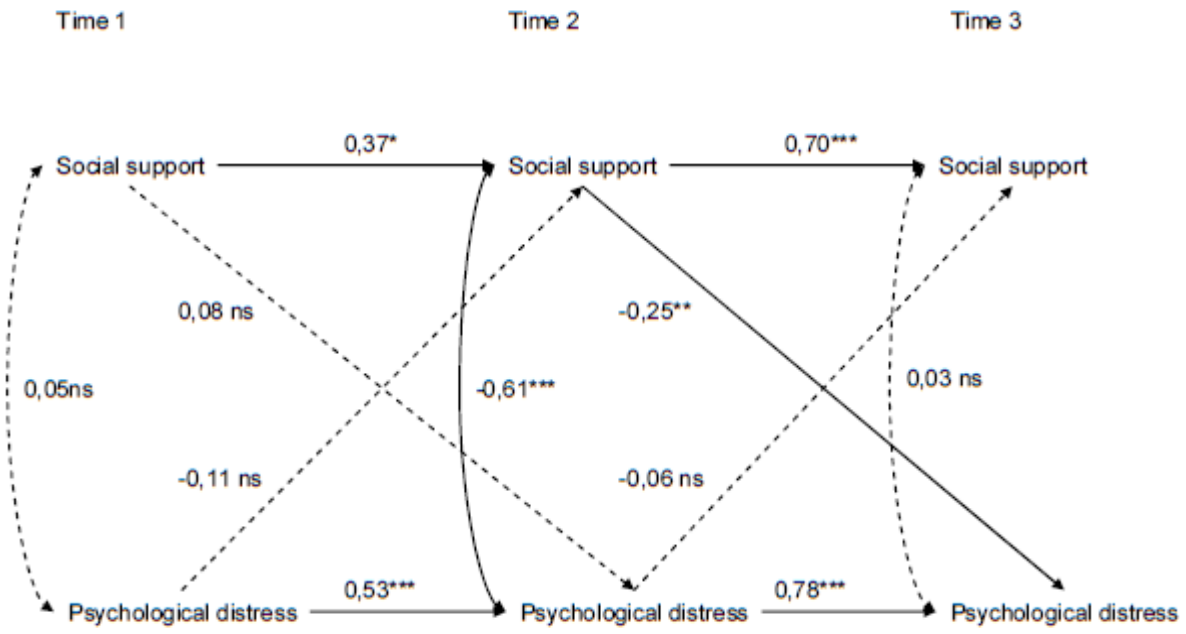
Figure 6. Appraisal of coping efficacy and psychological distress – cross-lagged model results

cause not by situation itself, but a subjective appraisal of a situation. The more poorly the families appraise coping efficacy, the more psychological distress they experience. When controlled for gender, relationship, and living together with a patient, earlier model relationships did not change; prognostic values of appraisal of coping efficacy increased partially, and additionally it was estimated that these variables are the most significant to psychological distress in the stage of acute crisis. Living together with a patient can be greatly significant to appraisal of coping efficacy in an acute crisis.

Relationship between appraisal of situation difficulty, coping efficacy, caregiving experience, and psychological distress over time. We tested a cross-lagged model with the variables of caregiving experience and psychological distress. However, model fit estimates showed a poor model fit to data (χ^2 = 11,10, kai p = 0,03; CFI = 0,94; TLI = 0,80; RMSEA = 0,24). When controlled for variable stability over time and the relationships between the variables in the same measurement, the above-mentioned variables did not predict changes in each other over time. No cross-lagged relationships were found in analysis. There was only one statistically significant possibility to predict later caregiving experience measures from the earlier measures, and to predict later measures of psychological distress from earlier measures. Therefore, the estimates of appraisal of situation difficulty, coping efficacy and individual aspects of caregicing, were converted to standardized Z scores and were incorporated into general "appraisal of illness situation" variable, in order to test the relationship between the illness situation variable and psychological distress over time. The model fit estimates show a good model fit (χ^2 = 2,43, kai p = 0,66; RMSEA = 0,00; TLI = 1,00; CFI = 1,00). Model results show that appraisal of illness situation remains stable over time (standardized autoregression coefficients 0,70 and 0,88), but psychological distress is not stable between Time 1 and Time 2 (standardized autoregression coefficient 0,71), and moderately stable between Time 2 and Time 3 (standardized autoregression coefficient 0,62). In this model the most important relationships were between different measurements; that is, a path from appraisal of illness situation to psychological distress, and a path from psychological distress to appraisal of illness situation. It was found that psychological distress cannot determine appraisal of illness situation (standardized autoregression coefficients 0,09 and -0,01). However, the results show that the appraisal

of illness situation can predict an experienced psychological distress, when controlled for all model relationships. It was found that psychological distress in families in the late stage of recovery can be predicted by the appraisal of illness situation in the early stage of recovery (standardized autoregression coefficient 0,49). This partially supports an assumption that psychological distress in families is cause not by the situation itself, but a subjective appraisal of a situation. The more negative appraisal of illness situation in families, the more psychological distress they experience over time. When controlled for gender, relationship, and living together with a patient, earlier model relationships did not change; prognostic values of appraisal of illness situation increased partially, and additionally it was estimated that these variables are the most significant to psychological distress in the stage of acute crisis. Living together with a patient can be greatly significant to the overall appraisal of situation difficulty in an acute crisis.

