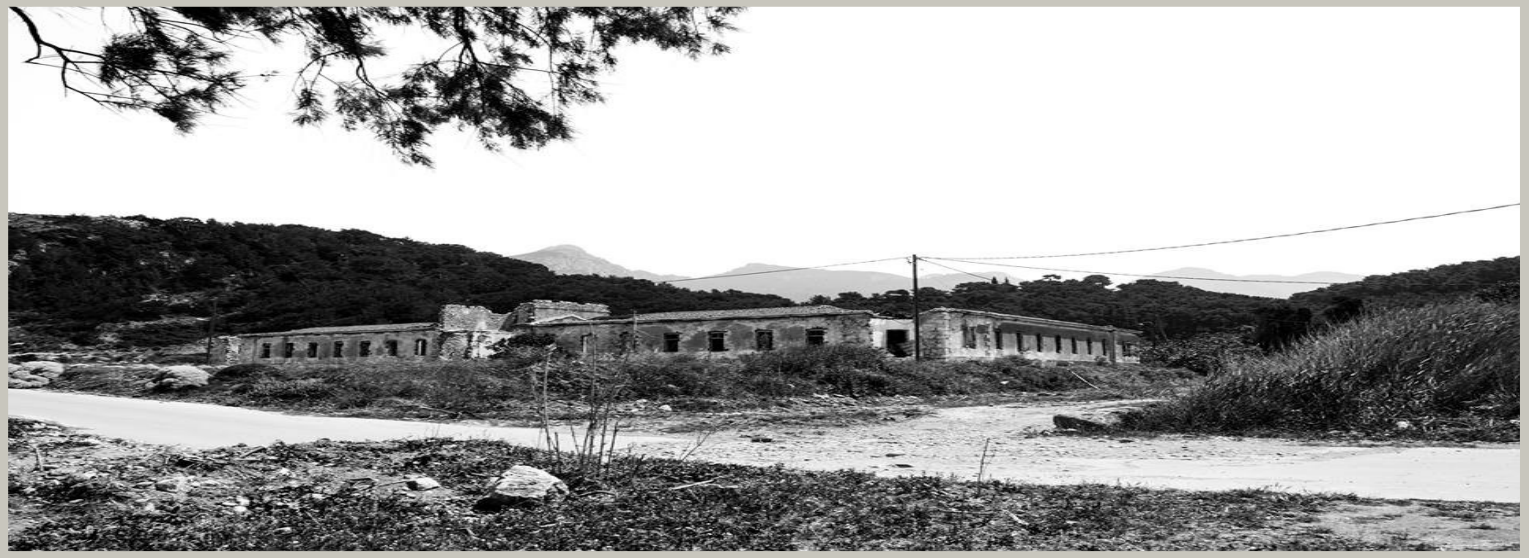
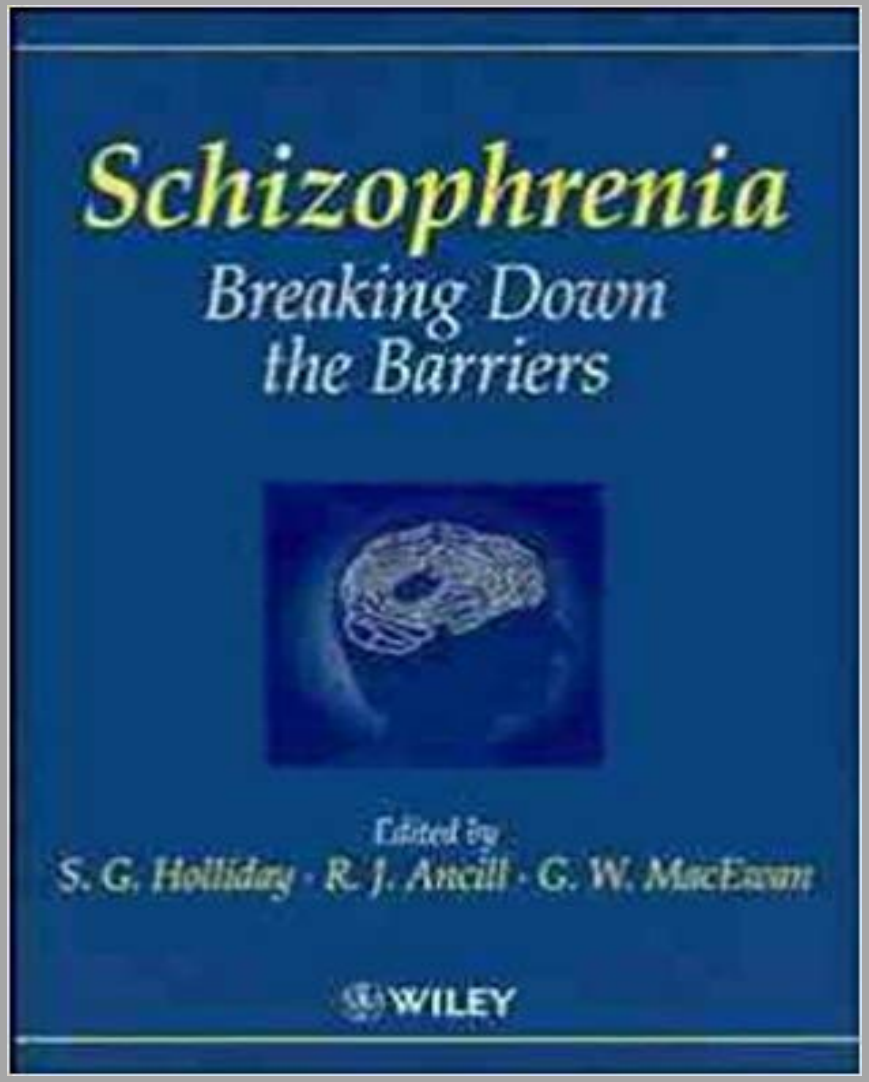
Παράμετροι που δυσκολεύουν τη θεραπεία της Σχιζοφρένειας

