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SOCIO-DEMOGRAPHIC CHARACTERISTICS OF PATIENTS WITH SCHIZOPHRENIA, DELUSIONS OF CONTROL, MANIFESTATIONS OF SELF-DESTRUCTIVE BEHAVIOR AND SOCIAL MALFUNCTIONING WHO HOSPITALIZED FORCIBLY AND VOLUNTARILY

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Abstract
The aim of the research was to explore the socio-demographic characteristics of patients with schizophrenia with delusional ideas of influence, manifestations of self-destructive behavior, and social dysfunction, who are hospitalized both forcibly and voluntarily. The study involved 155 patients diagnosed with paranoid schizophrenia. The patients were divided into two groups: the main group of 80 patients and the comparison group of 75 persons. The socio-demographic data obtained for the groups were processed using clinical-psychopathological, psychodiagnostic, and statistical methods. From the analysis it was noted that compulsorily hospitalized patients with schizophrenia showed fairly high levels of violence and victimization. Patients in the compulsorily hospitalized group had a higher severity of manifestations of self-destructive behavior and of delusional ideas of influence with fantastic content. Also, there was a difference in the level of social dysfunction between the two groups. The results will be used in the development of the program of medical and social rehabilitation of the studied contingent of patients.
Keywords: *delusional ideas, compulsorily hospitalized patients, life quality, medical and social rehabilitation, self-destructive behavior, schizophrenia, social maladaptation.*

Introduction

People with schizophrenia in many cases do not voluntarily participate in the treatment process (Gonchar, 2015). Such patients often undergo involuntary hospitalization, consume a disproportionate amount of high-intensity compulsory medical services, while the outcome of treatment is not always positive (Boltivets et al., 2019). These individuals often come into conflict with the criminal system, they develop disorders that are accompanied by alcohol abuse (Ridgeli et. al., 2001).

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Recent studies examining the subjective quality of life of people in compulsory outpatient treatment have long shown significant improvement thereof. Quality of life deteriorated if treatment was accompanied by rehospitalization or by increased sense of coercion (Swanson et al., 2003).

Despite the decrease in the total number of hospitalized in psychiatric hospitals, there is a growing tendency in the number of compulsorily hospitalized patients with delusional ideas of influence, and manifestations of self-destructive behavior. Statistics shows that the symptoms of mental illness become more complicated, more severe and more acute, resulting in an increase in the number of patients prone to socially dangerous acts (Gonchar, 2011).

But today's realities are such that only the prevention of socially dangerous actions and treatment (voluntary or forced) of those who committed them cannot by itself guarantee a reduction in future hospitalizations associated with danger to the patient and his environment because in most cases after discharge from hospital the patient remains face to face with himself: socially maladapted, without employment prospects, with biased thinking about the psychiatric care system and with stigma. Therefore, it is expedient to reorganize medical and social rehabilitation in a hospital and out of hospital conditions, in particular for such contingent of patients (Gonchar, 2010).

The recent medical practice employs a concept of the "quality of life". The concept is associated with health and reflects groups of physical, psychological, and social criteria that characterize its condition. Each of these groups contains indicators that can be assessed both objectively and at the level of subjective perception. The quality of life is exactly what is considered as an integral characteristic to be followed when evaluating the effectiveness of patient rehabilitation (Gonchar, 2011). According to the WHO research on the global assessment of the burden of diseases in the world, schizophrenia is among the 10 most common causes of loss of working capacity in young people, which in turn is accompanied by frequent disability, significant impairment of social adaptation, reduced quality of life (Koval, 2017).

Despite a decrease in rehospitalization of patients with psychotic disorders due to psychopharmacotherapy, research looking for the factors influencing the level of social functioning remains relevant, as pharmacotherapy does not affect functional outcome (Zubatiuk & Pyliagina, 2017).

Studies show that one of the factors disrupting the social functioning of patients with schizophrenia is suicidal behavior, which in a state of psychosis under the influence of psychopathological experiences (delusions, hallucinations) should be classified as self-destructive behavior, quite common in this group of patients (Mork et al., 2012).

Self-destructive behavior in patients with psychotic disorders is a fairly common problem. Research shows that self-destruction here is not homogeneous, but differs depending on the nosology, plot, genesis (Plotnikov et al., 2010).