Importance of social support to psychological distress. ***Relationship of social support and psychological distress over time.*** Received social support is fairly stable over time. Mean differences of received social support in different moments in time were not statistically significant. In order to test the relationship between psychological distress and social support, we tested a cross-lagged model, when controlled for earlier model relationships. The model fit estimates show a good model fit to data (χ^2 = 1,68, kai p = 0,79; CFI = 1,00; TLI = 1,00; RMSEA = 0,00). Model results show (Figure 7) that social support remains fairly stable over time (standardized autoregression coefficients 0,37 and 0,70), psychological distress also remains stable (standardized autoregression coefficients 0,53 and 0,78). In this model the most important relationships were between the measurements; that is, a path from social support to psychological distress, and a path from psychological distress to social support. The results show that psychological distress cannot predict social support, when controlled for all model relationships. However, results show that social support can determine an experienced psychological distress, when controlled for all model relationships. This would support an assumption that social support predicts later psychological distress. The less social support is received by families, the more psychological distress they experience, and vice versa – the more social support is received by families, the less psychological distress they experience. When controlled for gender, relationship, and living together with a patient, earlier model relationships did not change.



*p < 0,05, **p < 0,01, ***p < 0,001, ns – non significant.

Figure 7. Social support and psychological distress – cross-lagged model results

Additionally it was estimated that gender was the most significant to social support in the stage of acute crisis. This could show that women receive more social support than men in the stage of acute crisis, but later this difference evens out.

Interaction of social support and appraisal of illness situation. In order to estimate the protective role of social support, we tested the relationship between social support, appraisal of situation difficulty, and psychological distress (Table 2), and performed a regression analysis. When testing the relationships, we found that social support is neither related to psychological distress, nor with the appraisal of illness situation in the stage of acute crisis. The relationship between psychological distress and these variables appears only in Time 2 and Time 3.

Table 2. Relationship of social support, appraisal of illness situation, and psychological distress over time (N = 21)

	Time 1	**Time 2**	**Time 3**
	Social support	**Social support**	**Social support**
Psychological distress	0,05	-0,49*	-0,49*
Appraisal of illness situation:	0,17	-0,52*	-0,37†
Appraisal of situation difficulty	0,08	-0,50*	-0,35†
Appraisal of coping efficacy	0,19	-0,53*	-0,45*
Negative appraisal of caregiving experience	0,20	-0,35 †	-0,24

† $p < 0,1$, * $p < 0,05$

We estimated that received social support in Time 2 and Time 3 is inversely related with an intensity of psychological distress and the negativity of appraisal of illness situation (appraisal of situation difficulty, coping efficacy, and negative caregiving experience). This means that when social support decreases, it increases the appraisal of negative illness situation and psychological distress.

In order to test if psychological distress decreases when social support increases, if the appraisal of illness situation is negative, we performed a regression analysis. Appraisal of illness situation, social support, and a product of social support and appraisal of illness situation were independent variables. A product of social support and appraisal of illness situation reflects the interaction of these variables, and its statistical significance to psychological distress lets us assume that social support may be of a protective importance. Since social support correlates with variables of illness situation

and psychological distress only in Time 2 and Time 3, we performed a regression analysis of these measurements. Standardized variable scores were used in the analysis.

