journal homepage: http://kont.zsf.jcu.cz
DOI: 10.32725/kont.2019.025

KONTAKT / Journal of nursing and social sciences related to health and illness

Original research article

Case study of a psychotherapeutic programme for people with severe mental illness experience

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Abstract
Objective: The case study aims at answering the following question: "What are the effects of a psychotherapeutic programme on its participants?" The psychotherapeutic programme under examination is intended for people with severe mental illness (SMI) experience and falls under community psychiatric care. The psychotherapeutic programme subject to this research can be an alternative to, or directly follow after, psychiatric hospitalisation, or can also be preventive.
Methods: Both quantitative and qualitative methods and techniques were used; the participants were monitored over a period of one year. More specifically, data were obtained through participant observation, field notes, by analysing documents and using the SIS (Social Integration Survey) questionnaire, which was translated from the English original in co-operation with Dr. Jane Scott-Lennox, head of the team of authors at the Piedmont Research Institute.
Results: The programme has a positive effect on improving communication, activation and increasing awareness in the sense of understanding the illness, treatment, self-discovery and insight, while respecting the participants' individual potential. In terms of recovery, it gives hope, contributes to developing and maintaining competences and skills, and promotes empowerment and restoration of social roles.
Conclusions: The data obtained have confirmed that participation in a psychotherapeutic programme contributes to the participants' social integration.

Keywords: Case study; Psychotherapeutic programme; Recovery; Severe mental illness (SMI); Social integration

Introduction

There is an increasing number of people with psychiatric diagnoses; according to Nechanská et al. (2017), there are 50 people newly diagnosed with a schizophrenic disorder per 100,000 people each year. Schizophrenic disorders qualify as some of the most serious disorders, with symptoms including delusions and hallucinations that reduce the ability to distinguish reality from illusion (Kapur, 2016; Tsuang et al., 2011).

According to Matoušek et al. (2013) these people *"… show deficits, conflicts and problems in experiencing, behaviour and social functioning, which can be determined either genetically, or by the person having developed in an unsuitable environment"*. Such people are often hospitalised in psychiatric hospitals and thus removed from their natural environment and, at the same time, burdened with the stigma of a mental illness.

The following have been identified as typically problematic areas that limit social integration of people with a SMI, in particular psychosis:

- close personal relationships;
- contacts with strangers;
- joint activities;
- appropriateness of behaviour;
- effective communication;
- empathy;
- self-control;
- hygiene;
- everyday activities (Parasuraman et al., 2000; Scott-Lenox, 2000).

These areas are measured using the Likert scale in the SIS questionnaire that was used in the presented study.

Social integration is a process in which people with a SMI develop and strengthen their capacity for social reintegration (Social Inclusion Strategy 2014–2020, 2014), through developing and maintaining their existing competences and skills. Social competences include, for example, effective communication in which participants are able to express their feelings, needs etc. Moral competences are based on trust and they can develop e.g. responsibility and sincerity. Emotional competence includes, for example, empathy. Equally important in the social reintegration process is the sense of belonging to society (Ware et al., 2007). At present, the recovery model serves to attain this goal. Recovery is *"a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or*

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http://doi.org/10.32725/kont.2019.023
Submitted: 2018-07-31 • Accepted: 2019-03-27 • Prepublished online: 2019-04-17
KONTAKT 21/2: 222–229 • EISSN 1804-7122 • ISSN 1212-4117

roles. It is a way of living a satisfying, hopeful and contributing life even with the limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness" (Anthony, 1993). Psychotherapy can assist on the path to recovery; sometimes it is the method of first choice (Kostka, 2017). Therefore, this work endeavours to find out the effects of a selected psychotherapeutic programme on the programme's participants.