It's worth noting that self-destructive behaviors in psychotic register patients in the acute stage and in remission are different. During the acute phase, self-destructive behavior is due to the nature of actual psychotic experiences and is characterized by special brutality and sophistication. It is then that the most common self-amputations, self-castration, enucleation of the eyes take place. At the same time, in the remission stage self-destructive behavior reflects the changes in personality that are caused by the disease itself (Sevryukov et al., 2016).

Research aim was to study socio-demographic characteristics of patients with schizophrenia with delusions of control, manifestations of self-destructive behavior and social dysfunction, who are hospitalized both forcibly and voluntarily.

Research Methodology

General Characteristics

In recent years, on the clinical bases of the Department of Psychiatry, Psychotherapy and Medical Psychology, Shupyk National Medical Academy of Postgraduate Education - Territorial Medical Association (TMA) "PSYCHIATRY" a clinical examination, diagnosis, and treatment of 155 patients with paranoid schizophrenia was conducted with informed consent in compliance with the principles of bioethics and deontology.

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Sample Selection

Patients were divided into 2 groups: the main group consisted of 80 subjects (51 males and 29 - females, aged 20 to 55 years, who received compulsory psychiatric care); the comparison group consisted of 75 patients (32 men and 43 women, whose age was in the same range as in the main group, who sought psychiatric care voluntarily).

Instruments and Procedures

The diagnosis was established according to the International Statistical Classification of Diseases, Injuries, and Causes of Death (10th revision), adapted for use in domestic psychiatry.

The study used a clinical-anamnestic method to collect and analyze data on the life and illness history of patients with schizophrenia receiving compulsory psychiatric care, and patients with schizophrenia who sought psychiatric care voluntarily. We accounted for the hereditary burden of the studied contingent with mental pathology, the dynamics of the clinical picture, the presence or absence of victimization in the social environment, the quality and features of emission periods, the volume and nature of psychiatric care received by far, its effectiveness.

The clinical-psychopathological method allowed us to determine the main psychopathological disorders and syndromic structure in the groups, as well as the dynamics of symptomatic manifestations in participants with paranoid schizophrenia in the process of providing them with inpatient and outpatient psychiatric care.

In order to obtain objective data and assess such social characteristics as age, level of education, family structure, occupational adaptation, the study used the socio-demographic method. The presence and severity of self-destructive behavior was determined by the clinical-diagnostic interview. Determination of the level of social functioning in patients with delusional ideas of influence with fantastic and everyday content, and manifestations of self-destructive behavior was carried out using the scales of PSP, GAF, WHODAS 2.0. We studied social exclusion, self-care, participation in household chores, sexual role, interpersonal communication, performance at workplace and interest in getting employed, desire to return to study, levels of interest and awareness, socially useful activities including work and study, relationships with relatives and other social relations, self-care, anxiety and aggressive behavior.

To determine levels of depression and anxiety in the study groups we used the Hamilton Rating Scale for Depression (Hamilton, 1968) that takes into account mood swings, anxiety, depression, cognitive and autonomic symptoms; the scale 21 score points.

To identify positive and negative symptoms, and assess their severity on the PANSS scale (Kay et al., 1987) we used the psychodiagnostic method comparing two groups both at the beginning of the study and at the final stage after the introduction of the algorithm of medical and social rehabilitation in patients with paranoid schizophrenia who received compulsory psychiatric care.

Data Analysis

Digital data processing was performed by various mathematical means, the choice of which was determined by the specific task in each case. The calculations were performed using the application package STATISTICA. The difference was considered significant at $p<.005$.

Research Results

Age Groups of Patients with Schizophrenia who Hospitalized Forcibly

The socio-demographic parameters of the study were as follows. The majority of the patients who received compulsory psychiatric (68.75%) care belonged to the age range from 21-40 years. There were 2.7 times more males than females. No patients aged 18 to 20 years were present in the main group. The fraction of involuntarily treated patients with self-destructive behavior and

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delusional ideas of influence(control) with fantastic content within the age range of 41-50 years was 18.75% and that of the people in the range 50-55 years – 12.5% (Table 1).