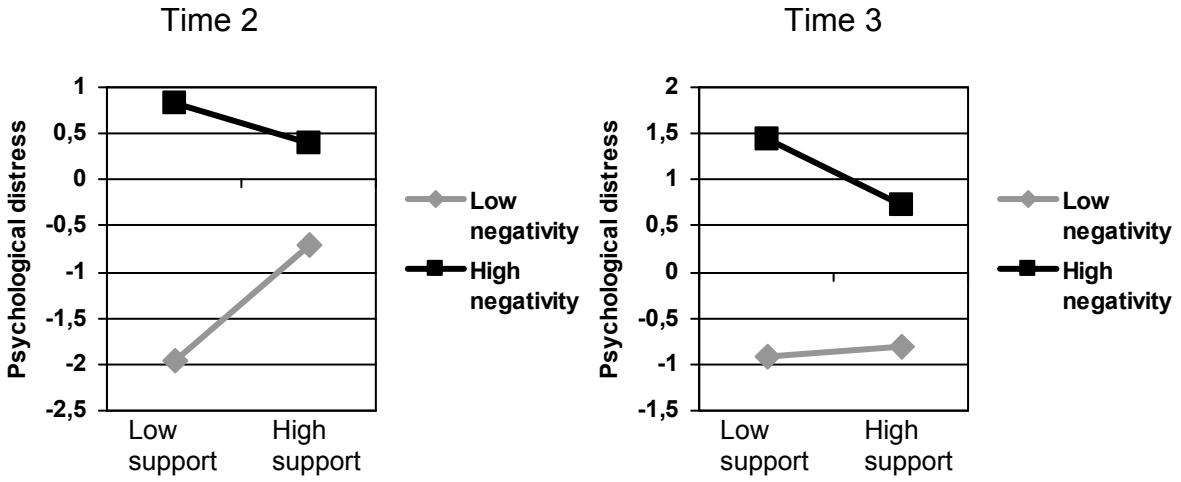


Figure 8. Interaction of appraisal of illness situation and social support in predicting psychological distress (N=21)

In order to test if psychological distress decreases when social support increases, if the appraisal of illness situation is negative, we performed a regression analysis. Appraisal of illness situation, social support, and a product of social support and appraisal of illness situation were independent variables. A product of social support and appraisal of illness situation reflects the interaction of these variables, and its statistical significance to psychological distress lets us assume that social support may be of a protective importance. Since social support correlates with variables of illness situation and psychological distress only in Time 2 and Time 3, we performed a regression analysis of these measurements. Standardized variable scores were used in the analysis.

The results show that the interaction of social support and appraisal of illness situation in Time 2 and Time 3 is significant to psychological distress (B = -0,42, p = 0,01; B = -0,20, p = 0,05). When presented the interaction of these variables (Figure 8), we can see that families, which appraise the illness situation extremely negatively and receive lower social support, experience the utmost psychological distress. Their psychological distress decreases as the social support increases. This tendency is more apparent in Time 3. This can point to the protective importance of social support.

Families, whose appraisal of illness situation is least negative ("low negativity") and those who receive low support, experience the least psychological distress. Families, whose appraisal of illness situation is least negative and who receive greater social support in Time 2, experience greater psychological distress. There is a tendency that low negativity and greater support which is associated with greater psychological distress in Time 2, disappears in Time 3. It may point to peculiarities of social support in different stages, e.g., to long-term influence of social support and "satiation", therefore, the low negativity in Time 3 is associated to low psychological distress independent from the amount of social support.

CONCLUSIONS

1. The first episode psychosis of a family member is an extremely difficult and overwhelming event in relatives' lives. First psychosis in a stage of acute crisis was one of the most difficult life events to the most relatives. More than half of psychological distress in relatives reached a clinically significant level at the time.

2. The first episode psychosis families reactions are specific to the stage of a patient recovery:

- The negativity of illness situation and psychological distress in relatives differ across stages. The greatest changes in the appraisal of situation difficulty and psychological distress take place when the patient shifts from the stage of an acute crisis to the stage of early recovery (in the cases of stigma and the appraisal of negative symptoms – shifting to a late stage of recovery). Only the appraisal of coping efficacy, problems with services and positive personal experience remain fairly stable.
- The most significant aspects of caregiving to psychological distress in relatives differ across stages. In an acute crisis experience of dependency and problems with services are the most influential to psychological distress in relatives; in the early stage of recovery the importance of stigma to psychological distress emerges and remains significant in late stage of recovery and in the repeated psychosis families; in the late stage of recovery the importance of a loss variable to psychological distress emerges.

3. The appraisal of illness situation in relatives is more stable than their psychological distress over time – a later appraisal of illness situation can be predicted

from the initial appraisal of illness situation, but a later psychological distress cannot be predicted from the initial psychological distress. Those relatives who experience a greater psychological distress in the initial stage will not necessarily experience a greater distress in the later stages of recovery.

4. Later psychological distress can be predicted from appraisal of illness situation rather than from the initial psychological distress in the first episode psychosis families. We can predict a later psychological distress from the initial appraisal of situation difficulty, and from the coping efficacy in the early stage of recovery. However, we cannot make predictions using the appraisal of caregiving experience.

5. The received social support by families play a protective role: it is inversely related with psychological distress and negative appraisal of illness situation; it weakens the relationship between negative appraisal of situation and psychological distress; it predicts psychological distress in later stage; it interacts with the negative appraisal of illness situation in predicting psychological distress in the same measurement. The protective role of social support emerges in the early stage of recovery and improves over time.

6. Practical implications of results would mean that in order to reduce a later psychological distress in families, we should first improve their appraisal of the illness situation.