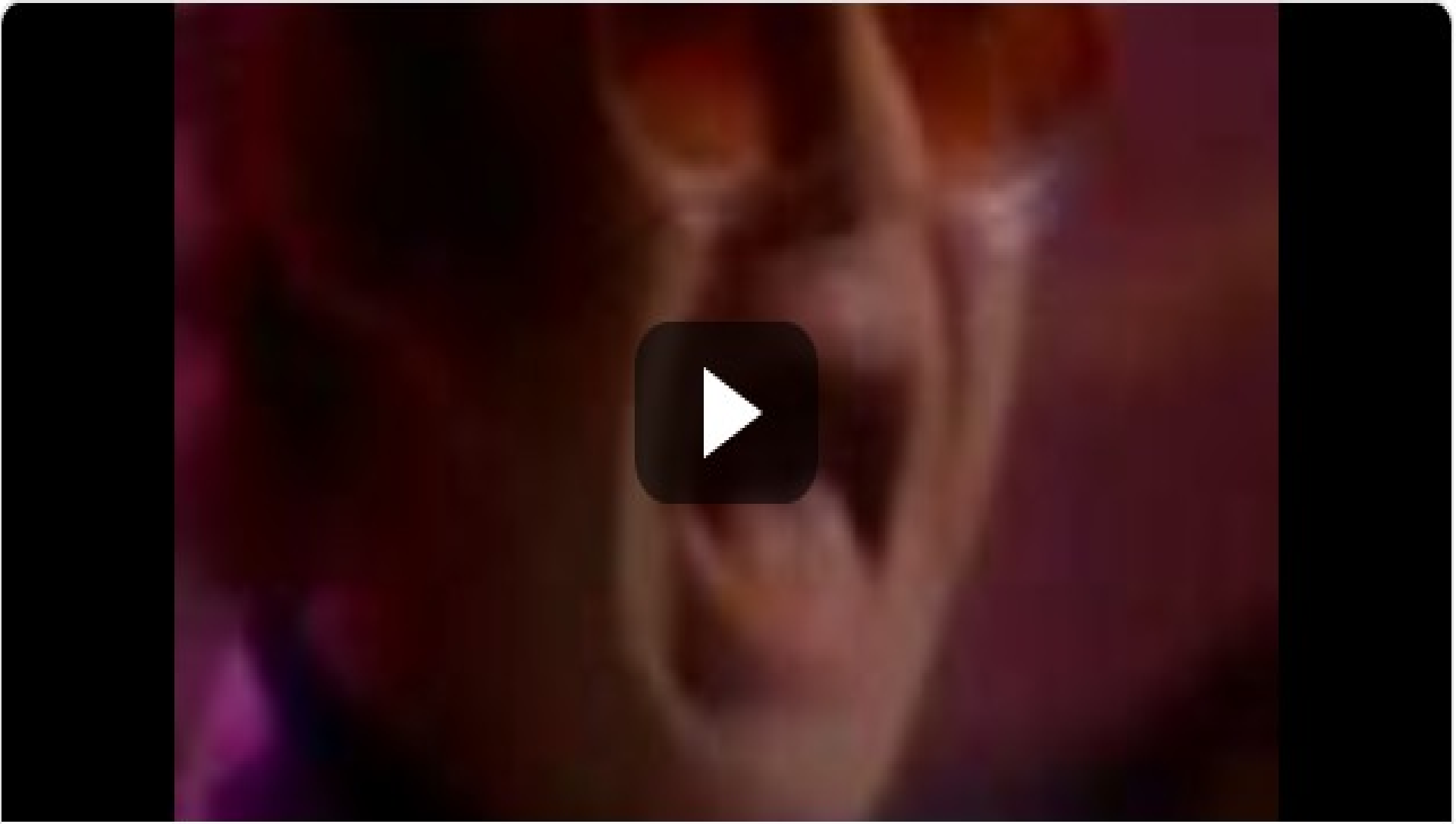
Μαρίνα Οικονόμου
Αναπληρώτρια Καθηγήτρια Ψυχιατρικής
Α΄ Ψυχιατρική Κλινική Ιατρικής Σχολής Πανεπιστημίου Αθηνών, Αιγινήτειο Νοσοκομείο
Ερευνητικό Πανεπιστημιακό Ινστιτούτο Ψυχικής Υγιεινής (Ε.Π.Ι.Ψ.Υ.)



Σαμος
2-5 Μαΐου 2019

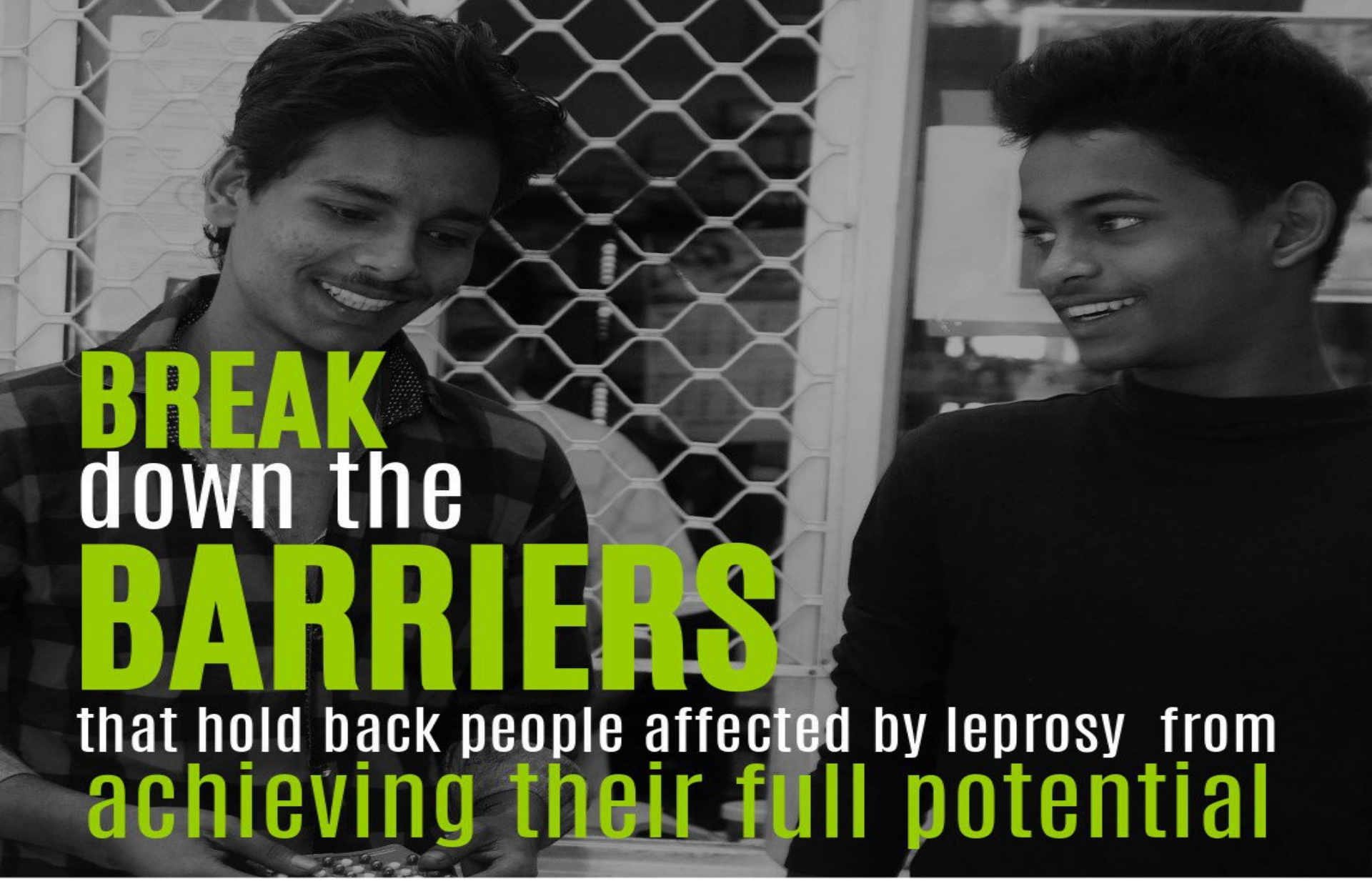

Schizophrenia
Breaking Down the Barriers
Edited by
S. G. Holliday · R. J. Ancill · G. W. MacEwan
WILEY