Table 1

Age characteristics of patients with schizophrenia who received compulsory psychiatric care, absolute number N (%)

Age ranges	Main group		
	Men (*n*=51)	Women (*n*=29)	Total (*n*=80)
18-20 years	-	-	-
21-30 years	24 (30.00)	10 (12.5)	34 (42.5)
31-40 years	16 (20.00)	5 (6.25)	21 (26.25)
41-50 years	7 (8.75)	8 (10.00)	15 (18.75)
51-60 years	4 (5.00)	6 (7.50)	10 (12.50)

The Level of Education Groups of Patients with Schizophrenia Who Hospitalized Forcibly

Characteristics of the level of education of the subjects of the main group are given in Table 2.

The data indicate a fairly high level of education of patients in the main group: 42.50% of them had higher and incomplete higher education, and 25% - secondary special. Secondary school education and incomplete secondary school education accounted for 23.75% and 8.75% of participants, respectively.

The education level is an important indicator of the perception of coercion concerning further treatment. Better educated patients of the main group before the initial hospitalization or after a short stay in the hospital were unable to integrate the disease into their perception of themselves in the environment. Therefore, although they may function better, they still do not accept their illness, and the intervention of care givers causes in them anger and increased feelings of coercion, a tendency to discontinue treatment with a subsequent risk of never ending returns to the hospital.

Table 2

The level of education of patients with schizophrenia who were forcibly hospitalized in a psychiatric hospital, absolute number N (%)

Education level	Main group		
	Men (*n*=51)	Women (*n*=29)	Total (*n*=80)
Higher	13 (16.25)	14 (17.50)	27 (33.75)
Incomplete higher	4 (5.00)	3 (3.75)	7 (8.75)
Secondary special	12 (15.00)	8 (10.00)	20 (25)
Secondary	16 (20.00)	3 (3.75)	19 (23.75)
Incomplete secondary	6 (7.5)	1 (1.25)	7 (8.75)

Social Status Groups of Patients with Schizophrenia Who Hospitalized Forcibly

Also, it was analyzed the social status of patients with schizophrenia receiving compulsory psychiatric care. This factor to some extent affects the resources and opportunities provided by society to a person, her sphere of personal relations, occupational adaptation, and, of course, the

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quality of life. The characteristics of the social status of the patients with schizophrenia in the main group are shown in Table 3.

According to the data, during involuntary treatment 90% of patients were unemployed, disabled people with mental illness accounted for 55% of the groups. This situation leads to unfavorable conditions for social security, health care, to the tense atmosphere in the family, if the latter exists, and to the inability to have it otherwise, it contributes to the commission of particularly dangerous actions.

Table 3

The social status of patients with schizophrenia who were forcibly hospitalized in a psychiatric hospital, absolute number N (%)

Social status	Main group		
	Men (*n*=51)	Women (*n*=29)	Total (*n*=80)
Employed	3 (3.75)	5 (6.25)	8 (10.00)
Unemployed	48 (60.00)	24 (30.00)	72 (90.00)
Disabled of the first group	1 (1.25)	-	1 (1.25)
Disabled of the second group	31 (38.75)	10 (12.5)	41 (51.25)
Disabled of the third group	1 (1.25)	1 (1.25)	2 (2.50)

Family Status of Patients with Schizophrenia Who Hospitalized Forcibly

During the study, much attention was paid to the family status of the patients in the main and comparative groups. Although a family is not directly related to the causes of the disease, its very existence under the condition of a good emotional climate within leads to decrease in the recurrence of psychosis, to a favorable end of the disease for some patients, and to some extent due to the reduction of emotions expressed in families, to the improvement of the social functioning of patients with schizophrenia.

Characteristics of the family status of the patients with schizophrenia during hospitalization are shown in Table 4. The high level of familial maladaptation of patients with schizophrenia who under involuntary psychiatric care is noteworthy. In the study, 60% of them had never had a family of their own, and 31.25% were divorced. These data should be accounted for in rehabilitation programs of family interventions, as the latter are aimed at changing family status and unfavorable family conditions.

Table 4

Family status of patients with schizophrenia under coercive psychiatric treatment, absolute number N(%)

Family status	Main group		
	Men (*n*=51)	Women (*n*=29)	Total (*n*=80)
Has wife (husband)	2 (2.50)	5 (6.25)	7 (8.75)
Divorced	16 (20.00)	9 (11.25)	25 (31.25)
Never was married	33 (41.25)	15 (18.75)	20 (60.00)

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Age Groups of Patients with Schizophrenia Who Hospitalized Voluntarily

The results of the analysis of socio-demographic indicators show that the age of patients with schizophrenia who sought psychiatric care voluntarily, in 56% of cases belonged to the age range from 21 to 40 years. To this age range also belongs the majority of persons in the main group. The data on the age characteristics of the groups are presented in the Table 5.