Psychotherapeutic programme

Within the reform of psychiatric care which is currently underway, community services are given priority (Strategic Reform of Psychiatric Care, 2014) as they enhance the quality of life of clients (Šumbera, 2015) and are cost-effective (Pfeiffer, 2003). The psychotherapeutic programme under examination is one of many services offered by the establishment and its multidisciplinary team (more information about the establishment are not provided in order to respect anonymity of the participants). The programme consists of two phases. Initially the participants attend the programme every workday from 9 a.m. to 2 p.m. for a period of ten weeks. The group usually consists of 10 people with a relatively recent and, as a rule, first psychosis experience. This more intensive phase of the psychotherapeutic programme involves two stays outdoors, each lasting one week. An educative course for the participants' family members (Leff et al., 2002) and professional social advice are offered in parallel. In the second phase of the psychotherapeutic programme the group meets once every week for one and a half hours during a period of ten months; the participants are supported in study, work, building relationships, etc. The objectives of the psychotherapeutic programme are to improve interpersonal relationships and increase the participants' social involvement and awareness in the sense of understanding the illness, its treatment, prognosis and relapse prevention.

The psychotherapeutic programme accomplishes these objectives by combining the following activities:

- psychotherapeutic group;
- physical exercise;
- art therapy;
- stress coping training;
- lectures on the disease, medicines, lifestyle habits, career opportunities, sheltered housing options, abuse of addictive substances;
- development of cognitive functions (memory, attention, speed of information processing, executive functions – planning, organising, problem solving, emotional self-regulation; ability to express oneself and understanding spoken language, spatial orientation and perception);
- development of non-verbal communication skills through self-discovery games;
- community;
- two weekly stays outdoors.

Each activity is conducted by a different (psycho) therapist; the main responsibility is with experienced psychotherapists who lead the most time-consuming psychotherapeutic groups and communities and accompany the participants during the stays outdoors.

Materials and methods

The objective of the presented case study is to understand and interpret the events related to the psychotherapeutic programme and its effect on people with SMI experience (Hancock and Algozzine, 2001; Matoušek et al., 2013; Švaříček et al., 2014). The following themes serve as a means of answering the key research question of *"What are the effects of a psychotherapeutic programme on its participants?"*:

- psychotherapeutic programme in the context of the participants' experience with a SMI;
- psychotherapeutic programme in the context of development of "problem" areas (Parasuraman et al., 2000; Scott-Lennox et al., 2000) of social integration;
- psychotherapeutic programme in the context of participants' competences and abilities;
- structure and organisation of the psychotherapeutic programme.

Triangulation of data collection methods, techniques and sources was carried out in order to increase the trustworthiness and reliability of the case study (Hendl, 2016). The data were obtained through the following:

- participant observation and field notes (the researcher actively participated in the various activities and phases of the psychotherapeutic programme and made notes during interviews with experts and working meetings);
- document analyses – especially workers' records from all activities of the psychotherapeutic programme, which serve as basic documents for insurance companies;
- SIS (Social Integration Survey) questionnaire– the questionnaire was translated from English in co-operation with Dr. Jane Scott-Lennox, head of the team of authors at the Piedmont Research Institute; the questionnaire's validity and reliability were confirmed by Kawata and Revicki (2007); it focuses on the quality of interpersonal relationships and degree of social engagement;
- participants of the psychotherapeutic programme with SMI experience.

The questions were divided into nine domains (areas limiting social integration); a maximum of 40 points for all questions in total could be obtained in each domain in order to ensure comparability of the results from the various domains. The higher the value given by the respondent in answering a question, the better his/her assessment of the relevant domain. The questionnaire was filled in before commencement and after the end of the intensive phase of the psychotherapeutic programme and subsequently one year after starting the intensive part of the programme; thus, three sets of data were available in total. The semantic differential method and its graphic output (Hayes, 1998) was used to assess which areas the respondents consider as improving.

Characteristics and selection of the research participants

The research is a case study of a group of ten members (or rather nine because one participant left the therapeutic programme soon after joining it) observed over a period of one year.

The selection was deliberate; the research criteria were given by active participation in the therapeutic programme and participants' verbal informed consent to the research.

The available characteristics of the research participants are provided in Table 1.