1996



Elton John Breaking Down The Barriers - YouTube

https://www.youtube.com/watch?v=570vPBOQnSs



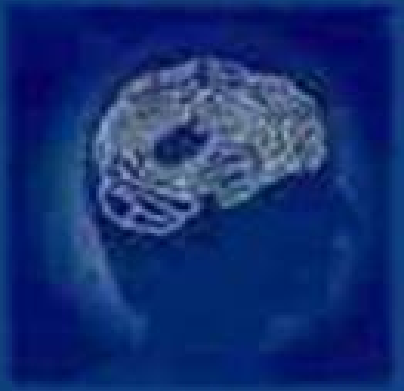
The Leprosy Mission Trust India

healing.inclusion.dignity

www.leprosymission.in

Schizophrenia

Breaking Down the Barriers



Edited by
S. G. Holliday · R. J. Ancill · G. W. MacEwan

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ΤΑ ΣΥΧΝΟΤΕΡΑ ΑΝΑΦΕΡΟΜΕΝΑ ΕΜΠΟΔΙΑ ΣΤΗ ΘΕΡΑΠΕΙΑ

- Στίγμα
- Πτωχή συνεργασία με τον ψυχίατρο και τις υπηρεσίες ψυχικής υγείας
- Παρενέργειες- πτωχή συμμόρφωση
- Ελλιπής ενημέρωση και εκπαίδευση για τη νόσο και τη θεραπεία της
- Μη κατανόηση της φύσης της νόσου
- Μη αποτελεσματικά φάρμακα
- Μειωμένη εναισθησία και κρίση

Από John Talbott στο **«Schizophrenia: Breaking Down the Barriers»** 1996

From Noncompliance to Collaboration in the Treatment of Schizophrenia

1990

Patrick W. Corrigan, Psy.D.
Robert Paul Liberman, M.D.
Jeremy D. Engel, B.A.

Although effective treatment for schizophrenia is available, patients' compliance with treatment prescriptions is notoriously poor. The authors reframe compliance as a collaborative relationship in which both the patient and practitioner assume responsibility for producing a treatment regimen to which the patient can adhere. Barriers that prevent a partnership in treatment may be related primarily to treatment techniques, to characteristics of the patient and his family, to the patient-clinician relationship, or to the treatment delivery system. A comprehensive approach to addressing these sources of noncompliance includes specific skills that can be acquired by the patient, family members, and the practitioner.

be noncompliant within the first year of treatment, and 74 percent within the first two years (17).

Medication compliance is unsatisfactory even on inpatient units (18). Van Putten and his colleagues (19) found that inpatients' compliance with antipsychotic medication is associated with the subjective effect of the drug. Sixty-two percent of schizophrenic inpatients who became dysphoric with medication ultimately refused further drugs, while only 11 percent of medicated patients who were syntonic failed to comply.

Adherence to specific treatment plans can be closely monitored in inpatient settings, and patients can be prompted to take medication if they fail to do so on their own. In addition, the close observation made possible by the high staff-to-patient ratios in these settings can help overcome noncompliance among patients who have a negative subjective response to antipsychotic drugs (20). Even though compliance is obviously facilitated by inpatient treatment

While data on the compliance of schizophrenic patients with psychosocial programs are limited, poor adherence may be inferred from dropout rates of 18 to 40 percent found in investigations of psychosocial interventions (27–34). Similarly, 29 percent of the patients in a study of a vocational day treatment program refused to join the program, while another 32 percent dropped out before half of the treatment sessions were completed (35).

Most accounts in the literature portray the patient's adherence to treatment in terms of compliance by the patient rather than collaboration between the patient and the clinician. This representation perpetuates the misconceptions that adherence derives primarily from the patient's motivation or resistance and that the clinician is powerless to affect the patient's behavior. Rather than viewing the schizophrenic patient as a passive receptacle for treatment, the therapist can mobilize the patient to cooperate in a partnership in treatment and can share with

Table 1
Barriers to patient collaboration in treatment and corrective measures

Barrier	Corrective measure
Treatment techniques	
Side effects	Use low-dose medication for maintenance.
	Prescribe medication to treat side effects.
	Titrate medication to minimum optimal dose.
	Reframe side effects as signs that the drug is working.
	Teach patient to keep a diary for tracking side effects.
	Educate patient about side effects and their management.
Complex treatment regimen	Ask patient to repeat back written and spoken instructions.
	Use simple words.
	Increase complexity of treatment in stepwise increments.
	Enlist patient participation in creating the treatment regimen.
	Use stimulus control to remind patient to take medication.
	Teach family members or caregivers to mediate in reinforcing compliance.
Long-term treatment	Institute treatment holidays.
	Administer medication intermittently, when symptoms of relapse occur.

Patient characteristics	
Cognitive disorganization	Minimize complexity of treatment regimen.
	Use telephone calls, compartmentalized pill boxes, and other stimuli to remind patient to take medication.
	Use cognitive rehabilitation techniques to improve patient thought disorder.
	Teach self-monitoring techniques to patient.
	Enlist caregivers' assistance in monitoring patient compliance.
Ignorance about illness	Teach patient about the biomedical nature of mental illness and its relation to stress.
	Use cognitive restructuring techniques to enhance learning.
	Offer destigmatizing analogies to other diseases.
Fatalistic attitude	Teach patient about the long-term normalizing outcomes of illness.
	Use cognitive restructuring techniques to enhance change in attitude.
	Give patient increased control in goal setting, administration of medication, and psychosocial treatments.
	Use paradoxical interventions such as contingency contracting.
Secondary gains from psychosis	Build therapeutic relationship as a lever to change.
	Help the patient sample reinforcers of behaviors that compete with psychosis.
	Enlist significant others as mediators.

Family characteristics	
Ignorance about benefits of treatment	Encourage family participation in psychoeducation and support groups.
Unrealistic expectations	Encourage family to participate in psychoeduction, survival skills training, and training in communication and problem solving. If other strategies fail, suggest a constructive separation of patient from the family.
Indifference	Promote family education to galvanize social support for patient. Identify reinforcers, such as decreased family chaos, to motivate family involvement. Teach patient to improve relationship with family.

Clinician-patient relationship	
Clinician believes patient has poor prognosis	Learn about practical modes of rehabilitation. Consult professional role models. Ask the patient and family members about their aspirations.
Clinician has aversive interpersonal style	Obtain training in counseling skills.
Clinician ignores patient's dissatisfaction with treatment	Learn about the impact of side effects and how to manage them.

Treatment delivery system	
Aversive clinic setting	Improve clinic decor and ambience. Offer coffee or other refreshments. Encourage clerical staff to be pleasant.
Long waits at clinic	Maintain realistic appointment schedule. Remind patient about appointments.
Lack of coordination in treatment delivery system	Use case managers and continuous treatment teams to coordinate services.

Table 2
Skills and goals of training in medication and symptom management for chronic schizophrenic patients

Skill	Goal
Medication management	
Obtaining information about antipsychotic medication	To understand how antipsychotic drugs work, why maintenance drug therapy is used, and what benefits result from taking medication
Self-administering medication and evaluating the effect of medication	To learn appropriate procedures for taking medication and evaluating responses to medication daily
Identifying side effects of medication	To learn the side effects that sometimes result from taking medication and what can be done to alleviate these problems
Negotiating medication issues with health care providers	To practice ways of getting assistance when problems occur with medication—for example, how to call the hospital or doctor and how to report symptoms and progress
Learning about long-acting, injectible medication	To understand the effects of this type of drug administration
Symptom management	
Identifying warning signs of relapse	To learn how to identify and monitor personal warning signs with assistance from others
Managing warning signs	To learn specific techniques for managing warning signs and to develop an emergency plan
Coping with persistent symptoms	To learn how to recognize persistent symptoms and to use techniques for coping with them
Avoiding alcohol and street drugs	To learn the adverse effects of alcohol and illicit drugs and the benefits of avoiding them

Patient Related Outcome Measures

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REVIEW

Nonadherence with antipsychotic medication in schizophrenia: challenges and management strategies