Table 5

Age ranges of patients with schizophrenia who asked for psychiatric help voluntarily, absolute number N (%)

Age ranges	Comparison group		
	Men (*n*=32)	Women (*n*=43)	Total (*n*=75)
18-20 years old	2 (2.67)	2 (2.67)	4 (5.33)
21-30 years old	14 (18.67)	13 (17.33)	27 (36.00)*
31-40 years old	8 (10.67)	12 (16.00)	20 (26.67)
41-50 years old	2 (2.67)	9 (12.00)	11 (14.67)
More then 50 years old	6 (8.00)	7 (9.33)	13 (17.33)*

Note: *-difference between the main and comparison groups ($p<.05$)

The Level of Education Groups of Patients with Schizophrenia Who Hospitalized Voluntarily

The levels of education of patients of the comparison group are shown in Table 6. As can be seen from the data in the table, the number of patients in the group with higher and incomplete higher education exceeded that of the people in the same group who had secondary special, secondary and incomplete secondary education. Analysis of the levels of education of the patients with schizophrenia, both of those undergoing coercive treatment and those who asked for the treatment voluntarily didn't show any significant statistical difference between two groups (in the main group 42.50% of participants had higher and incomplete higher education and correspondently in the comparison group – 42.67%).

Table 6

Level of education in patients with schizophrenia who asked for psychiatric help voluntarily, absolute number N (%)

Education level	Comparison group		
	Men (*n*=32)	Women (*n*=43)	Total (*n*=75)
Higher	7 (9.33)	16 (21.33)	24 (32.00)
Incomplete higher	2 (2.67)	6 (8.00)	8 (10.67)
Secondary special	10 (13.33)	14 (18.66)	23 (30.66)
Secondary	10 (13.33)	5 (6.67)	15 (20.00)
Incomplete secondary	3 (4.00)	2 (2.67)	5 (6.67)

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Social Status Groups of Patients with Schizophrenia Who Hospitalized Forcibly

From the data in Table 7, it follows that during the psychiatric treatment 86.67% of patients in the main group were unemployed, 50.67% were disabled due to the psychiatric disease and only 13.33% had jobs. Comparative analysis of data from the main group and the group of comparison hasn't revealed any significant statistical differences between them.

Table 7

Social status of patients with schizophrenia who asked for psychiatric help voluntarily, absolute number N (%)

Social status	Comparison group		
	Men (*n*=32)	Women (*n*=43)	Total (*n*=75)
Employed	3 (4.00)	7 (9.33)	10 (13.33)
Unemployed	29 (38.67)*	36 (48.00)*	65 (86.67)
Disabled, first group	-	1 (1.33)	1 (1.33)
Disabled, second group	27 (36.00)*	8 (10.67)	35 (46.67)
Disabled, third group	1 (1.33)	1 (1.33)	2 (2.67)

Note: *-difference between the main and comparison groups ($p<.05$)

Family Status of Patients with Schizophrenia Who Hospitalized Forcibly

According to the study of the family status of patients with schizophrenia who received psychiatric care voluntarily, it was found that 53.3% were those who had never had a family, 28% of patients were divorced, 18.67% had their own family. Based on the data of the comparative analysis, it should be noted that patients of both groups are characterized by family maladaptation.

Table 8

Family status of patients with schizophrenia who asked for psychiatric help voluntarily, absolute number (%)

Family status	Comparison group		
	Men (*n*=32)	Women (*n*=43)	Total (*n*=75)
Has wife (husband)	5 (6.67%)*	9 (12.00%)*	14 (18.67%)
Divorced	5 (6.67%)*	16 (21.33%)*	21 (28.00%)
Never was married	22 (29.33%)*	18 (24.00%)*	40 (53.33%)

Note: *-difference between the main and comparison groups ($p<.05$)

To detect violence and victimization in the groups, we used the "Questionnaire to identify cases of domestic violence and victimization" by P.A.Gallon, 2006. The questionnaire asks whether the interviewed person was an initiator or victim of violence in the last 6 months. The questionnaire has items with questions about slapping, kicking, throwing things at other people. There are also questions about sexual violence and the use of weapons, about a sense of danger in the area where the person lives. Both groups provided information on violence. Violence and victimization rates were calculated by adding the numbers of cases reported by patients in each category

Discussion

Schizophrenia is one of the 10 most common causes of disability in young people (Murray et al., 1996; Koval, 2017), accompanied by frequent disability, significant impairment of social adaptation, and reduced quality of life. It is well known that in the period of aggravation self-destructive behavior in patients in a psychotic register is caused by the nature of psychotic experiences and is characterized by special brutality and sophistication (Sevryukov et al., 2016). At the same time, during remission stages self-destructive behavior reflects the changes in personality due to the disease.