The group consists of people aged 19 to 36 years, of which two are women and the rest are men. Two live with a partner, others in a common household, most often with parents or one parent. Four of the participants were receiving disability

Table 1. Participants' characteristics

Participant	Gender	Age	Marital status	Housing	Work status
R1	male	27	single	I share a flat with another person	I was in a psychiatric hospital but I want to work after treatment; client left the programme soon after commencement
R2	male	22	single	I share a flat with another person	disability pension, I do not want to work
R3	male	28	single	I live alone	paid work; subsequently unfit to work; returned to paid work
R4	male	28	single	I live with my mother	disability pension, I do not want to work
R5	male	36	single	I live with my mother	disability pension, I do not want to work
R6	male	23	single	I live with my parents	temporary job, I want to work more; then paid work, freelance; seeks employment at the end of the intensive phase of the psychotherapeutic programme
R7	female	24	single	I share a flat with another person	I am looking for a new job because I work more than I would like to at the moment; subsequently disability pension + temporary job
R8	female	23	single	I live with my partner	student, temporary job, I work less than I would like to; client did not finish the full programme
R9	male	19	single	I live with my parents	temporary job, I work less than I would like to
R10	male	32	single	I live alone	disability pension, I want to work; disability pension granted at the end of the intensive phase of the psychotherapeutic programme, does not want to work

None of the items in Table 1 changed during the programme, only the working status of some clients changed; changes are separated by a semicolon and go chronologically, from joining the programme to completion of the intensive phase to completion of the full programme; follow-up services were obviously offered to the clients.

pension, the others had successfully applied for it to be granted. Only one of the participants had an employment contract and returned to a part-time job after completing the psychotherapeutic programme. The participants were employed as casual workers, usually in the shadow economy, which is the reason why some declared a zero income in the questionnaire.

Research ethics

The participants gave verbal consent and participated on a voluntary basis in the research. It was explained to them that the goal was to assess the psychotherapeutic programme provided to them (Schneider, 2010). They were assured that the research was anonymous. The researcher's active participation in the full psychotherapeutic programme, together with deliberate avoidance of recorded interviews, helped strengthen the participants' trust.

Results and discussion

Since the case (psychotherapeutic programme) is to be interpreted as an integrated system, the data obtained using all the techniques and methods applied will be interpreted together (Švaříček et al., 2014).

Psychotherapeutic programme in the context of the participants' experience with SMI

Experience with a SMI is the basic prerequisite for entering the psychotherapeutic programme that is covered by the public healthcare system. One half of the participants had been recently hospitalised in a psychiatric hospital for the first time, some had been hospitalised repeatedly (R2, R4, R5, R10), one (R3) was admitted to the psychotherapeutic programme based on the psychiatrist's recommendation without a prior hospitalisation; he had sought help himself after *"saying things at work I should not be saying"*. All were diagnosed with disorders within the psychotic group. In most of the participants the outbreak had been triggered by substance abuse – alcohol, drugs (R2, R4, R6, R8, R9). Debts were a complicating factor in the life situation of R4, R6 and R10. R4 was the only one who recalled a suicide attempt – the most frequent cause of death in people diagnosed with schizophrenia (Meyer et al., 2017).

R2 repeatedly emphasised he had a *"cognitive deficit"* while in fact even the other members of the group noticed that he remembered more details about others than any other participant, and *"emotional blunting"* – he described himself using medical terms, which can be interpreted as a display of self-stigma. Towards the end of the intensive phase of the programme, some of the participants began to talk about a desire to find a partner (R2, R3, R4); R10 also wished to lose weight and get rid of his debts; he refused an offer by R4 to play floorball together but R2 and R6 accepted the offer and made it a reality. Lack of will, which may be associated with low self-esteem, is recognised as one of the manifestations of psychosis. R2 had great plans at the end of the intensive phase (work, study). Over time, each participant developed an insight into the illness – understanding of what was and what was not attributable to the illness. Art therapy helped R9 express himself, painting helped provide an insight into his feelings, *"when he feels emotions, mostly the painful ones"*. Adverse reactions to medicines had a strong effect on the participants, causing mainly fatigue; R7 and R3 wished to discontinue taking their

medicines in order to perform better at work; the sedative effect of medication is described e.g. in the study by Perez-Crusado et al. (2018).

The participants did not note stigmatisation at all even though it has been found to exist to a high degree in the Czech Republic (Janoušková et al., 2016; Ocisková and Praško, 2015), perhaps because they did not talk about the illness with strangers and did not mention their experience in job interviews. On the contrary, *"When will the loonies arrive?"* asked the landlady during the 7-day stay in the mountains, and, when told that the group was already complete, she wondered: *"Those bright boys?"*

Only R3 had an employment contract, the others worked mostly in short casual jobs, often in the shadow economy, which is the reason why they did not indicate such employment in the SIS questionnaire.