2014

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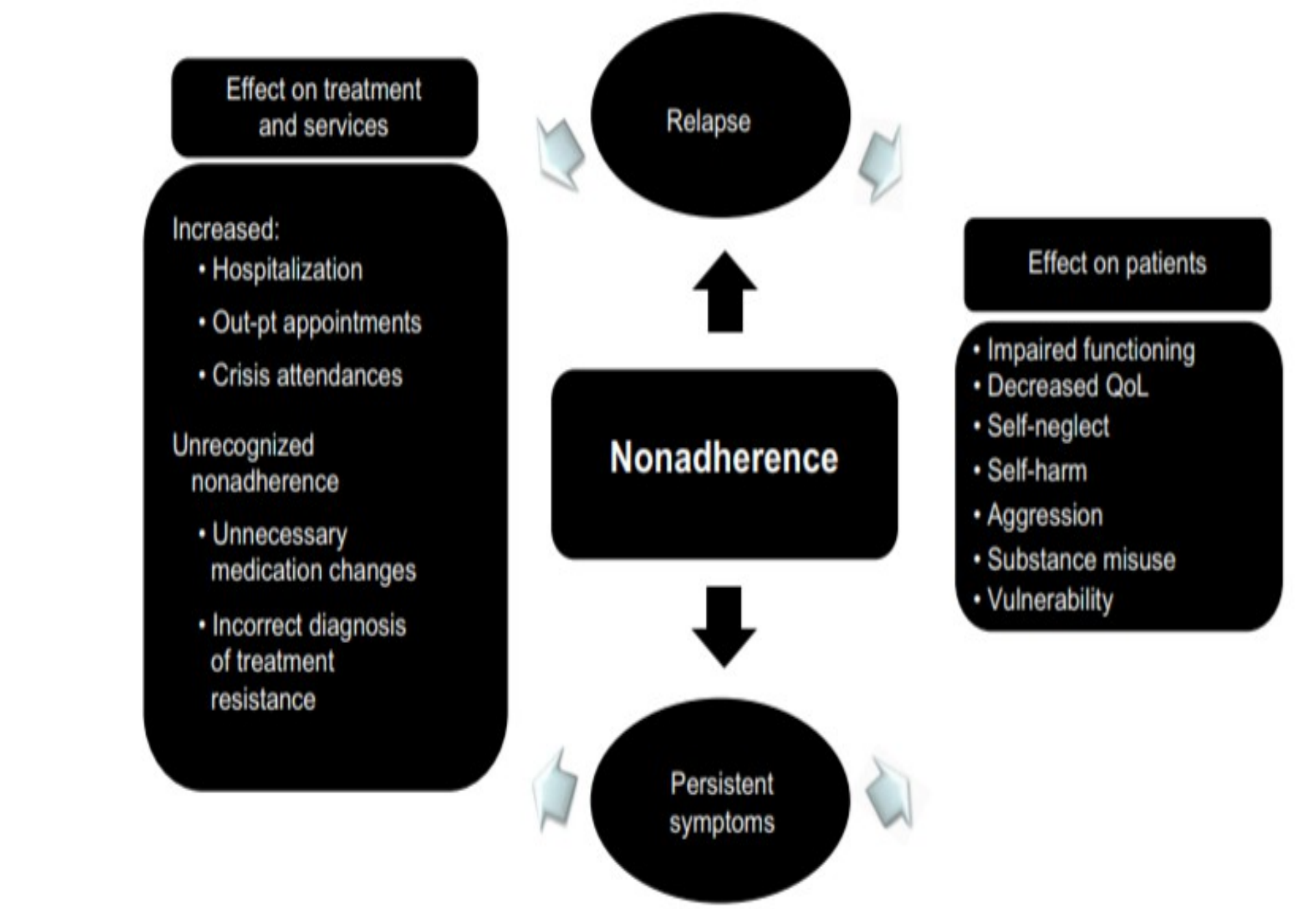
Patient Related Outcome Measures
23 June 2014
Number of times this article has been viewed

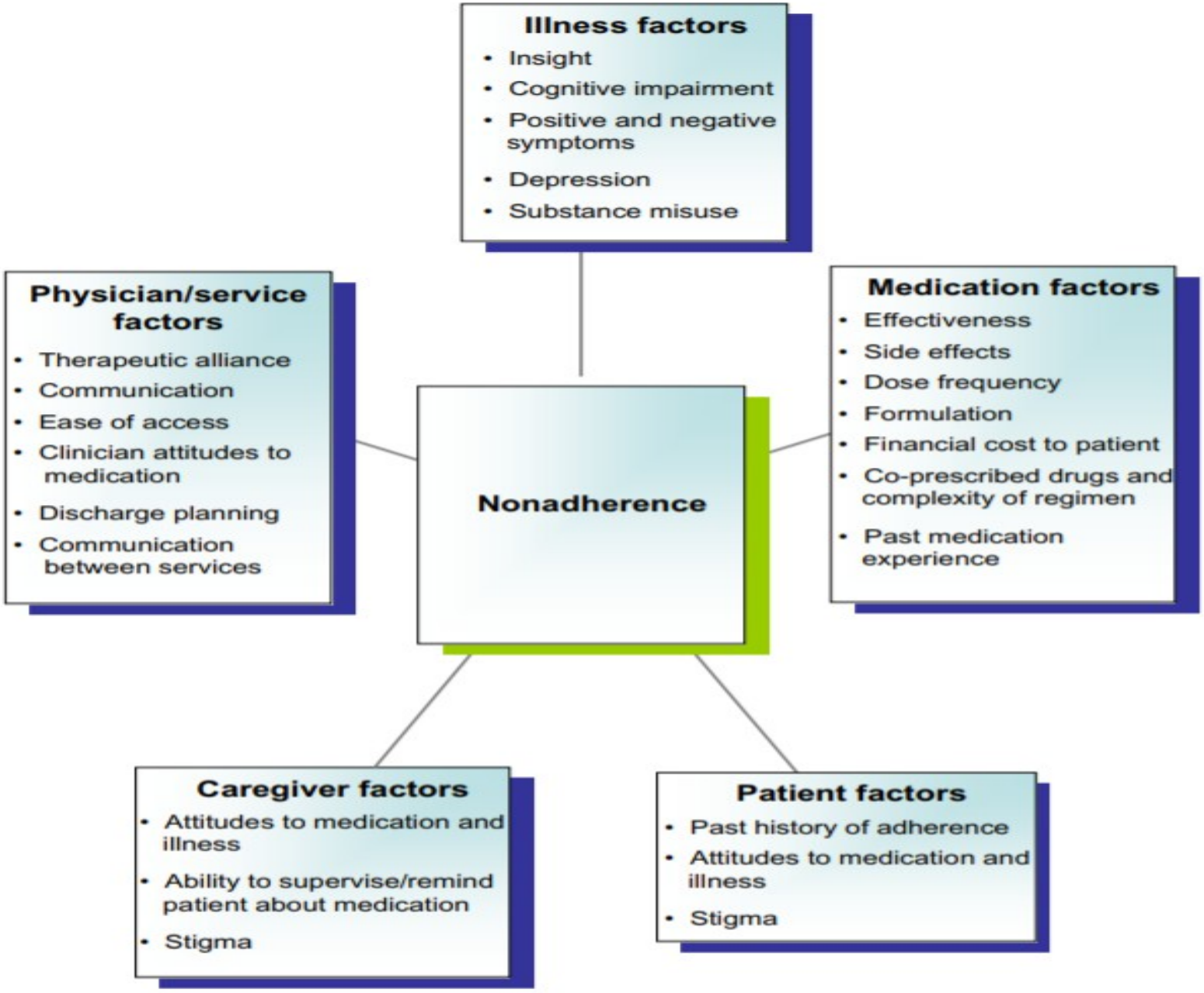
Peter M Haddad[1,2]
Cecilia Brain[3,4]
Jan Scott[5,6]