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RESUME

ĮVADAS

Temos aktualumas. 2001 metų Pasaulio sveikatos pranešimas, apibendrinantis psichikos sveikatos mokslinių tyrimų ir praktikos naujoves, paskelbė, kad į psichikos sveikatos sutrikimų atsiradimą ir pagalbą jų atveju būtina žvelgti plačiau – pereiti nuo vienpusiško medicininio prie įvairialypio biopsichosocialinio modelio. Šios mokslinės ir praktinės tendencijos turėjo atgarsį ir psichozinių sutrikimų aiškinimui bei gydymui. Ilgą laiką psichozė reiškė lėtinę ligą, palaipsnę asmens degradaciją, tačiau pastarąjį dešimtmetį požiūris į psichozes iš esmės pasikeitė. Nustatyta, kad pacientai, kurių psichozė atspari gydymui, sudaro apie 10 proc. (Edvards et al., 1998). Taigi psichozė nebūtinai reiškia neišvengiamą asmens funkcionavimo pablogėjimą, negalią, o jos pasekmės yra kur kas įvairesnės ir optimistiškesnės nei buvo manyta iki šiol.

Asmens atsigavimo po psichozės sėkmė glaudžiai susijusi su laiku suteikta veiksminga pagalba. Tačiau tai nebūtinai yra įgyvendinama. Neretai šiurkštus, traumuojantis ir susvetimėjimą skatinantis pradinis gydymas ir prastas tolesnių paslaugų tęstinumas lemia paciento nenorą priimti pagalbą (McGorry, 2004). Be to, veiksmingas ankstyvų psichozių gydymas yra neįmanomas be psichologinės pagalbos tiek sergančiajam, tiek jo šeimai. Patiriantys pirmą psichozę asmenys ir jų artimieji gali gauti ypač daug naudos iš psichologinės pagalbos (Killackey, 2009; Gleeson et al., 2010). Ji spartina atsigavimą, pagerina ryšį su profesionalais, palaiko įsitraukimą į gydymo procesą.

Šeima yra arčiausiai sergančiojo ir jos vaidmuo yra labai svarbus paciento klinikinio, emocinio, socialinio atsigavimo procese (Addington et al., 2005a). Tačiau šeimos nario psichozė artimiesiems yra iššūkis, su kuriuo nelengva susidoroti. Kad artimieji galėtų būti talkininkai sergančiojo atsigavimo procese, jie patys turi gebėti susitvarkyti su savo reakcijomis. Veiksminga profesionalų pagalba gali padidinti artimųjų galias, tačiau, norint veiksmingai padėti, svarbu žinoti, ką artimieji išgyvena, kaip kinta šie išgyvenimai reikšmingais sergančiojo atsigavimo po psichozės laikotarpiais, kas šiuos išgyvenimus didina, kas mažina, kaip artimųjų išgyvenimai siejasi su įvairiais ligos situacijos aspektų vertinimais, kurie ligos situacijos aspektai yra

reikšmingiausi artimųjų psichologinei kančiai skirtingais atsigavimo po ligos laikotarpiais, ir pan.

Mokslinis naujumas. Mokslininkai pirmą psichozę išgyvenančias šeimas intensyviau pradėjo tirti pastarąjį dešimtmetį. Tai susiję su empiriniais įrodymais, kad pirmieji 2–5 atsigavimo po psichozės metai yra „kritinis laikotarpis“, prognostiškai reikšmingas tolesniam paciento funkcionavimui (Birchwood and Mcmillan, 1993). Taigi šiuo laikotarpiu veiksmingas artimųjų dalyvavimas sergančiojo atsigavimo procese yra ypač svarbus. Iki to laiko mokslininkų akiratyje dažniausiai buvo ilgą laiką psichoze sergančiųjų šeimos. Svarbiausi klausimai, į kuriuos tyrėjai ieškojo atsakymo paskutinius porą dešimtmečių, – kokį poveikį artimiesiems turi šeimos nario liga (pvz., Magliano et al., 2006; Laidlaw et al., 2002), kaip artimieji veikia sergančiojo atsigavimo procesą (pvz., Kuipers et al., 2006; van Os et al., 2001), kiek ir kokia pagalba artimiesiems yra efektyvi (pvz., Jenner et al., 2006). Mūsų tyrimas priklausytų psichozės poveikio artimiesiems tyrimų grupei. Ilgą laiką šiuose tyrimuose dominavo naštos koncepcija, kuri ribojo mokslinių tyrimų galimybes, nes traktavo sergantįjį kaip pagrindinį artimųjų kančios šaltinį, neleido paaiškinti psichozę išgyvenusių asmenų artimųjų reakcijų įvairovės ir neatsižvelgė į pozityvius globėjo patirties aspektus. G. I. Szmukler ir kolegos (1986) pirmieji pritaikė R. S. Lazarus ir S. Folkman (1984) streso įveikos modelį, siekdami paaiškinti ilgą laiką sergančiųjų psichoze asmenų artimųjų psichologines ir fizines pasekmes, susijusias su ligos situacija. Šiame modelyje kognityvus ligos situacijos vertinimas laikomas tarpiniu kintamuoju tarp objektyvios situacijos ir artimųjų reakcijos į ją. Modelis buvo patikrintas empiriškai (Szmukler et al., 1996; Joyce et al., 2000) ir pradėtas taikyti pirmą psichozę išgyvenusių artimųjų imtyje (Addington et al., 2003, 2005b). Tyrimais nustatyta, jog artimųjų ligos situacijos vertinimas yra tiesiogiai susijęs su jų psichologine kančia, jis netgi geriau prognozuoja artimųjų kančią nei objektyvūs sergančiojo simptomai (Addington et al., 2003; Möller-Leimkühler, 2005), o artimųjų gaunama socialinė parama atvirkščiai susijusi su psichologine kančia (Lee et al., 2006). Tačiau lieka neaišku, kaip artimųjų ligos situacijos vertinimas, gaunama socialinė parama, psichologinė kančia sąveikauja tarpusavyje ir kinta reikšmingais sergančiojo atsigavimo po psichozės laikotarpiais: ar artimųjų ligos situacijos vertinimo pokyčiai atsigaunant po psichozės gali prisidėti prie jų psichologinės kančios pokyčių, ar atvirkščiai – psichologinė kančia nulemia ligos situacijos vertinimo pokyčius? Kurie iš