Psychotherapeutic programme in the context of development of "problem" areas of social integration

Chart 1 and Table 2 with the semantic differential data show that the participants describe on average some improvement in the domains of *contacts, behaviour, self-control* (especially just after completion of the programme, with a small decrease after its end) and activities (with an even more significant improvement stated by the participants one year later). On average, the participants do not state any significant improvement in the other domains, sometimes they experienced a slight worsening (the *relationships, activities and empathy* domains).

Table 2. Semantic differential

Domain	At the start	After the end of the intensive phase	After one year
relationships	15.89	15.89	14.00
contacts	21.22	22.56	24.00
activities	16.22	16.22	15.40
behaviour	27.56	30.44	30.80
communication	26.33	27.33	27.00
empathy	29.33	28.11	28.00
self-control	26.89	31.67	29.40
hygiene	31.33	31.00	33.60
activities	28.89	32.22	35.00

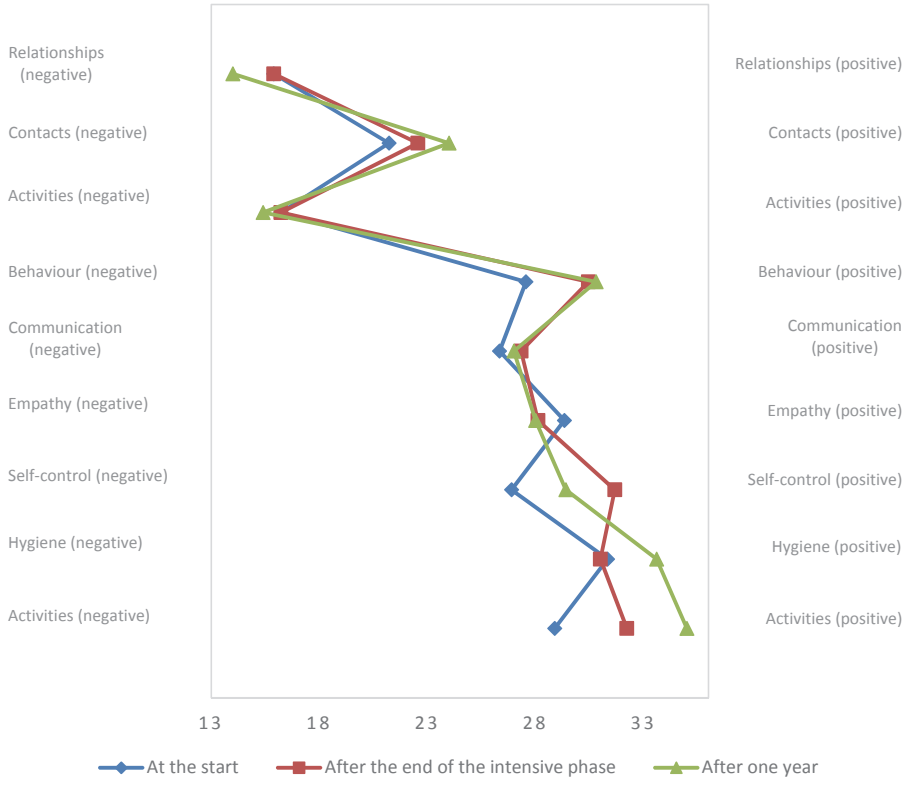

Chart 1. Comparison of the domains under evaluation on entry, at the end of the intensive phase and one year after entry to the psychotherapeutic programme

Chart 1 shows that the participants viewed themselves better (relationships, communication, empathy, self-control, activities) or slightly better (contacts) after the end of the intensive part of the psychotherapeutic programme compared with the situation at the time of entry to the programme. It is impossible to clearly determine which changes are attributable to participation in the therapeutic programme because there was a wide range of other circumstances that had an effect on the participants, their decisions and behaviour. In addition, in the context of psychotherapeutic treatment, a small sample was monitored over a short period of time, whereas psychotherapy is a long-term process that largely depends on the participant's motivation and the relationship they build with the psychotherapist (Slade and Holmes, 2019).