[1]Neuroscience and Psychiatry Unit, University of Manchester, Manchester, [2]Greater Manchester West Mental Health NHS Foundation Trust, Salford, UK; [3]Institute of Neuroscience and Physiology, Department of Psychiatry and Neurochemistry, Sahlgrenska Academy, University of Gothenburg, [4]Nå Ut-teamet, Psychosis Clinic, Sahlgrenska University Hospital, Gothenburg, Sweden; [5]Academic Psychiatry, Institute of Neuroscience, Newcastle University, [6]Centre for Affective Disorders, Institute of Psychiatry, London, UK

Abstract: Nonadherence with medication occurs in all chronic medical disorders. It is a particular challenge in schizophrenia due to the illness's association with social isolation, stigma, and comorbid substance misuse, plus the effect of symptom domains on adherence, including positive and negative symptoms, lack of insight, depression, and cognitive impairment. Nonadherence lies on a spectrum, is often covert, and is underestimated by clinicians, but affects more than one third of patients with schizophrenia per annum. It increases the risk of relapse, rehospitalization, and self-harm, increases inpatient costs, and lowers quality of life. It results from multiple patient, clinician, illness, medication, and service factors, but a useful distinction is between intentional and unintentional nonadherence. There is no gold standard approach to the measurement of adherence as all methods have pros and cons. Interventions to improve adherence include psychoeducation and other psychosocial interventions, antipsychotic long-acting injections, electronic reminders, service-based interventions, and financial incentives. These overlap, all have some evidence of effectiveness, and the intervention adopted should be tailored to the individual. Psychosocial interventions that utilize combined approaches seem more effective than unidimensional approaches. There is increasing interest in electronic reminders and monitoring systems to enhance adherence, eg, Short Message Service text messaging and real-time medication monitoring linked to smart pill containers or an electronic ingestible event marker. Financial incentives to enhance antipsychotic adherence raise ethical issues, and their place in practice remains unclear. Simple pragmatic strategies to improve medication adherence include shared decision-making, regular assessment of adherence, simplification of the medication regimen, ensuring that treatment is effective and that side effects are managed, and promoting a positive therapeutic alliance and good communication between the clinician and patient. These elements remain essential for all patients, not least for the small minority where vulnerability and risk issue dictate that compulsory treatment is necessary to ensure adherence.



Consequences of nonadherence to antipsychotic medication.



Factors associated with nonadherence.

ΠΑΡΑΜΕΤΡΟΙ ΠΟΥ ΕΧΟΥΝ ΣΧΕΣΗ ΜΕ ΤΗΝ «ΣΥΜΜΟΡΦΩΣΗ»- ΕΜΠΟΔΙΑ ΣΤΗ ΘΕΡΑΠΕΙΑ

Σχετιζόμενες με τον ασθενή

- Η θεώρηση του ασθενούς για την πάθησή του, αποδοχή, στάσεις, στίγμα
- Παρελθούσα εμπειρία «συμμόρφωσης»

Σχετιζόμενες με την οικογένεια/ φροντιστές

- Στάσεις απέναντι στα φάρμακα και στη νόσο, ικανότητα υπενθύμισης, στίγμα

Σχετιζόμενες με την ασθένεια

- Εναισθησία, γνωσιακά ελλείματα, τύπος συμπτωματολογίας
- Διάρκεια νόσου, χρήση ουσιών, κατάθλιψη

Σχετιζόμενες με την αντιψυχωσική αγωγή

- Ανεπιθύμητες ενέργειες, συχνότητα δόσης, τρόπος χορήγησης, αποτελεσματικότητα
- Παρελθούσα εμπειρία από τη λήψη των φαρμάκων, στίγμα

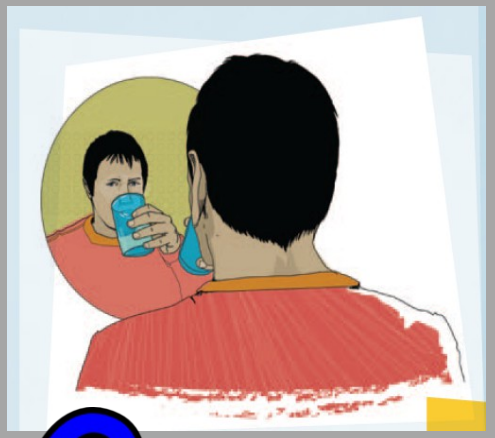
Σχετιζόμενες με τον ψυχίατρο/ υπηρεσίες

- Προσβασιμότητα
- Περιορισμένη ενσυναίσθηση, Θεραπευτική Συμμαχία
- Ελλιπής επεξήγηση / φτωχή επικοινωνία, στάσεις απέναντι στα φάρμακα

ΘΕΡΑΠΕΥΤΙΚΗ ΣΧΕΣΗ

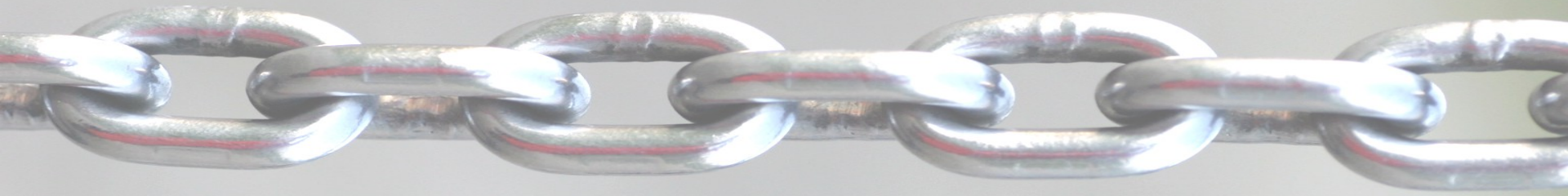
- **Χαρακτηριστικά του θεραπευτή**
  - Προσδοκίες
  - Επικοινωνιακές δεξιότητες
  - Προσωπικότητα
  - Ενσυναίσθηση
  - Καθοδήγηση
- **Χαρακτηριστικά του ασθενή**
  - Αισιοδοξία για την αποτελεσματικότητα της θεραπείας
  - Κίνητρο
  - Ελπίδα
  - Κοινωνική υποστήριξη
- **Χαρακτηριστικά της θεραπείας - παρέμβασης**
  - Ο ρόλος της Ψυχοεκπαίδευσης

Η ΑΞΙΑ ΤΗΣ ΘΕΡΑΠΕΥΤΙΚΗΣ ΣΧΕΣΗΣ



Η ΘΕΡΑΠΕΥΤΙΚΗ ΣΧΕΣΗ ΑΝΑΔΕΙΚΝΥΕΤΑΙ

Ο απαραίτητος αγνοούμενος κρίκος ανάμεσα στο φάρμακο και τον ασθενή



Malatee et al., Arch Psychiat Nursing, 2011

Patient Related Outcome Measures

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REVIEW

Nonadherence with antipsychotic medication in schizophrenia: challenges and management strategies

2014

- **Interventions to improve adherence** include **psychoeducation** and other **psychosocial interventions,** antipsychotic long-acting injections, electronic reminders, service-based interventions, and financial incentives

- **The intervention** adopted should be **tailored to the individual**

- **Combined approaches** seem more effective than unidimensional approaches

- **Simple pragmatic strategies** to improve medication adherence include **shared decision-making,** **regular assessment** of adherence, **simplification** of the medication regimen,

Table 1 Methods of assessing medication adherence

Objective adherence measurement	Subjective adherence measurement
Medication container with electronic monitoring, eg, MEMS	Clinician's view on adherence (often based on therapeutic response and side effects) ★
Pill count ★	Patient or key other report*
Biological markers ★	Patient diary of medication intake
Observed intake ★	Questionnaires, eg, DAI, MARS
Medication possession ratio	
Medication plasma level	
Electronic ingestible event marker	

Note: *Patient, case manager, other health care professional, next-of-kin, or carer are asked to estimate the adherence of the patient.