ligos situacijos aspektų yra reikšmingiausi artimųjų psichologinei kančiai skirtingais atsigavimo po ligos laikotarpiais ir ar keičiasi atskirų globėjo patirties aspektų reikšmingumas? Koks yra artimųjų gaunamos socialinės paramos vaidmuo šioje sąveikoje laikui bėgant ir ar socialinės paramos pobūdis priklauso nuo ligos specifikos ir atsigavimo etapo? Na ir paskutinis neatsakytas klausimas – ar iš ligos situacijos vertinimo galime prognozuoti vėlesnę psichologinę kančią?

Į šiuos klausimus leistų atsakyti ilgalaikiai tyrimai, tačiau pirmą psichozę išgyvenusių asmenų artimųjų ilgalaikiai tyrimai retai atliekami. Taigi tai paskatino prisidėti prie šios srities mokslinių tyrinėjimų atliekant ilgalaikį tyrimą, kuriame, kontroliuodami ankstesnius artimųjų ligos situacijos vertinimo, socialinės paramos ir psichologinės kančios matavimus, bandysime atsakyti į šiuos klausimus.

Tyrimo tikslas – nustatyti pirmą psichozę išgyvenusiųjų artimųjų ligos situacijos vertinimo, socialinės paramos ir psichologinės kančios ryšį laikui bėgant.

Uždaviniai:

1. Nustatyti kaip kinta artimųjų ligos situacijos vertinimas, psichologinė kančia ir gaunama socialinė parama laikui bėgant.
2. Nustatyti artimųjų psichologinei kančiai reikšmingus kintamuosius skirtinguose sergančiojo atsigavimo etapuose ir palyginti su pakartotinai dėl psichozės hospitalizuotų pacientų artimųjų rezultatais.
3. Nustatyti artimųjų ligos situacijos vertinimo prognostines galimybes vėlesnei jų psichologinei kančiai.
4. Įvertinti artimųjų ligos situacijos vertinimo ir psichologinės kančios tarpusavio sąveikos kryptį laikui bėgant.
5. Įvertinti artimųjų gaunamos socialinės paramos apsauginę reikšmę jų psichologinei kančiai.

Praktinė reikšmė. Šio tyrimo rezultatus, rodančius artimųjų ligos situacijos vertinimo, socialinės paramos ir psichologinės kančios tarpusavio sąveiką laikui bėgant, galima būtų taikyti klinikinėje praktikoje, teikiant kryptingesnę ir lankstesnę pagalbą pirmą psichozę išgyvenusių asmenų artimiesiems. Žinodami jog situacijos sunkumo vertinimas lemia psichologinę kančią ir norėdami sumažinti artimųjų vėlesnę psichologinę kančią, turėtume pirmiausia pagerinti artimųjų situacijos sunkumo vertinimą. Žinodami, kokie globėjo patirties aspektai reikšmingiausi artimųjų

psichologinei kančiai skirtingais laikotarpiais, galėtume lanksčiau ir kryptingiau atliepti šiuos artimųjų poreikius. Gautų rezultatų pritaikymas praktikoje galėtų padėti artimiesiems veiksmingiau tvarkytis su užklupusia krizine patirtimi ir padėti sergančio šeimos nario atsigavimo procese.