The chart can be interpreted in several ways. The increase in positive evaluations after the intensive part of the psychother-

apeutic programme could result from a sense of belonging to the group, feeling motivated and the strong optimistic support from the psychotherapists. Temporary worsening (regression) may occur during psychotherapy because difficult sensitive topics are discussed and revived in psychotherapeutic groups; as a rule, psychotherapy is a time-consuming process and in this respect the participants' subjective experience may have "worsened". They may also have gained an insight and become aware of the severity of their present life situation, precisely because they endeavoured to change existing behaviours and actions (for example, while it was unthinkable to speak to a stranger before, they are trying it now). The state of mind in completing the questionnaire could also play a role because the participants were somewhat melancholic about the end of the intensive phase and, later, about the end of the whole psychotherapeutic programme. Mintz et al. (2003) point out insight into the illness and symptomatology as factors that may have a significant effect on the data obtained. Another distortion was due to the fact that the data obtained at the end of the psychotherapeutic programme were not complete – two participants did not fill in the questionnaire and, in addition, the sample available is too small for a quantitative survey. The chart also seems to suggest that people with a SMI have a strong need for human contact and guidance because the participants were inclined to give the best scores immediately after the intensive stage of the psychotherapeutic programme. It would be appropriate to conduct interviews with the participants but, given the specific characteristics often attached to the manifestations of mental illnesses, the SIS questionnaire appeared to be more appropriate, especially at the beginning of the psychotherapeutic programme before mutual trust was built. It is by no means possible to generalise the results – they are relevant for the 9 participants concerned and the reliability of the data obtained is difficult to review because they can be biased by subjective interpretations.

The individual domains examined by the questionnaire are supplemented below with information from records and participant observation.

Close personal relationships

Relationships are viewed as the least satisfying domain of all the domains under evaluation. For R4, R5, R7, R8, R9 and R10, disagreements in close relationships led to the first psychiatric hospitalisation, for R6 problems with company co-founder had the same effect (while he viewed other relationships positively), R4 was hospitalised after a death in his family.

The result for close personal relationships considerably improved in all the participants when the relationships and friendships made in the psychotherapeutic programme group were included. One participant (R7) realised that she had hurt her parents a lot after the illness broke out. R3 shows a significant worsening in relationships, perhaps after realising how few people he meets and that in fact he has only one friend, while at the beginning of the psychotherapeutic programme he viewed his relationships well, perhaps unaware that he would like to have more friends or even a partner; the people from the group played an important role for him.

The close relationships domain was on a decrease in the next stage of the psychotherapeutic programme, although not below the level indicated at the time of entry to the programme. R7 had found her partner through classifieds; at the end of the psychotherapeutic programme she identified problems with confidence in people (that had been previously revealed during a game focusing on non-verbal communication). R2, R3 and R4 spoke about the adverse reaction to medicines that caused fatigue and, worse still, made intimate life physically impossible. Difficulties caused by adverse reactions to medicines are confirmed by authors of specialised literature (Kameníková et al., 2015; Probstová and Pěč, 2014). Some of the participants mentioned psychiatric problems of their parents (R2, R4, R9) and trying to look after themselves and "not to worry about parents" (R2). R6 had a larger network of friends than any other participant; he had known them before the outbreak of the illness and they were keeping in touch. R8 realised she did not seek active contacts with friends and set the objective of contacting them again.

Contact with strangers

The domain of contact with strangers generally improved, probably because the participants considered contacts within the group as contact with strangers. After the intensive phase of the psychotherapeutic programme, leisure time activities were not structured and the participants had to set them up themselves, as a result of which some closed themselves off again and avoided people after a few unsuccessful attempts (R5, R10). Others did not mention any difficulties in contact with strange people. R7 was very active in looking for a job and attended job interviews.

Joint activities

Joint activities took place within the intensive part of the psychotherapeutic programme. After the intensive phase, the participants perceived emptiness in comparison with the everyday programme (R5, R10); three of them formed a group for weekend trips and playing floorball (R2, R4, R6).

