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# Social Adaptation of Patients with Paranoid Schizophrenia

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**Abstract:** In psychiatry over the past decades, there has been a surge of interest in the social aspects of the lives of mentally ill patients, including as a result of the provision of psychiatric care from hospital to out-of-hospital levels. In this regard, the issues of social functioning of mentally ill people, their social competence, and ability to live independently have acquired particular importance. Over the past years, schizophrenia has remained the most mysterious and, at the same time, the most widely diagnosed psychiatric disease, regardless of the population and diagnostic systems used. The prevalence of schizophrenia in the world is estimated at 0.8-1%, the incidence is 15 per 100,000 population. The widespread prevalence of schizophrenia throughout the world suggests a genetic basis for the disease, which contradicts the view that it is a "new disease", and most researchers believe that schizophrenia existed long before its first detailed descriptions in the early 19th century.

Relevance.Symptoms of paranoid schizophrenia Positive symptoms of paranoid schizophrenia include:

1. Crazy ideas. These are firmly held beliefs that are not supported by objective facts and have traits of paranoia. There are many types of misconceptions, but the most common are the following:
2. delusion of control - the belief that a person’s actions are controlled by someone;
3. delusions of grandeur - belief in the presence of special or exceptional powers and abilities;
4. delusions of jealousy - the belief that a spouse or partner is cheating;
5. delusion of persecution - the belief that someone is persecuting a person;
6. delusion of thought insertion - the assertion that other people's ideas are inserted into the mind.
7. hypochondriacal delusions are irrational ideas about one’s body and its condition.
8. Hallucinations. This is a false sensory perception that can affect any of a person's five senses (hearing, vision, smell, touch, taste). In paranoid schizophrenia, auditory and visual hallucinations are most common:
9. voices coming from an external source, for example, from a tape recorder speaker;
10. commanding voices within the mind;
11. sounds of music, buzzing, whistling, laughter;
12. images of people, situations or events.
13. Disorganized thoughts and speech. These are ways of thinking or speaking that are strange or illogical.
14. Suicidal activity.

Negative symptoms of paranoid schizophrenia include:

1. Asociality. Decreased interest or motivation to form close relationships with other people.
2. Decreased ability to experience pleasant emotions.
3. Deterioration of emotional expression. For example, monotonous conversation without changes in facial expression (smile or frown).
4. Affective disorders (mania, depression and others).

Cognitive signs of paranoid schizophrenia manifest themselves as:

1. Attention and memory disorders.
2. Tendency to jump to conclusions.
3. Difficulty understanding the mental state of others (for example, people with paranoid schizophrenia mistakenly identify a neutral facial expression as an angry one).

Currently, an approach that reflects a multidimensional consideration of mental pathology with the involvement of not only clinical-psychopathological, but also social-environmental and personal indicators is becoming more and more obvious. There is a clear trend towards multiprofessional management of patients with the participation of psychiatrists, psychologists, social workers and other specialists. Indicators of social functioning, along with clinical data, are actively used as diagnostic criteria. In some cases, they are even included in official classifications of mental illness. Thus, the DSM-IV introduced a special axis designed to characterize social disorders that are detected in a particular mental pathology. In the International Classification of Diseases, 10th revision (ICD-10), the description of diagnostic categories also indicates possible impairments in the social functioning of patients. It should be noted that such an integrated approach is not an achievement of recent years and has been used for quite a long time. In particular, this area has developed fruitfully, emphasizing the need to synthesize social and clinical data. He put forward and developed the idea of a functional diagnosis, which allows one to assess the patient's functional capabilities and takes into account both his mental state and personal characteristics, attitude to the disease, social position, and the preservation of the emotional-volitional characteristics of work skills. Such a multi-aspect approach is, in the author's opinion, the most productive in prognostic and rehabilitation terms.

In this regard, the first years from the onset of the disease are usually considered as a "critical period", during which the most significant changes occur in all areas of the patient's life. Thus, in most patients, the ability to establish interpersonal relationships suffers, there is a decrease in interest in life, self-esteem and the desire for personal growth weaken, and interest in previous hobbies and new activities disappears. According to the concept of psychopathological diathesis, already at the initial stage of schizophrenia there is a pronounced decrease in personal resources, which impedes successful social adaptation. Today, decreased social adaptation is considered by Western psychiatrists as one of the diagnostic criteria for schizophrenia. According to some data, a decrease in social and psychological functioning is already observed in 14% of individuals among primary patients with schizophrenia. In most cases, this is due to hospitalization in a psychiatric hospital, prescription of drug therapy, the stigmatizing impact of the diagnosis, decreased ability to work, family problems, emotional discomfort and other undesirable manifestations. According to the data, only 40% of patients maintain the same level of social functioning after the first hospitalization. Social adaptation of patients with schizophrenia, from a psychological point of view, includes three components: coping, psychological defense and the internal picture of the disease, and depends not only on the nature of the disease itself and the therapy provided, but also largely on the support from the patient's microsocial environment.

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