PRINCIPLES OF ART THERAPY FOR PATIENTS WITH INORGANIC PSYCHOSIS

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Annotation: *Art therapy constitutes a non-verbal and intrinsically accessible form of self-expression, enabling individuals to externalize their emotional states, inner experiences, and cognitive processes through creative activity. The products of artistic expression-such as drawing, movement, or other creative modalities-serve as symbolic representations of a person’s emotional background, internal conflicts, and subjective perception of reality. Throughout the therapeutic process, continuous observation is conducted with regard to emotional tone, level of activity, changes in self-perception, patterns of interaction with the therapist, and the direction and quality of communication.*

Key words: *art therapy, acute psychosis, non-organic psychotic disorders, treatment.*

Introduction

According to the World Health Organization, acute psychotic disorders represent one of the leading causes of disability worldwide, ranking among the most severe conditions in terms of social and functional impairment. Major psychotic disorders are associated with a reduction in average life expectancy of approximately ten years, reflecting both the direct and indirect consequences of the disease [1-3]. The onset of psychosis typically occurs during young adulthood, a critical period for social, educational, and professional development, which results in profound disruption of social roles, occupational functioning, and family life. Moreover, the burden of the disease extends beyond the patient, significantly limiting the social functioning and quality of life of family members and caregivers [4-7].

Contemporary research indicates a high risk of relapse following the first psychotic episode. Recurrent episodes are observed in 57,0-67,0% of patients within the first year after onset, increasing to 69,0-95,5% over a five-year period. Each subsequent psychotic episode is associated not only with substantial economic and healthcare costs but also with progressive worsening of the disease course, deterioration of cognitive functioning, and an increased risk of early and persistent disability [8-11].

Despite the clinical heterogeneity and often atypical presentation of non-organic psychotic episodes, these conditions fully meet the criteria for early rehabilitation interventions. One of the key components of such interventions, as outlined in clinical care protocols for this patient population, is psychotherapy, which plays a decisive role in facilitating social reintegration and improving long-term outcomes [12-23]. Evidence-based psychosocial treatment approaches for patients with non-organic psychotic disorders include psychoeducation for patients and their families, family-oriented therapeutic interventions, training in social skills, and programs aimed at restoring cognitive functions. The effectiveness of these approaches has been confirmed by numerous national and international studies, as well as extensive clinical experience [24-30].

In recent years, increasing attention has been directed toward the therapeutic potential of art therapy as a component of комплексной psychosocial rehabilitation. International research suggests that art therapy may serve as a valuable adjunctive method in the treatment of psychotic disorders by enhancing emotional regulation, facilitating symbolic expression, and improving engagement in the therapeutic process [31-38].

The purpose of the study

The aim of the present study was to develop and substantiate principles of art therapy for patients with non-organic psychotic disorders based on a comprehensive analysis of changes in clinical-psychopathological and pathopsychological characteristics during the course of treatment (ICD-10 codes F20–F29).

Materials and methods

The study sample consisted of 150 patients aged 18 to 45 years diagnosed with non-organic psychotic disorders (F20-F29). Diagnostic verification was conducted in accordance with the clinical and diagnostic criteria of the International Classification of Diseases, 10th Revision (ICD-10). The dynamics of clinical and psychopathological symptoms were assessed using the Positive and Negative Syndrome Scale (PANSS),

allowing for standardized statistical evaluation of symptom severity and treatment-related changes.

Cognitive functioning and its dynamics were examined using a neuropsychological assessment framework based on the methodological approaches proposed by A. R. Luria. To evaluate personality characteristics and dominant psychological defense mechanisms, the Kellerman–Plutchik "Lifestyle Index" questionnaire was applied. Changes in behavioral coping patterns, including the frequency and intensity of coping strategy use under stressful conditions, were analyzed using a standardized coping behavior assessment methodology.

Social functioning and levels of social activity were assessed using the World Health Organization Disability Assessment Schedule, with particular attention to the domain related to the performance of social roles. Additionally, limitations in life activity were evaluated using a psychiatric scale designed to assess the degree of functional impairment in everyday life. The integration of clinical, psychological, and social assessment tools provided a comprehensive framework for evaluating the effectiveness of art therapy within the overall treatment process.

Results and their discussion

The median age of the participants included in the study was 27,8 ± 4,2 years, indicating a predominantly young adult population. Gender distribution demonstrated a notable disparity: male participants comprised 61,3 ± 4,8% of the sample, approximately twice as many as female participants, who represented 38,6 ± 4,8%. This gender imbalance is consistent with epidemiological trends observed in non-organic psychotic disorders and may reflect differential vulnerability and healthcare-seeking behaviors between sexes.