Appropriateness of behaviour

Emotions associated with ongoing psychotherapy may play a role in appropriateness of behaviour (see the above-mentioned regression in the psychotherapeutic process). All the participants identified warning signs of the illness during the psychotherapeutic programme such as sleep disorders (R5), which have been confirmed to have a higher incidence in people with psychiatric diagnoses in comparison with the general population (e.g. by Hobali et al. (2018)), as well as risk-taking behaviour (in particular, alcohol and drug abuse) – Bahorik et al. (2017) note in this respect that 40% of participants (of 1,434 people diagnosed with schizophrenia in total) abused drugs; the mental hygiene instruments applied were sports, music, painting.

Communication

The communication domain significantly improved at the end of the intensive phase as the participants became friends; the group was active, with a very open communication. R3 was able to praise himself, which he had never done during the intensive part. They also trained assertive communication.

Empathy

People in the group shared very personal experiences that were often related to experience with a SMI. They found similarities in their lives, knew the same doctors or medical establishments. The psychotherapists were very empathic and supportive and fostered a spirit of confidence. All this contributed to closeness and ability to empathise with the situation of a colleague. Nevertheless, R2 repeatedly pointed out his inability to feel any affection and "emotional blunting". An important factor was the sense of belonging, e.g. in the training of feedback, or when R9 found himself inside a group which praised and supported him despite his inappropriate responses to the situations he faced, incomprehensible speech etc.

As the participants set themselves ambitious goals after the end of the intensive phase, any failure could redirect their attention back to themselves and reduce empathy to others.

Self-control and everyday activities
Problem-free coping with everyday activities was obvious in the two weekly stays with a daily duty roster for teams of two who cooked for the whole group, washed dishes, chopped wood, maintained the wood stove etc. During the intensive phase of the psychotherapeutic programme the participants took turns in washing dishes and making tea and coffee.

Hygiene
None of the participants of the psychotherapeutic programme had difficulties with maintaining good hygiene. Yet it seems that the participants paid more attention to this aspect at the end of the psychotherapeutic programme in terms of dressing better. The group appreciated the smooth shave of R10; R7 changed her hair colour.

Psychotherapeutic programme in the context of participants' competences and abilities

The level of trust among the participants significantly increased during the psychotherapeutic programme, probably as a result of sharing very personal experiences. The sense of belonging to the group manifested itself in mutual help, praising each other and, later, the ability to give negative feedback about oneself or others (sincerity). R2 did not fear to say that he did not enjoy the non-verbal communication training when role-playing was not involved. Improvement was also observed in social skills: *"I think I can tell now by the facial expression and body language whether people are sincere in what they are saying."*

Many authors have identified the difficulties faced by the close persons of people with a SMI (Chien, 2010; Matens and Addington, 2001; Riley-McHugh et al., 2016). R9 had been stealing money from his parents and abusing drugs; after the end of the intensive part of the psychotherapeutic programme he was able to speak about his wish to repay the money and to find a temporary job, thus showing a strong trust towards the group. R10 defined himself as an alcoholic; his parents recommended him alcohol treatment; he began to drink more after the end of the intensive phase of the psychotherapeutic programme. It can be said that in line with the recognised stages of recovery, the participants gained hope, were empowered to achieve progress and had trust in their abilities; they were supported in taking responsibility and an opportunity was opened for meaningful roles (Ragins, 2018). There is considerable research evidence (Cullberg, 2000; Fenton, 2000; Martindale, 2000; Probstová and Pěč, 2014) of the positive effect of psychotherapy on psychotic disorders; some authors emphasise the importance of psychotherapy in combination with medication (Gottdiener, 2006) and, only exceptionally, without medication (Dorman, 1999).

Structure and organisation of the psychotherapeutic programme

The participants confirm that the psychotherapeutic programme helped prevent relapse thanks to *"understanding the situation"*, obtaining new information and experiences; it also helped activate them – *"I know I have to get up from bed sometimes"*. The participants confirm what Kostka (2017) states about the positive effect of psychiatry on communication, self-discovery and attitude changes. R10 appreciated that the psychotherapeutic programme filled his free time; *"otherwise I would be doing nothing"*. R2 and R5 initially found it difficult to get up but later they began to arrive on time for the programme and their sleep regimen became adjusted.

They considered the stays outdoors as the most beneficial aspect, mainly because they involved a change of settings, physical exercise, nature, freedom, and being together in the group. The lecture on medicines was clearly viewed as the most beneficial lecture (interaction of medicines with alcohol, other medicines, side effects of medicines). R2 learned from the lecture about the illness that the cognitive deficit was not permanent and could be changed; he began to admit that his memory and attention were not so poor after all and was very interested in information about the medicines-alcohol interaction.

In relation to group therapy, the participants highlighted the psychotherapists' caring and attentive approach. Self-help and self-discovery also played a positive role – *learning about others, learning how others view me*.

The stress coping activity was appreciated mainly because it focused on feelings, thoughts, consequences, ability to give vent to feelings, improvement of the ability to express oneself. *Handling problems right away while they are small*, information, open communication.

Art therapy was positive in helping express feelings, enhancing imagination, training attention, ability to paint a theme, inspiration, all in line with the propositions of British art therapist Liesl Silverstone (2009).

The activity focusing on the cognitive function was beneficial, according to the participants, in *analysing model social situations*, work with notions and vocabulary and attitude to people; they enjoyed the entertaining, sometimes competitive style.

Physical exercise helped most of the participants realise how they neglected their fitness (Happel et al., 2014), relaxation *"helped relax thoughts"* (R2). The most important thing about the training of non-verbal communication was fun, play, relaxation, teamwork, *"unusual form"*, improvement of attitudes and communication.

After the end of the intensive phase of the psychotherapeutic programme, they were strongly motivated "to live a normal life", but encountered their first failures e.g. in job interviews and recruitment procedures. One of the participants had another attack after the end of the psychotherapeutic programme and was hospitalised for a short time (R9).

Conclusions

The psychotherapeutic programme successfully activated and motivated the research participants, contributed to self-discovery, education, structuring and meaningful spending of leisure time, including the ability to cope with the transition to normal life after hospitalisation. An important benefit of the psychotherapeutic programme is that the pace and goals are set by each participant individually; they are not pushed or scored but receive guidance and support.

The highest degree of support is offered in the intensive part of the psychotherapeutic programme. The research suggests that the most important aspect is the psychotherapists' work, and their ability to create a safe, inspirational environment of trust, including humour.

It would be beneficial to use e.g. semi-structured interviews in further research; the participants would also be able to share less positive information about the psychotherapeutic programme and it would be possible to better identify their success/failure outside the psychotherapeutic programme; it would be desirable to receive feedback from the attending psy-

chiatrists and the participants' close persons and to obtain a larger sample of participants for using quantitative research.

Conflict of interests

The authors have no conflict of interests to declare.

Případová studie psychoterapeutického programu pro lidi se zkušeností s duševním onemocněním

Souhrn

Cíl: Předkládaná případová studie si klade za cíl zodpovědět otázku: „Jak ovlivňuje psychoterapeutický program své respondenty?" Sledovaný psychoterapeutický program je určen lidem se zkušeností s duševní poruchou, spadá do komunitní psychiatrické péče. Zkoumaný psychoterapeutický program může být alternativou hospitalizace na psychiatrii nebo na hospitalizaci přímo navazuje, případně má i preventivní charakter.

Metody: Byly využity jak kvantitativní, tak kvalitativní metody a techniky, přičemž respondenti byli monitorováni jeden rok. Konkrétně byla data získávána prostřednictvím zúčastněného pozorování, z terénních poznámek, analýzou dokumentů a pomocí dotazníku SIS (Social Integration Survey), jenž byl přeložen z anglického originálu za spolupráce vedoucí autorského týmu Výzkumného ústavu Piedmont Dr. Jane Scott-Lennox.

Výsledky: Program má pozitivní vliv na zlepšení komunikace, aktivizaci, zvýšení informovanosti, ve smyslu porozumění nemoci, léčbě, sebepoznání a náhledu s respektem k individuálním možnostem respondentů. Z hlediska zotavení dodává naději, přispívá k rozvoji a udržení kompetencí a dovedností, podporuje zplnomocnění a obnovení sociálních rolí.

Závěr: Získaná data potvrdila, že účast na psychoterapeutickém programu přispívá k sociální integraci členů.

Klíčová slova: duševní porucha; případová studie; psychoterapeutický program; recovery; sociální integrace

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