Ginamieji teiginiai:

1. Artimieji pirmą šeimos nario psichozę suvokia kaip sunkiausią ir labiausiai sukrečiantį įvykį gyvenime.
2. Pirmą psichozę išgyvenusių asmenų artimųjų reagavimas yra specifiškas sergančiojo atsigavimo etapui:

- įvairiais sergančiojo atsigavimo etapais skiriasi artimųjų ligos situacijos vertinimas ir psichologinės kančios stiprumas;
- įvairiais sergančiojo atsigavimo etapais skiriasi psichologinei kančiai reikšmingi prognostiniai kintamieji.

3. Pirmą psichozę išgyvenusių asmenų artimųjų vėlesnę emocinę būseną nuspėja kognityvus aspektas, o ne pradinė emocinė būsena.
4. Pirmą psichozę išgyvenusių asmenų artimųjų gaunama socialinė parama saugo juos nuo psichologinės kančios – socialinė parama reikšminga artimųjų psichologinei kančiai tiek atskirai, tiek sąveikoje su ligos situacijos vertinimu.

METODIKA

Tyrimo dalyviai. Tyrimo dalyviai – pirmą kartą gyvenime dėl psichozės hospitalizuotų pacientų artimieji. Tyrimo dalyvių įtraukimo kriterijai: pirmą kartą hospitalizuoto paciento vienas ar daugiau šeimos narių (tėvai, broliai ar seserys, sutuoktiniai); paciento diagnozė turėjo būti psichozės spektro (F20–29, pagal TLK–10) arba afektinio spektro su psichoze (F30.2, F31.2, F31.5, F32.3, pagal TLK–10); pacientas – ne vyresnis kaip 40 m. Atmetimo kriterijai: jei pacientas anksčiau buvo hospitalizuotas dėl kitų psichikos sutrikimų; jei paciento psichozė buvo išprovokuota psichoaktyviųjų medžiagų arba organinių sutrikimų; jei paciento artimieji nepilnamečiai.

Duomenims analizuoti naudotos imties dydis – 30 artimųjų (63 % tėvų, 26 % brolių ar seserų, 10 % sutuoktinių). Artimųjų: amžius (M = 42,3), lytis (37 % vyrų, 63 % moterų). Pacientų: amžius (M = 24,1), lytis (70 % vyrų, 30 % moterų).

Siekiant tiksliau atsakyti į antrą mūsų tyrimo uždavinį buvo pasitelkta lyginamoji grupė. Šią grupę sudarė 36 pakartotinai dėl psichozės hospitalizuotų pacientų artimieji (58 % tėvų, 11 % brolių ar seserų, 11 % partnerių, 25 % vaikų, 5 % kita). Artimųjų: amžius (M = 51,1), lytis (22 % vyrų, 78 % moterų). Pacientų: amžius (M = 39,9), lytis (47 % vyrų, 53 % moterų), hospitalizacijų skaičius (M = 7,2), ligos trukmė metais (M = 10,3).

Tyrimo kintamieji ir matavimo metodai. ***Ligos situacijos vertinimas*** - mūsų tyrime yra sudėtinis kintamasis apimantis situacijos sunkumo vertinimą, įveikos veiksmingumo vertinimą, ir įvairių globos aspektų vertinimą.

Situacijos sunkumo vertinimas – Krizės būsenos vertinimo skalės Suvoktos psichologinės traumos subskalė (CSAS-PPT; Lewis, 2005).

Įveikos veiksmingumo vertinimas – Krizės būsenos vertinimo skalės Įveikos veiksmingumo sunkumų subskalė (CSAS-PCE; Lewis, 2005).

Neigiamas globėjo patirties vertinimas:

- *Sudėtingo elgesio vertinimas* – Globėjo patirties aprašas Sudėtingo elgesio subskalė (ECI-DB; Szmukler et al., 1996)
- *Negatyvių simptomų vertinimas* – Globėjo patirties aprašas Negatyvių simptomų subskalė (ECI-NS; Szmukler et al., 1996)
- *Stigma* – Globėjo patirties aprašas Stigmos subskalė (ECI-S; Szmukler et al., 1996)
- *Problemos dėl paslaugų* – Globėjo patirties aprašas Problemų dėl paslaugų subskalė (ECI-PS; Szmukler et al., 1996)
- *Poveikio šeimai vertinimas* – Globėjo patirties aprašas Poveikio šeimai subskalė (ECI-EF; Szmukler et al., 1996)
- *Priklausomybės nuo sergančiojo vertinimas* – Globėjo patirties aprašas Priklausomybės subskalė (ECI-D; Szmukler et al., 1996)
- *Netekties vertinimas* – Globėjo patirties aprašas Netekties subskalė (ECI-L; Szmukler et al., 1996)

Pozityvios globėjo patirties vertinimas:

- *Gerų santykių aspektų* – Globėjo patirties aprašas Gerų santykių aspektų subskalė (ECI-GR; Szmukler et al., 1996)

- *Pozityvios asmeninės patirties vertinimas* – Globėjo patirties aprašas Pozityvios asmeninęs patirties subskalė (ECI-PPE; Szmukler et al., 1996)

Socialinė parama – Paramos krizėje skalė (CSS; Joseph, 1999).