Regarding marital status, a significant majority of participants were single, accounting for 65.3 ± 4,8% of the sample. The living arrangements of the participants revealed that most individuals resided with parents or other relatives (70,0 ± 4,6%), emphasizing the role of the family as the primary support system during the acute and early rehabilitation phases. Educational attainment varied across the sample: 49,3 ± 5,0% of participants had completed secondary education, 30,7 ± 4,6% had attained secondary specialized education, 12,7 ± 3,3% had higher education, and 7,3 ± 2,6% had incomplete higher education. Occupational engagement was similarly heterogeneous, with 20,6 ± 4,0% employed in physically demanding jobs with reduced qualifications, 9,3 ± 2,9% engaged in physical work without reduced qualifications, 7,3 ± 2,6%

employed in physically demanding roles without formal qualifications, and 3,3 ± 1,8% employed in mental work with reduced qualifications.

In addition to deficits in professional qualifications, many patients exhibited decreased labor activity. A majority of participants (59,3 ± 5,0%) were not working, 24,6 ± 4,3% maintained continuous employment, and 16,0 ± 3,7% were employed on a periodic or intermittent basis. This reduction in occupational engagement reflects the functional impact of psychotic disorders and highlights the importance of integrating vocational rehabilitation into comprehensive treatment programs.

The average duration of the acute phase of the disorder was 25,9 ± 4,8 months. During this stage, the clinical presentation included a combination of psychopathological and characterological changes. Psychopathological manifestations were polymorphic, with emotional disturbances observed in 69,3 ± 4,6% of participants, thought disorders in 67,3 ± 4,7%, effector-volitional disturbances in 50,7 ± 5,0%, perceptual abnormalities in 37,3 ± 4,8%, and concerns regarding somatic health reported in 36,0 ± 4,8%.

Characterological features included prominent signs of passivity and subordination in 67,3 ± 4,7% of cases, dependent behavior in 22,7 ± 4,2%, social withdrawal or isolation in 28,6 ± 4,5%, apathy in 14,3 ± 4,5%, and less pronounced inefficient hyperactivity in 5,1 ± 2,2% of participants. The syndromic structure during active psychotic episodes revealed a predominance of hallucinatory-paranoid syndrome (40,7 ± 4,9%), followed by paranoid syndrome (28,7 ± 4,5%), depressive-paranoid syndrome (27,3 ± 4,5%), and a smaller proportion exhibiting manic-paranoid syndrome (3,3 ± 1,8%).

To address the objectives of the study and comprehensively characterize the sample, multiple research methodologies were employed. These included structural-functional and structural-level analyses, clinical-psychopathological assessments, clinical-anamnestic and clinical-catamnestic methods, psychodiagnostic evaluations, socio-demographic profiling, and statistical analysis of the collected data. The integration of these approaches facilitated a multidimensional understanding of both clinical and functional characteristics of patients with non-organic psychotic disorders and informed the development of targeted therapeutic interventions.

Art therapy interventions are structured in two major blocks: an intensive block during inpatient treatment and a supportive block in outpatient or community settings. The intensive block spans two months and comprises three stages: psychodiagnostics and organizational training, symptomatic correction, and personal recovery. The

supportive block extends over two years and focuses on maintaining positive therapeutic outcomes. During the psychodiagnostic stage, which lasts two weeks, patients participate in sessions twice per week. The symptomatic correction stage also lasts two weeks, with therapy frequency gradually adjusted. The personal recovery stage occurs over four weeks, beginning with three sessions per week and subsequently reduced to two. The supportive phase involves weekly sessions totaling 96 lessons, bringing the overall number of art therapy sessions to 117. Session duration ranges between 45 and 90 minutes, depending on the stage and therapeutic objectives.

Group therapy is primarily employed, allowing patients to develop self-control, interpersonal skills, and the capacity for effective communication. During the inpatient intensive block, therapy is conducted in closed groups, whereas outpatient support groups are partially open. The level of therapist intervention and guidance is adjusted based on the stage of therapy and the progress of patients. Each session is structured around three main phases: introduction (setting intentions and checking mood), creative work (performing tasks related to the thematic focus), and discussion (reflecting on experiences and consolidating insights). Both repetitive and unique exercises are included, fostering skill development and promoting group cohesion. Ritualized opening and closing procedures, such as mood sharing at the beginning and a collective "handshake" ceremony at the end, help establish a supportive and psychologically safe environment.

Art therapy is conducted in specially equipped centers with all necessary materials and tools, ensuring that patients can fully engage in creative processes. The structured, progressive, and individualized nature of the program maximizes therapeutic outcomes, encourages self-expression, and supports the development of adaptive coping strategies that can be generalized to daily life.

Conclusions

The principle of timeliness emphasizes the strategic activation of art therapy at optimal points during the patient's treatment course. Specifically, interventions are introduced after stabilization of the acute phase of psychosis to create a "psychotherapeutic window" conducive to psychocorrective work. Timely application also involves adhering to the intended chronological and structural sequence of intensive, core, and supportive components of the art therapy program, while accounting for the natural rhythms of behavioral and cognitive change that occur in response to comprehensive medical and psychotherapeutic interventions.

The principle of dynamic monitoring entails continuous assessment of both individual patients and group processes during therapy. Through ongoing observation and feedback, therapists can optimize the effectiveness of interventions, adjust the therapeutic load, and ensure appropriate interaction within the group. This iterative monitoring enables adaptive modifications to the program, fostering maximal engagement, safety, and therapeutic benefit for each participant.

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