Abbreviations: MEMS, Medication Event Monitoring System; DAI, Drug Attitude Inventory; MARS, Medication Adherence Rating Scale.

ΛΟΓΟΙ ΜΗ ΙΚΑΝΟΠΟΙΗΣΗΣ ΤΩΝ ΑΣΘΕΝΩΝ ΑΠΟ ΤΟΝ ΨΥΧΙΑΤΡΟ

- δεν αφιέρωσε αρκετό χρόνο (52%)
- δεν με κατάλαβε (49%)
- δεν μου εξήγησε τα φάρμακα (40%)
- δεν έδωσε σημασία στις ανησυχίες μου για τα φάρμακα (40%)
- δεν με φρόντισε (39%)
- δεν με σεβάστηκε (32%)
- δεν εξέλαβε σοβαρά το πρόβλημά μου (21%)

Colom F. et al., J Clin Psychiat, 2000; Adherence to long term Therapies, WHO, 2003; Masand P and Narasimhan M. Current Clinical Pharmacology 2006; Baldessarini et al., Hum Psychopharmacol, 2008

Αν

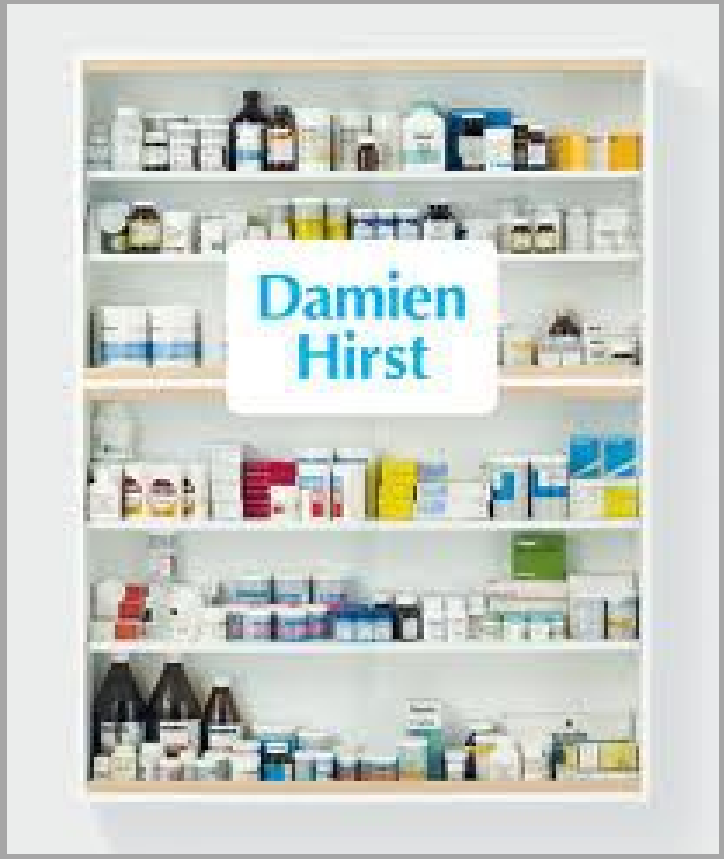
“η συμμόρφωση”

ήταν ένα απλό θέμα δεν θα αποτελούσε πρόβλημα…

Τι γίνεται στην πράξη ;

;;;;;

…Γιατί και το καλύτερο φάρμακο να δίνει κανείς στον ασθενή, αυτό δεν θα έχει κανένα αποτέλεσμα εάν **δεν λαμβάνεται συστηματικά** από τον ασθενή.



ΠΕΠΟΙΘΗΣΕΙΣ ΤΩΝ ΨΥΧΙΑΤΡΩΝ ΓΥΡΩ ΑΠΟ ΤΗ «ΣΥΜΜΟΡΦΩΣΗ»

131 ψυχίατροι και 429 ασθενείς με ΔΔ

Ποιο ποσοστό ασθενών σας θεωρείτε ότι δεν παίρνει θεραπεία;

Απάντηση Ψυχιάτρων : 6%

Πραγματικότητα : 34% των ασθενών δήλωσαν ότι δεν παίρνουν τη θεραπεία τους

(Baldessarini et al., Hum Psychopharmacol, 2008)

MAKING PEACE WITH MY MEDS

Overcoming adherence obstacles

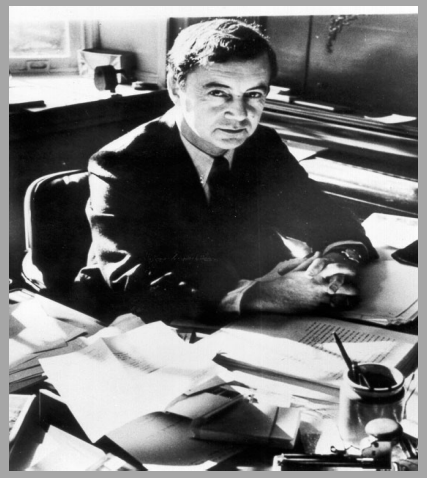
Χρειάζεται

μετακίνηση από την απλή παροχή ενημέρωσης σε μια ολοκληρωμένη εκπαιδευτική και ψυχοθεραπευτική πλατφόρμα που να αλλάζει τη συμπεριφορά.....

psychoeducation

ΣΤΙΓΜΑ: ΟΡΙΣΜΟΣ

«Έντονα μειωτικός χαρακτηρισμός που αποδίδεται σε κάποιον και από τον οποίο είναι πολύ δύσκολο να απαλλαγεί, του στερεί το δικαίωμα της πλήρους κοινωνικής αποδοχής και τον αναγκάζει να κρύψει την αιτία που προκαλεί αυτή την αντιμετώπιση.»



(Goffman 1963)

ΣΤΕΡΕΟΤΥΠΑ

ΒΙΑ

ΜΥΘΟΙ

ΦΟΒΟΣ

ΜΟΝΑΞΙΑ

ΠΡΟΚΑΤΑΛΗΨΗ

ΑΠΟΚΛΕΙΣΜΟΣ

ΔΙΑΚΡΙΣΕΙΣ

ΑΓΝΟΙΑ

ΝΤΡΟΠΗ

ΠΟΙΟΣ ΣΤΙΓΜΑΤΙΖΕΤΑΙ;

- Άτομα ή ομάδες με ιδιαίτερα χαρακτηριστικά
- Ειδικές καταστάσεις - νοσολογικές οντότητες

ΣΤΙΓΜΑ ΚΑΙ ΝΟΣΟΛΟΓΙΑ

Σε διάφορες εποχές και κοινωνίες, ποικίλα ήταν τα συμπτώματα και οι νόσοι που τους είχαν αποδοθεί μειωτικοί χαρακτηρισμοί.