Psichologinė kančia – Klinikinė anketa apie nerimą ir depresiją (HADS; Zigmont and Snaith, 1983).

Sociodemografiniai kintamieji matuoti sociodemografinių duomenų anketa.

Tyrimo eiga. Tyrimas buvo tęstinis, sudarytas iš trijų įvertinimo etapų. Pirmą kartą artimieji buvo apklausti pirmąją hospitalizacijos savaitę, pakartotinai – po trijų bei devynių mėnesių. Su artimaisiais buvo susitinkama individualiai. Tyrimo metu pasitraukė 41 proc. imties. Pirmame matavime dalyvavo 51 asmuo, antrame – 37 asmenys iš jų, trečiame – 30 asmenų. Norint nustatyti ar tyrimo kintamieji ir tyrimo dalyvių demografinės charakteristikos galėjo nulemti tyrimo dalyvių pasitraukimą iš tyrimo, buvo atlikta logistinė regresinė analizė. Gauti rezultatai rodo, kad viename ar visuose tyrimo etapuose dalyvavę pacientų artimieji panašiai suvokia situacijos sunkumą, globėjo patirtį, patiria psichologinę kančią ir pasižymi panašiomis demografinėmis charakteristikomis. Tačiau galima matyti tendenciją, kad tie, kurie jaučiasi neveiksmingai besitvarkantys su situacija - turi 2,5 karto didesnę tikimybę pasitraukti iš tyrimo. Gali būti, kad iš tyrimo labiau linkę pasitraukti tie, kurie jautėsi neveiksmingai besitvarkantys su situacija.

TYRIMO REZULTATAI IR IŠVADOS

1. Pirmas šeimos nario psichozės epizodas yra ypač sunkus ir sukrečiantis įvykis artimųjų gyvenime. Pirma psichozė ūmios krizės metu daugumai artimųjų buvo vienas sunkiausių gyvenimo įvykių ir daugiau nei pusės artimųjų psichologinė kančia tuo metu siekė kliniškai reikšmingą lygį.

2. Pirmą psichozę išgyvenusių asmenų artimųjų reagavimas yra specifiškas sergančiojo atsigavimo etapui:

- Skirtingame etape skiriasi artimųjų ligos situacijos ir psichologinės kančios neigiamumas. Didžiausi artimųjų ligos situacijos vertinimo ir psichologinės kančios pokyčiai vyksta sergančiajam pereinant iš ūmios krizės į ankstyvąjį atsigavimo etapą (stigmos ir negatyvių simptomų vertinimo atveju – pereinant į vėlyvąjį atsigavimo

etapą). Gana stabilūs lieka tik įveikos veiksmingumo, problemų dėl paslaugų ir pozityvios asmeninės patirties vertinimai.

- Skirtingame etape skiriasi artimųjų pichologinei kančiai reikšmingiausi globos aspektai. Ūmios krizės metu artimųjų psichologinei kančiai reikšmingiausias priklausomybės išgyvenimas ir patiriamos problemos dėl gaunamų paslaugų; ankstyvuoju atsigavimo laikotarpiu išryškėja stigmos reikšmė psichologinei kančiai ir išlieka reikšminga tiek vėlyvuoju atsigavimo laikotarpiu, tiek pakartotinai dėl psichozės hospitalizuotų pacientų artimiesiems; vėlyvuoju atsigavimo laikotarpiu pradeda ryškėti netekties kintamojo reikšmė artimųjų psichologinei kančiai.

3. Artimųjų ligos situacijos vertinimas yra stabilesnis nei jų psichologinė kančia laikui bėgant – iš pradinio ligos situacijos vertinimo galima prognozuoti vėlesnį ligos situacijos vertinimą, tačiau iš pradinės psichologinės kančios negalima prognozuoti vėlesnės psichologinės kančios. Artimieji, didesnę psichologinę kančią patiriantys pradiniame etape, nebūtinai jaus didesnę kančią vėlesniais atsigavimo etapais.

4. Pirmą psichozę išgyvenusių asmenų artimųjų vėlesnę psichologinę kančią nuspėja ligos situacijos vertinimas, o ne pradinė psichologinė kančia. Vėlesnę psichologinę kančią galime prognozuoti iš pradinio situacijos sunkumo vertinimo ir iš įveikos veiksmingumo vertinimo ankstyvuoju atsigavimo laikotarpiu. Tačiau negalime to padaryti iš globėjo patirties vertinimo.

