COGNITIVE-BEHAVIORAL THERAPY IN THE MANAGEMENT OF HOSPITALIZED PATIENTS WITH SCHIZOPHRENIA

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Abstract. *Schizophrenia remains a leading cause of disability in mental disorders, accounting for approximately 40% of affected individuals. High disability rates highlight the limitations of secondary and tertiary preventive measures and indicate underutilization of psychotherapeutic interventions in clinical practice. Cognitive-behavioral therapy (CBT) has been shown to complement pharmacotherapy by addressing persistent delusional beliefs, hallucinations, and maladaptive behavioral patterns, ultimately improving remission quality and social functioning. This study explores the application and effectiveness of CBT in hospitalized patients with schizophrenia.*

Keywords: *Schizophrenia, cognitive-behavioral therapy, psychotherapeutic intervention, mental disorders, hospital treatment.*

Introduction. Longitudinal studies suggest that individuals with schizophrenia exhibit genetically mediated hypersensitivity to social stress, while psychosocial factors can trigger relapses. Social competence, conversely, plays a protective role in relapse prevention [1-4].

Delusions and hallucinations are prominent in approximately 74% of patients, and persistent delusional ideas are often the primary reason for initial psychiatric hospitalization [5-9]. Pharmacotherapy addresses biological dysfunction but does not directly modify the personal cognitive mechanisms underlying delusions. Consequently, antipsychotic treatment alone may be insufficient to reduce paranoid beliefs. Cognitive-behavioral psychotherapy has demonstrated efficacy in mitigating drug-resistant delusional symptoms and improving overall patient outcomes [10-16]. Delusions are frequently grounded in the patient's prior experiences, worldview, and personality traits, emphasizing the need for individualized psychotherapeutic intervention [17-21]. CBT facilitates the exploration of these beliefs, providing patients with strategies to manage stress and reshape dysfunctional thought patterns [22].

The purpose of the study. To evaluate the effectiveness of cognitive-behavioral therapy in improving clinical, cognitive, and social outcomes in hospitalized patients with schizophrenia.

Materials and Methods. Twelve female patients diagnosed with paranoid schizophrenia (ICD-10 F20.0), aged 20-50 years (median age 29 ± 10), participated in this study. The primary reasons for hospitalization were symptom exacerbation (82%) and poor-quality remission (20%).

A control group of eight patients, aged 20-50 years (mean age 31 ± 8), received standard pharmacotherapy only.

CBT interventions were implemented during the acute treatment phase and for patients with low-quality remission, beginning immediately upon hospital admission.

Inclusion criteria included stable behavior, absence of substance abuse, no severe somatic comorbidities, and preserved intellectual functioning.

Therapeutic techniques focused on:

Development of communication skills and self-esteem

Strengthening social relationships

Psychoeducation and coping strategies for symptom management

Directed discovery, focus on core cognitions, and behavioral modification strategies

Individual and family counseling was conducted to support psychosocial integration.

Therapy was individualized, reflecting the heterogeneity of schizophrenia and the specific needs of each patient.

Results and Discussion. Patients in the CBT group demonstrated faster clinical improvement compared to the control group (average hospital stay: 51 vs. 70 days). They exhibited increased independence, socially appropriate behavior, active engagement in symptom management, and enhanced life satisfaction. Family counseling contributed to improved familial relationships and reduced conflict.

CBT interventions enabled patients to identify and modify cognitive distortions such as egocentric interpretations, misperception of others' intentions, and attribution of internal experiences to external forces. Methods included thought recording, analysis of cognitive errors, alternative interpretations, and evaluation of evidence supporting delusional beliefs.

Group and individual CBT were both effective, although group interventions remain less studied. The use of structured, hypothesis-driven therapy sessions facilitated patient engagement, reinforced adherence to pharmacotherapy, and promoted psychosocial reintegration.

Art therapy complemented CBT by enhancing self-expression, creativity, and social skills. Patients participated in painting, poetry, and diary writing, which supported self-esteem, reduced apathy, and facilitated return to work and educational activities. Art therapy also improved interpersonal interaction and overall quality of life.

Cognitive-behavioral therapy is a flexible, structured intervention that can be effectively integrated with pharmacotherapy. It addresses dysfunctional cognitive and behavioral patterns, accelerates symptom remission, and enhances social functioning. The inclusion of art-based interventions further supports emotional expression, self-esteem, and creative problem-solving.

Together, CBT and art therapy represent a multimodal approach that improves clinical outcomes and long-term psychosocial adaptation in patients with schizophrenia.

Conclusion. CBT is an effective adjunct to pharmacotherapy for hospitalized patients with schizophrenia, facilitating symptom reduction, improved adherence to medication, and social reintegration. Art therapy enhances these outcomes by fostering creativity, emotional expression, and life skills. Implementing structured psychotherapeutic programs within hospital settings can significantly improve functional recovery and overall quality of life in patients with schizophrenia.

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