"Στιγματίζονταν" διαταραχές με "ορατά σημάδια".

Φυματίωση → Καρκίνος

Σύφιλη → Aids

Ψυχική νόσος

Σχιζοφρένεια


overturning
the
STIGMA
of leprosy

Τόσες λέξεις…

- Τόσες ιστορίες, μα πάντα ο ίδιος πρωταγωνιστής. Ο μιασμένος, ο απόβλητος, ο χτικιασμένος, ο επικίνδυνος, ο ρυπαρός, ο ακάθαρτος, ο στιγματισμένος, ο μολεμένος, ο αμαρτωλός, ο νεκροζώντανος, ο καταραμένος, ο αποδιοπομπαίος τράγος, ο βρώμικος, ο έκλυτος, ο ανώμαλος, ο βρωμερός, ο παρίας, ο απόβλητος, ο λωβός.. Τόσο ξόδεμα λέξεων κι όμως δεν φτάνει να χωρέσει το φόβο, την αμάθεια

- Ο WHO και η WPA έχουν χαρακτηρίσει το στίγμα ως **«μέγιστη πρόκληση»** για τις υπηρεσίες ψυχικής υγείας

(WHO 2001, WPA 2004)

- Το κοινωνικό στίγμα αποτελεί το βασικότερο **εμπόδιο** στην **παροχή επαρκούς ψυχιατρικής φροντίδας και την παροχή αποτελεσματικής θεραπείας**

(WHO 2001, Sartorius 2002)

- Ανασκόπηση ερευνών καταδεικνύει πως το στίγμα αποτελεί βασικό **εμπόδιο στην αναζήτηση βοήθειας**.

(Clement et al., 2015)

«Υπάρχουν πλέον αποδείξεις για την τοξική επίδραση του στίγματος που συνοδεύει τις ψυχικές νόσους…
Έτσι, αρκετοί ασθενείς αποφεύγουν να ζητήσουν βοήθεια.»

Η ταμπέλα του «ψυχασθενούς» κάνει το άτομο να καθυστερεί την επίσκεψη στον ειδικό για μήνες, χρόνια ή επ' αόριστον, κάτι που με τη σειρά του καθυστερεί σημαντικά τη θεραπεία.

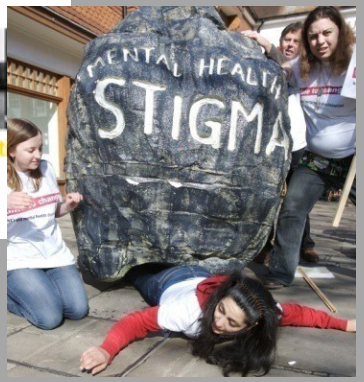
(Clement et al., Psychological Medicine, 2015
"What is the impact of mental health-related stigma on help-seeking?
A systematic review of quantitative and qualitative studies")

ΣΤΡΑΤΗΓΙΚΕΣ ΓΙΑ ΤΗΝ ΚΑΤΑΠΟΛΕΜΗΣΗ ΤΟΥ ΣΤΙΓΜΑΤΟΣ

- **Ενημέρωση**
- **Διαμαρτυρία**
- **Εκπαίδευση**
- **Επαφή με τον ψυχικά ασθενή**
- **Συνηγορία**

(Warner 2000, Corrigan & Lundin 2001, Corrigan et al. 2005)

ΔΙΕΘΝΗ ΠΡΟΓΡΑΜΜΑΤΑ
ΓΙΑ ΤΗΝ ΚΑΤΑΠΟΛΕΜΗΣΗ ΤΟΥ ΣΤΙΓΜΑΤΟΣ



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Stigma- and non-stigma-related treatment barriers to mental healthcare reported by service users and caregivers

Lisa Dockery*,[1], Debra Jeffery, Oliver Schauman, Paul Williams, Simone Farrelly, Oliver Bonnington, Jheanell Gabbidon, Francesca Lassman, George Szmukler, Graham Thornicroft, Sarah Clement, MIRIAD study group

Section of Community Mental Health Box PO29, Health Service and Population Research Department, Institute of Psychiatry, King's College London, De Crespigny Park, London SE5 8AF, United Kingdom

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ABSTRACT

Delayed treatment seeking for people experiencing symptoms of mental illness is common despite available mental healthcare. Poor outcomes are associated with untreated mental illness and caregivers may eventually need to seek help on the service user's behalf. More attention has recently focused on the role of stigma in delayed treatment seeking. This study aimed to establish the frequency of stigma- and non-stigma-related treatment barriers reported by 202 service users and 80 caregivers; to compare treatment barriers reported by service users and caregivers; and to investigate demographic predictors of reporting stigma-related treatment barriers. The profile of treatment barriers differed between service users and caregivers. Service users were more likely to report stigma-related treatment barriers than caregivers across all stigma-related items. Service users who were female, had a diagnosis of schizophrenia or with GCSEs (UK qualifications usually obtained at age 16) were significantly more likely to report stigma-related treatment barriers. Caregivers who were female or of Black ethnicities were significantly more likely to report stigma-related treatment barriers. Multifaceted approaches are needed to reduce barriers to treatment seeking for both service users and caregivers, with anti-stigma interventions being of particular importance for the former group.

ABSTRACT

Delayed treatment seeking for people experiencing symptoms of mental illness is common despite available mental healthcare. Poor outcomes are associated with untreated mental illness and caregivers may eventually need to seek help on the service user's behalf. More attention has recently focused on the role of stigma in delayed treatment seeking. This study aimed to establish the frequency of stigma- and non-stigma-related treatment barriers reported by 202 service users and 80 caregivers; to compare treatment barriers reported by service users and caregivers; and to investigate demographic predictors of reporting stigma-related treatment barriers. The profile of treatment barriers differed between service users and caregivers. Service users were more likely to report stigma-related treatment barriers than caregivers across all stigma-related items. Service users who were female, had a diagnosis of schizophrenia or with GCSEs (UK qualifications usually obtained at age 16) were significantly more likely to report stigma-related treatment barriers. Caregivers who were female or of Black ethnicities were significantly more likely to report stigma-related treatment barriers. Multifaceted approaches are needed to reduce barriers to treatment seeking for both service users and caregivers, with anti-stigma interventions being of particular importance for the former group.

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A systematic review of the implementation of recommended psychological interventions for schizophrenia: Rates, barriers, and improvement strategies

Paul Ince, Gillian Haddock* and Sara Tai

School of Psychological Sciences and Clinical Psychology Department, Manchester Mental Health and Social Care Trust, University of Manchester, UK

Purpose. A systematic review of the literature exploring if the UK recommendations for psychological interventions for schizophrenia were being met was carried out. Rates of implementation for cognitive behavioural therapy (CBT) and family intervention (FI) were compared. The barriers against implementation and described strategies aimed at improving implementation were reviewed.

Methods. A literature search of electronic bibliography databases (*Psychinfo*, *Medline*, *Pubmed*, *AMED*, *CINHAL*, and *EMBASE*), reference and citation lists, the Evaluation and Review of NICE Implementation (ERNIE) database, a manual search of Clinical Psychology Forum, governmental reports, charity, and service user group reports was conducted.