5. Artimųjų gaunama socialinė parama atlieka apsauginį vaidmenį: ji atvirkščiai susijusi su psichologine kančia ir neigiamu ligos situacijos vertinimu; silpnina ryšį tarp neigiamo situacijos vertinimo ir psichologinės kančios; nuspėja psichologinę kančią vėlesniu laikotarpiu; sąveikauja su neigiamu ligos situacijos vertinimu nuspėjant psichologinę kančią tuo pačiu matavimu. Socialinės paramos apsauginė reikšmė išryškėja ankstyvuoju atsigavimo laikotarpiu ir stiprėja laikui bėgant.

6. Praktinis rezultatų taikymas reikštų, kad, norėdami sumažinti vėlesnę artimųjų psichologinę kančią, turėtume pirmiausia pagerinti jų ligos situacijos vertinimą.

ABOUT DOCTORAL STUDENT

Ieva Povilaitienė studied psychology at Vilnius University from 1994 to 1998. She graduated with her bachelor‘s degree in 1998, with her master’s degree in Educational Psychology in 2000, and also fulfilled a program of Clinical Psychology. She was a doctoral student at the Department of Clinical and Organizational Psychology at Vilnius University from 2006 to 2011. During her PhD studies she discussed her study plan at the Nordic-Baltic Doctoral Network symposium/ PhD seminar (in Tromso, Norway) and presented her study results in a few international conferences.

She got interested in psychoses and mental health care during the years of her undergraduate studies. She got involved in the Consensus Project, organized by the Association of Psychosocial Rehabilitation, helped in organizing an international conference, was a co-editor of the “Best mental health care programs in Lithuania”. Since 2001 together with her colleagues she’s been establishing a psychosocial rehabilitation service system in a newly established Vilnius Center for Psychosocial Rehabilitation. While working in the center, she’s been working with mentally disabled people, their relatives, and training mental health care professionals. She has also worked as a medical psychologist at Republican Vilnius Psychiatric Hospital, and later in Vilnius Mental Health Center. She is a co-author of an educational book for mental health care professionals, methodical recommendations for emergency medical service workers, and police officers, an editor of an information publication for patients and their relatives.

In 2004 she completed a Gestalt psychotherapy basic level program and in 2010 was qualified in a Jungian psychotherapy program. She is interested in psychological-psychotherapeutic help in the cases of psychoses and other mental disorders.

Research interests – psychological aspects of psychosis, crisis psychology, health psychology, family psychology.

TRUMPOS ŽINIOS APIE DOKTORANTĘ

Ieva Povilaitienė Vilniaus universitete studijavo psichologiją nuo 1994 metų. 1998 įgyjo psichologijos bakalauro, o 2000 – įgyjo pedagoginės psichologijos magistro laipsnį ir įvykdė klinikinės psichologijos studijų programą. Nuo 2006 iki 2011 metų Vilniaus universiteto Klinikinės ir organizacinės psichologijos katedros doktorantė.

Doktorantūros studijų metu disertacijos tyrimo planą aptarinėjo Nordic-Baltic Doctoral Network organizuojamame simpoziume /PhD seminare (Tromso, Norvegija), o atlikus disertacijos tyrimą, gautus rezultatus pristatė keliose tarptautinėse konferencijose.

Psichozių ir psichikos sveikatos priežiūros tema susidomėjo dar studijų metais. Įsitraukė į Psichosocialinės reabilitacijos asociacijos organizuojamą Konsensuso projektą, padėjo rengti tarptautinę konferenciją, sudaryti "Geriausių Lietuvos psichikos sveikatos priežiūros programų" leidinį. Nuo 2001 m. kartu su kolegomis kūrė psichosocialinės reabilitacijos paslaugų sistemą naujai įsteigtame Vilniaus psichosocialinės reabilitacijos centre. Šiame centre teikė pagalbą sunkią psichikos negalią turintiems asmenims, jų artimiesiems, vedė mokymus psichikos sveikatos priežiūros specialistams. Taip pat dirbo medicinos psichologe Vilniaus m. Respublikinėje psichiatrijos ligoninėje, o vėliau - Vilniaus m. psichikos sveikatos centre. Yra mokomosios knygos, skirtos psichikos sveikatos priežiūros specialistams bendraautorė, metodinių rekomendacijų greitosios pagalbos darbuotojams ir policijos pareigūnams bendraautorė, informacinio leidinio sergantiesiems ir jų artimiesiems sudarytoja.

2004 m. baigė geštaltinės psichoterapijos bazinio lygmens mokymosi programą, o 2010 m. - kvalifikacinio lygmens jungiškos krypties psichoterapijos programą. Domisi psichologine-psichoterapine pagalba psichozių ir kitų psichikos sutrikimų atvejais.

Mokslinių interesų sritys – psichologiniai psichozių aspektai, krizių psichologija, sveikatos psichologija.

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