In 2015, suicide became the second leading cause of death among young people (World Health Organization, 2019) and is seen as an autoaggressive act aimed at inflicting any kind of harm to patient's physical or mental health (Ambrumova et al., 1990). It is known that suicides of the mentally ill who are in a state of psychosis committed under the influence of psychopathological experiences (delusions, hallucinations), are classified as an autoaggressive behavior (Chuprikov et al., 1999). Statistics reported in the literature also indicate a significant frequency of manifestation of certain delusional ideas in schizophrenia (McCutcheon et al., 2018; Gonchar, 2011; Brissos et al., 2016). There exists extensive research on the mechanisms of emergence of delusions (Kameneva, 1957; Krylov, 2016; Rybalskyi, 1993), on syndromygenesis (Derecha, 2006), on therapeutic dynamics of acute affective-delusional states in schizophrenia (Malygina, 1992), on paroxysmal schizophrenia with delusions (Varavikova, 1994), on clinical manifestations and course of schizoaffective psychoses with a predominance of delusional clinics (Bologov, 1998) on psychopathology and clinics of acute paraphrenic states during schizophrenia (Subbotskaya, 2006), on coenesthesiopathic paranoia (dermatozoic delusions) (Frolova, 2006), on delusional and hallucinatory psychoses in geriatric patients (Tuter, 2011), on religious-archaic delusional complex (Logutenko, 2014), on differential diagnosis and evaluation of delusional conditions (Ilyushina, 2014). Despite all that research the problem of connections between social functioning impairment in patients suffering from schizophrenia and self-destructive behavior manifestations in those hospitalized compulsorily remains unsolved (Gonchar, 2011).

Thus, it is important to research the structural and dynamic features of self-destructive behavior in patients with schizophrenia taking into account different pathogenetic mechanisms. This includes studying how social dysfunction in schizophrenia patients with a delusion of influence depends on the severity of psychopathological symptoms. After all, the results of investigations by numerous authors point at contradictions in the conclusions about the dependency of the quality of life on psychopathological symptoms. A number of authors refute this dependence (Jarema et al., 1997; Larsen et al., 1996; Spiridonow et al., 1998). At the same time there are others that confirm its existence (Awad et al., 1997; Gonchar, 2010; Gaite et al., 2002; Voruganti et al., 1998). Assessment of quality of life as an integrative indicator of social functioning gives a complete picture of subjective satisfaction and a holistic picture of the effectiveness of treatment and rehabilitation of patients with schizophrenia. Perception and evaluation of the degree of satisfaction with the main aspects of life involve all the main components of the mental sphere: cognitive, emotional, motivational, and the part of self-awareness expressing itself in behavior; all that points at a link between mental health and quality of life (Pidkorytov & Baibarak, 2017). Thus, the presence of severe psychopathological symptoms confirms our hypothesis of impaired social functioning in patients with delusional ideas of influence and self-destructive behavior, justifies the feasibility of compulsory treatment in this group of patients.

On the basis of the results, it can be seen that patients with schizophrenia with delusional ideas of influence and self-destructive behavior are socially dysfunctional due to the severity of psychopathological manifestations that impair quality of life and justify involuntary treatment.

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Conclusions

It should be noted that compulsorily hospitalized patients with schizophrenia showed a fairly high level of violence and victimization (76%) compared with those who were hospitalized voluntarily. For the latter group, this index was 37.30%. Compulsorily hospitalized patients showed higher severity of manifestations of self-destructive behavior and delusional ideas of influence with fantastic content. Social dysfunction of the group of patients who received compulsory psychiatric care was significantly lower than in the group of voluntarily hospitalized people. The obtained results will be used in the development of the program of medical and social rehabilitation of the studied contingent of patients.

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