Results. Twenty-six articles met the inclusion criteria, 11 provided data on implementation rates, 13 explored the barriers to implementation, and 10 gave information about improvement strategies. Rates of implementation varied from 4% to 100% for CBT and 0% to 53% for FI, and studies varied in the methodology used and quality of the articles. Previously reported barriers to implementation were found, with organisational barriers being most commonly followed by barriers met by staff members and service users. Implementation strategies discovered included training packages for CBT, FI, and psychosocial interventions as well as empirical evidence suggesting methods for engagement with service users.

Conclusions. Rates of implementation for CBT and FI are still below recommended levels with wide variation of rates found. This suggests inequalities in the provision of psychological interventions for schizophrenia are still present. Previously identified barriers to implementation were confirmed. Attempted implementation strategies have been met with modest success.

Practitioner points

- Inequalities in the provision of psychological therapies for schizophrenia persist.
- Good quality cognitive behavioural therapy and FI training do not ensure implementation.
- Collaboration at all levels of healthcare is needed for effective implementation.

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Special Issue: Cognition in Neuropsychiatric Disorders

Stigma as a barrier to recovery from mental illness

Otto F. Wahl

University of Hartford, 200 Bloomfield Avenue, West Hartford, CT 06117, USA

Advances in neuroscience, technology and research sophistication have greatly increased understanding of mental illnesses and improved the treatment of these disorders. However, there are also important psychosocial aspects of mental illness that play a significant role in recovery from these conditions. One set of these factors involves the prejudice and discrimination, often referred to as 'stigma', faced by people when others learn that they have been diagnosed with, and/or treated for, a mental disorder.

There is a long history of research documenting unfavorable public opinions about mental illnesses. There is also recent research that demonstrates that such negative attitudes have been slow to change. Pescosolido and her colleagues [1] used the 2006 General Social Survey to examine contemporary public attitudes toward mental illnesses in the USA. Survey results revealed several widespread negative attitudes about mental illnesses. For example, 47% of respondents indicated that they would be unwilling to work on a job with someone with depression; 62% expressed unwillingness to work with a person with schizophrenia. In addition, a strong tendency to associate mental illness with violence was apparent. One-third indicated a belief that those with major depression were likely to be violent toward others; 60% expected violence from someone with schizophrenia. Furthermore, the researchers found relatively little change when they compared the 2006 results with those obtained from the same survey done 10 years earlier. Fear of those with a psychiatric disorder and a reluctance to engage them in social activities remained, despite the many known efforts to improve public understanding that occurred during the decade between surveys.

Survey and attitude findings, however, do not capture the actual experience of people with mental illnesses. An increasing number of studies have attempted to document those life experiences, and such studies verify that stigma is a significant ongoing obstacle to recovery. Surveying over 1400 people with mental illness diagnoses about their experiences of stigma, and following up with interviews of 100 of the survey respondents, Wahl [5] found many common and troubling experiences. Social rejection, for example, was a frequently reported occurrence. Individuals with mental illnesses reported that others avoided them once their psychiatric disorder or mental health treatment was disclosed. Friends, they said, stopped calling, neighbors' visits decreased and social invitations declined, all contributing to an increased sense of isolation and alienation from their communities. Furthermore, Thornicroft and his colleagues [6] established that these kinds of experience occur worldwide. Using a standardized survey instrument, these researchers found consistent stigma experiences across 27 countries. The most common area of problematic experience involved making and keeping friends, and negotiating sexual or intimate relationships.

Wahl's survey respondents also reported being devalued and diminished once their mental disorder was known. They described how others no longer placed the same value on their opinions or their abilities, treated them as less competent and relegated them to less important roles at home and work. Strong opinions or emotions were unheeded and instead assumed to be simply manifestations of cognitive impairment or emotional loss of control as a result of psychiatric illness. Thornicroft [7] has described how care providers often discourage those with mental illnesses from pursuing employment or education with well-intended protectiveness that nevertheless conveys a

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Review Article

CITATION: Shrivastava A, Johnston M, Bureau Y. Stigma of Mental Illness-1: Clinical Reflections. Mens Sana Monogr 2012; 10: 70-84.

Stigma of Mental Illness-1: Clinical Reflections

Amresh Shrivastava, Megan Johnston**, Yves Bureau****

ABSTRACT

Although the quality and effectiveness of mental health treatments and services have improved greatly over the past 50 years, therapeutic revolutions in psychiatry have not yet been able to reduce stigma. Stigma is a risk factor leading to negative mental health outcomes. It is responsible for treatment seeking delays and reduces the likelihood that a mentally ill patient will receive adequate care. It is evident that delay due to stigma can have devastating consequences. This review will discuss the causes and consequences of stigma related to mental illness.

Key Words: *Barriers; Compliance; Intervention; Psychosis; Schizophrenia; Stigma; Treatment*

Introduction

Although the quality and effectiveness of mental health treatments and services have improved greatly over the past 50 years, therapeutic revolutions in psychiatry have not yet been able to reduce stigma. Stigma is universally experienced, isolates people and delays treatment of mental illness, which in turn causes great social and economic burden.

A study from India showed that the duration of untreated illness from first psychotic illness to neuroleptic treatment in schizophrenia was 796 weeks (Tirupati et al., 2004[57]).

ΠΑΡΑΜΕΤΡΟΙ ΠΟΥ ΔΙΕΥΚΟΛΥΝΟΥΝ ΤΗ ΘΕΡΑΠΕΙΑ ΤΗΣ ΣΧΙΖΟΦΡΕΝΕΙΑΣ

1. Φαρμακευτική θεραπεία και ψυχοκοινωνικές παρεμβάσεις, **ολιστική προσέγγιση**
2. **Εξατομίκευση** όλων των παρεχόμενων υπηρεσιών
3. **Μεγιστοποίηση της εμπλοκής του ασθενή** και σεβασμός στις προτιμήσεις και τις επιλογές του
4. Υπηρεσίες που παρέχονται στην **κοινότητα**
5. **Ενίσχυση των δυνατοτήτων - εκπαίδευση στις δεξιότητες**

6. **Τροποποίηση του περιβάλλοντος** και στήριξη
7. Συνεργασία με την **οικογένεια**
8. **Κοινωνική υποστήριξη και καταπολέμηση του στίγματος**

(Από: Anthony, Cohen, Farkas, 1990, με τροποποίηση)

Για μένα στίγμα είναι
ο φόβος που βλέπω
στο βλέμμα των άλλων,
το χύρισμα της πλάτης,
ο ήχος της πόρτας που
κλείνει.

Μ., 31 ΧΡΟΝΩΝ

Ακόμη αδιάβατα είναι…

- *Αυτή την αρρώστια δεν την νίκησαν ποτέ. Δεν έχει φάρμακο. Εκεί έξω έγιναν πολυτραυματίες, μέτρησαν πληγές που δεν τις γνώριζαν και δεν ήξεραν να τις γιατρέψουν. Βαθιές, κοφτερές, με μπόλικο φαρμάκι. Καινούριο φαρμάκι, ανίκητο. Καθάρισε το σώμα τους μα οι άλλοι ήθελαν μια κάθαρση διαφορετική, τελειωτική, να έχει σύνορα συγκεκριμένα, αδιάβατα. Δεν βρέθηκε διαβατήριο για αυτά τα σύνορα. Ακόμη αδιάβατα είναι.*

  (από το οπισθόφυλλο του βιβλίου «Καταραμένες πολιτείες»)


ΕΛΕΝΑ ΧΟΥΣΝΗ
Καταραμένες
Πολιτείες
Κύφανται

Ευχαριστώ