

SCHEMA THERAPY: EVIDENCE BASED TREATMENT FOR CHALLENGING MENTAL DISORDERS

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Schema therapy (ST) was developed as a transdiagnostic approach for treatment challenging clinical disorders. It also provides disorder specific models for most personality disorders (PD). There are growing number of evidence that show that ST model is very effective for patients with borderline personality disorders (BPD), antisocial personality disorder (ASPD), all cluster C personality disorders. Good results are also reported by number of researchers for chronic depression, post- traumatic stress disorder, including complex PTSD, eating disorders, and complex obsessive compulsive disorders.

Schema therapy derives from cognitive-behavioral therapy (CBT) and considered by majorities of psychotherapists as a third wave CBT approach. ST was developed by Jeffrey Young (student of Aaron Beck) in 2003 for patients, which did not respond to standard CBT. These patients often had a comorbid personality disorders and showed complex, rigid, and chronic psychological problems in emotion regulation and in interpersonal relationships, which in most cases could be followed back into their childhood. These problems also impaired the psychotherapeutic process as those patients had difficulties in forming a collaborative relationship with the therapist and could not be reached with standard CBT techniques due to intensive emotional reactions and coping strategies such as avoidance or surrender. In order to solve these clinical challenges Young integrated ideas and techniques from other theoretical orientations into a classical CBT frame (attachment theory, Gestalt therapy). A strong emphasis was placed on the biographical aspects for the development of maladaptive psychological patterns through traumatization in childhood and frustration of basic childhood needs. The therapeutic relationship was conceptualized as "limited reparenting" meaning that the therapist creates an active, caring, parent-like relationship with the patient.

The major goal in ST is helping patients to understand their emotional core needs and learn ways of getting needs met in an adaptive manner or to help them deal with the frustration if needs cannot be satisfied. This requires breaking through long-standing emotional, cognitive and behavioral patterns, meaning change of dysfunctional schemas, coping strategies and modes.

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PSYCHOPHARMACOTHERAPY OPTIONS FOR PATIENTS WITH ORGANIC BRAIN DAMAGE

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Introduction: Despite considerable efforts of scientists and medical practitioners, neither treatment standards nor complete recommendations for various mental disorders in patients with organic brain damage have been developed so far.

The specific strategies of choice that increase the effectiveness of pharmacotherapy can be: a) considering the level of brain damage (stem, subcortical, hemispheric), b) stimulating interhemispheric connectivity, c) impacting a "weak" neurotransmitter component by stimulating or inhibiting separately different (choline, glutamate, dopamine and GABAergic) systems.

However, a main criterion of drug choice has been and remains clinical one which provides a pharmacological strategy needed in the patient's current state, with identifying not only negative symptoms of mental disorders, but also productive psychopathological symptoms produced by a deficient (due to brain damage) functional system to enable a coherent neuropsychic activity.

Goal: To find clinical options relating to the choice of therapeutic strategy for patients with mental disorders due to organic brain damage.

Subjects and methods: Treatment and side effects were analyzed during 1613 courses of psychotropic medication administered to 365 patients with traumatic or neoplastic brain damage.

Results: After examining the contingent of patients, the following treatment options were suggested for various clinical situations: