Aplicación de paroxetina combinada con intervención psicológica en el tratamiento de pacientes con depresión durante la rehabilitación

Application of Paroxetine Combined with Psychological Intervention in the Treatment of Depression Patients During Rehabilitation

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Resumen
Actualmente, los antidepresivos incluyen principalmente inhibidores selectivos de la recaptación de serotonina, paroxetina, serotonina e inhibidores de la recaptación de noradrenalina. Este artículo explora el efecto de la intervención psicológica sobre el efecto del tratamiento de pacientes. El grupo control recibió tratamiento de rutina y enfermería. El grupo de observación recibió intervención psicológica y tratamiento durante 8 semanas. Los dos grupos de pacientes fueron evaluados utilizando la Escala de depresión de Hamilton (HAMD) y la Escala de ansiedad de Hamilton (HAMA) y la Escala de observación de enfermería para pacientes hospitalizados (NOSIE). Resultados La tasa efectiva en el grupo de observación fue del 87%, y la tasa efectiva en el grupo de control fue del 61.11%. Hubo una diferencia significativa entre los dos grupos ($x^2 = 7.92, P <0.01$). Las escalas HAMD y HAMA mostraron que el grupo de observación y el grupo control tenían 2 y 2 después de la intervención. Comparando los fines de semana de 4, 6 y 8, la diferencia fue altamente estadísticamente significativa ($P <0.01$). El grupo de observación de puntaje NOSIE fue mejor que el grupo de control en el octavo fin de semana ($P <0.05$). La intervención psicológica tiene un buen efecto terapéutico en el período de rehabilitación de los pacientes con depresión, es propicio para la recuperación de las funciones mentales y sociales, y tiene cierta importancia clínica para la prevención de la recaída de la depresión.

Palabras clave: paroxetina; Intervención psicológica; Depresión; Antidepresivos tetracíclicos

Abstract
Currently, antidepressants mainly include selective serotonin reuptake inhibitors, paroxetine, serotonin, and norepinephrine reuptake inhibitors. This article explores the effect of psychological intervention on the treatment effect of depression patients during rehabilitation. Methods Seventy-two patients with depression were randomly divided into the observation group and the control group, with 36 cases in each group. The control group received routine treatment and nursing. The observation group received psychological intervention and treatment for 8 weeks. The two groups of patients were assessed using the Hamilton Depression Scale (HAMD) and the Hamilton Anxiety Scale (HAMA) and the Nurses’ Observation Scale for Inpatients (NOSIE). Results The effective rate in the observation group was 87%, and the effective rate in the control group was 61.11%. There was a significant difference between the two groups ($x^2 = 7.92, P <0.01$). The HAMD and HAMA scales showed that the observation group and the control group had 2 and 2 after the intervention. Comparing the weekends of 4, 6, and 8, the difference was highly statistically significant ($P <0.01$). The NOSIE score observation group was better than the control group at the 8th weekend ($P <0.05$). Psychological intervention has a good therapeutic effect in the rehabilitation period of depression patients, is conducive to the recovery of mental and social functions, and has certain clinical significance for the prevention of depression relapse.

Key words: Paroxetine; Psychological intervention; Depression; Tetracyclic antidepressants

1. Introduction

Depression is one of the most common mental illnesses in the clinic. It is mainly manifested in symptoms such as low mood, diminished interest, pessimism, slow thinking, lack of initiative, and conscious general malaise. Suicidal thoughts can occur in severe cases. Research reports that the incidence of depression has risen sharply, and its mortality rate has jumped to the top of various mental illnesses, claiming to be the number one killer[1]. Studies show that about 30% of patients with depression in clinical use of antidepressants show ineffectiveness or incomplete efficacy, and it is not easy to change their cognitive concepts and personality characteristics, suggesting that simple drugs have certain clinical effects on the treatment of depression Depression is a mental illness, and it can only be completely cured in conjunction with psychological treatment.
Therefore, it is of great clinical significance to treat patients with medication and psychological rehabilitation[2]. In this article, in addition to drug treatment for depression patients, psychological intervention measures are also applied to explore the effect of psychological intervention measures on the treatment effect of depression patients during rehabilitation. Here are the reports:

2. Materials and methods

2.1 General Information

72 patients with depression in our hospital from June 2018 to May 2019 were selected, and all met the diagnostic criteria for depression in the Chinese Mental Disorder Classification and Diagnostic Standards (CCMD-3), and the Hamilton Depression Scale (HAMD) score ≥18 points. They were divided into observation group and control group, with 36 cases in each group. All patients except those with severe physical diseases, those with cerebral organic diseases, and pregnant and lactating women can receive stable drug treatment, and the patients have the right of informed consent for the treatment. In the observation group, there were 20 males and 16 females, aged 16 to 61 years, with a disease duration of 4 months to 11 years[3]. The average HAMD score was (24.12 ± 3.21) points. In the control group, there were 19 males and 17 females, aged 18 to 59 years, with a course of 3 months to 10 years. The average HAMD score was (24.42 ± 3.71) points. There was no significant difference in age, gender, and HAMD score between the two groups (P > 0.05), and they were comparable.

2.2 Method

Both groups of patients were treated with paroxetine (20-40 mg / d). The control group performed routine nursing, that is, the nurse reminded the patients to take the medicines on time and work daily, pay attention to their own clothing and maintain concurrent hygiene, and at the same time do a good job of the patient's safety care[4]. In terms of diet, inform the patients to eat foods containing crude fiber, and advise their families Try to accompany the patient to dinner. On this basis, the treatment group began to adopt psychological intervention measures from the first week of admission. The psychological intervention methods are as follows:

2.2.1 Supportive psychotherapy

The attending doctor should carefully listen to the patient's voice, and after determining the specific symptoms and severity, help to solve the patient's actual problems and correct the wrong psychological thoughts of the patient, so as to reduce the patient's pain and annoyance, so that he can see his own advantages and Strengths, methods to restore self-confidence, achieve self-management and cope with external interference.

2.2.2 Cognitive Behavioral Therapy

Targeting individual patients with different psychological problems, targeted psychological treatment and counseling are provided to allow patients to change their inherent cognitive thinking mode, encourage patients to face life with a positive attitude, improve patient's social initiative, reduce Depression, prompting him to recover early and return to society as soon as possible.

2.2.3 Health education

Holding health education lectures and psychological knowledge counseling, the attending doctors explain the concept of depression, pathogenesis, diagnosis, treatment and prevention to patients. It also provides psychological guidance for patients with different personality characteristics, builds patients' confidence to fight the disease, strengthens patients' determination to cure, and allows them to be hospitalized with peace of mind. And timely communication with the patient's family, so that the patient's family can fully support the patient's treatment, which is important to the patient's rehabilitation.

2.3 Evaluation method

Patients in the two groups were assessed with the HAMD and Hamilton Anxiety Scale (HAMA) and the Nurses' Observation Scale for Inpatients (NOSIE) before and after 2, 4, 6, and 8 weeks after intervention. The curative effect was evaluated by its reduction rate (reduction rate ≥50% for healing, 35% - 49% for marked effect, 20% - 34% for improvement, and <20% for invalid). Before and 8 weeks after the intervention, the nurses in charge used NOSIE to assess the condition of the two groups of patients. Effective = marked effect + improvement.

2.4 Statistical methods

Statistical analysis was performed using SPSS17.0. Measurement data were expressed as mean ± standard deviation (x ± S), comparison between groups was tested by t test, count data was expressed as percentage, and comparison between groups was tested by x². The difference was statistically significant at P < 0.05.
3. Results

3.1 Comparison of HAMD and HAMA scores of depression patients in two groups at different periods

As can be seen from Tables 1 and 2, there was no statistically significant difference in the HMD and HAMA scores before the intervention between the two groups (P > 0.05); the comparison was highly statistically significant after the intervention (P < 0.01).

Table 1. Comparison of HAMD scores before and after intervention in two groups of depression patients (\(\bar{x} \pm S\), min)

<table>
<thead>
<tr>
<th>Group</th>
<th>Number of cases</th>
<th>Before intervention</th>
<th>2 weeks after intervention</th>
<th>4 weeks after intervention</th>
<th>6 weeks after intervention</th>
<th>8 weeks after intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation group</td>
<td>36</td>
<td>35.23±6.54</td>
<td>30.21±7.80</td>
<td>21.48±6.24</td>
<td>15.56±5.61</td>
<td>15.56±5.61</td>
</tr>
<tr>
<td>Control group</td>
<td>36</td>
<td>34.92±6.72</td>
<td>32.76±8.11</td>
<td>29.65±6.32</td>
<td>21.23±6.06</td>
<td>21.23±6.06</td>
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<tr>
<td>t</td>
<td></td>
<td>0.16</td>
<td>2.36</td>
<td>4.34</td>
<td>3.78</td>
<td>3.78</td>
</tr>
<tr>
<td>P</td>
<td></td>
<td>&gt;0.05</td>
<td>&lt;0.01</td>
<td>&lt;0.01</td>
<td>&lt;0.01</td>
<td>&lt;0.01</td>
</tr>
</tbody>
</table>

Table 2. Comparison of HAMA scores before and after intervention in two groups of depression patients (\(\bar{x} \pm S\), min)

<table>
<thead>
<tr>
<th>Group</th>
<th>Number of cases</th>
<th>Before intervention</th>
<th>2 weeks after intervention</th>
<th>4 weeks after intervention</th>
<th>6 weeks after intervention</th>
<th>8 weeks after intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation group</td>
<td>36</td>
<td>25.15±5.76</td>
<td>18.54±5.01</td>
<td>13.16±4.45</td>
<td>10.15±3.88</td>
<td>5.75±2.65</td>
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<tr>
<td>Control group</td>
<td>36</td>
<td>25.04±5.41</td>
<td>22.04±5.41</td>
<td>17.56±5.14</td>
<td>14.27±4.24</td>
<td>10.61±2.47</td>
</tr>
<tr>
<td>t</td>
<td></td>
<td>0.55</td>
<td>2.11</td>
<td>4.52</td>
<td>3.65</td>
<td>5.21</td>
</tr>
<tr>
<td>P</td>
<td></td>
<td>&gt;0.05</td>
<td>&lt;0.01</td>
<td>&lt;0.01</td>
<td>&lt;0.01</td>
<td>&lt;0.01</td>
</tr>
</tbody>
</table>

3.2 Comparison of NOSIE scores between the two groups of depression patients at 8 weeks after intervention

The comparison of NOSIE scores at 8 weeks after the intervention showed a significant difference (P < 0.05). See Table 3.

Table 3. Comparison of NOSIE scores 8 weeks after intervention between the two groups (\(\bar{x} \pm S\), min)

<table>
<thead>
<tr>
<th>Group</th>
<th>Number of cases</th>
<th>Social competence</th>
<th>Social interest</th>
<th>Personal tidiness</th>
<th>Irritability</th>
<th>Psychiatric manifestations</th>
<th>Slow</th>
<th>Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation group</td>
<td>36</td>
<td>30.17±7.20</td>
<td>26.76±8.12</td>
<td>26.45±3.16</td>
<td>3.78±1.27</td>
<td>2.36±0.85</td>
<td>2.96±1.2</td>
<td>2.56±1.38</td>
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<tr>
<td>Control group</td>
<td>36</td>
<td>25.78±3.91</td>
<td>22.81±6.04</td>
<td>23.18±3.04</td>
<td>5.56±3.21</td>
<td>3.96±1.17</td>
<td>4.26±1.0</td>
<td>3.96±1.34</td>
</tr>
<tr>
<td>t</td>
<td></td>
<td>2.21</td>
<td>2.33</td>
<td>2.31</td>
<td>1.78</td>
<td>2.02</td>
<td>1.99</td>
<td>4.94</td>
</tr>
<tr>
<td>P</td>
<td></td>
<td>&lt;0.05</td>
<td>&lt;0.05</td>
<td>&lt;0.05</td>
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<td>&lt;0.05</td>
<td>&lt;0.05</td>
<td>&lt;0.05</td>
</tr>
</tbody>
</table>

3.3 Comparison of clinical efficacy between the two groups

In the observation group, 19 cases were cured, 8 cases were markedly effective, 5 cases were improved, 4 cases were ineffective, and the effective rate was 88.89%; the control group was 9 cases, 5 cases were markedly cured, 8 cases were improved, and 14 cases were ineffective. Efficiency comparison, the difference is highly statistically significant (x² = 8.17, P < 0.01). See Table 4.

Table 4. Comparison of clinical efficacy between two groups (examples)

<table>
<thead>
<tr>
<th>Group</th>
<th>Number of cases</th>
<th>Recovery</th>
<th>Markedly effective</th>
<th>To become better</th>
<th>Invalid</th>
<th>Effective rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation group</td>
<td>36</td>
<td>19</td>
<td>8</td>
<td>5</td>
<td>4</td>
<td>88.89%</td>
</tr>
<tr>
<td>Control group</td>
<td>36</td>
<td>9</td>
<td>5</td>
<td>8</td>
<td>14</td>
<td>61.11%</td>
</tr>
</tbody>
</table>

4. Discussions

4.1 The concept of depression

Depression, also known as depression, is characterized by significant and lasting depression, and is the main type of mood disorder. It can be seen clinically that depression is not commensurate with their situation. Depression can range from sullen to distressed, inferior, depressed, and even pessimistic [5]. Suicidal attempts or behaviors can occur; even stiffening occurs. Some cases have obvious anxiety and sports agitation. In severe
cases, psychotic symptoms such as hallucinations and delusions may occur. Each episode lasts for at least 2 weeks, the elderly or even years. Most cases have a tendency to recur. Most episodes can be relieved, and some may have residual symptoms or become chronic.

So far, the etiology of depression is unclear, but it is certain that many aspects of the biological, psychological and social environment are involved in the pathogenesis of depression. Biological factors are mainly related to heredity, neurobiochemistry, neuroendocrinology, and neural regeneration. Psychological predispositions that are closely related to depression are pre-morbid personality characteristics, such as depression temperament. Stressful life events in adulthood are important triggers for clinically significant depression. However, the above factors do not work alone[6]. At present, it is emphasized that the interaction between genetics and environment or stress factors, and the time point at which such interactions occur, have an important impact on the occurrence of depression.

The diagnosis of depression should mainly be based on medical history, clinical symptoms, course of disease, physical examination and laboratory examination. Diagnosis of typical cases is generally not difficult. The current international diagnostic standards are ICD-10 and DSM-IV. ICD-10 is mainly used in China, which refers to the first episode of depression and relapsed depression, excluding bipolar depression. Patients usually have typical symptoms such as low mood, loss of interest and pleasure, lack of energy or fatigue. Other common symptoms are: ① Decreased ability to focus and pay attention; ② Reduced self-evaluation; ③ The concept of self-guilt and sense of worthlessness (even in mild attacks); ④ Pessimism about the future; ⑤ The idea of self-harm or suicide Or behavior; ⑥ Sleep disorders; ⑦ Decreased appetite. The course of the disease lasted at least 2 weeks.

4.2 Depression manifestations
Depression can be manifested as single or repeated depressive episodes. The following are the main manifestations of depressive episodes.

4.2.1 Low mood
Mainly manifested as significant and lasting emotional depression, depression and pessimism. The lightest person is unhappy, unhappy, and diminished. The serious person is unwilling to live, pessimistic and hopeless, living like a year, and not living as well[7]. Depressive mood of typical patients has light rhythm changes in the morning and night. On the basis of a depressed mood, patients will experience a decrease in self-evaluation, a sense of uselessness, hopelessness, helplessness, and worthlessness, often accompanied by self-blame and guilt, and serious cases of delusions of guilt and suspected illness. Hallucinations.

4.2.2 Slow thinking
The patient's thinking association speed is slow, the reaction is slow, the mind is blocked, and he consciously "the brain seems to be a machine with rust", "the brain is like a layer of paste". It can be seen clinically that active speech is reduced, the speed of speech is significantly slowed, the voice is low, the answer is difficult, and the communication cannot be performed smoothly in severe cases.

4.2.3 Decreased will activity
The patient's volition was significantly and persistently suppressed. Clinical manifestations Slow behavior, passive, lazy life, do not want to do things, unwilling to contact with people around, often sitting alone, or staying in bed all day, living behind closed doors, alienating relatives and friends, avoiding socializing. In severe cases, even eating, drinking and other physical needs and personal hygiene are disregarded[8]. They are unkempt, shameless, and even develop into a silent, motionless, and foodless, called "depressive stiffening", but the patient still shows pain and depression after careful mental examination mood. Patients with anxiety may have symptoms such as restlessness, finger gripping, rubbing their hands or rubbing their feet. Severe patients are often accompanied by negative suicidal ideas or behaviors[9]. Negative pessimism and self-blame and self-confidence, lack of self-confidence can germinate despairing thoughts, "Ending your life is a kind of relief", "I live in the world are redundant people", and will make suicide attempts into suicide behavior. This is the most dangerous symptom of depression and you should be alert.

4.2.4 Cognitive Impairment
Research suggests that patients with depression suffer from cognitive impairment. Mainly manifested in the decline of recent memory, attention deficit, prolonged response time, increased alertness, poor abstract thinking ability, learning difficulties, poor language fluency, spatial awareness, eye-hand coordination, and thinking flexibility[10]. Cognitive impairment leads to social dysfunction and affects patients' long-term prognosis.

4.2.5 Physical symptoms
There are mainly sleep disorders, fatigue, loss of appetite, weight loss, constipation, pain in any part of the body, loss of libido, impotence, amenorrhea and so on. Physical complaints of physical discomfort may involve various organs, such as nausea, vomiting, palpitation, chest tightness, and sweating. Symptoms of autonomic dysfunction are also more common. Complaints of pre-morbid somatic disease are usually exacerbated[11]. Sleep disturbance is mainly manifested by early awakening, which usually wakes up 2 to 3 hours earlier than usual, and cannot fall asleep after waking, which has a characteristic significance for depression. Some manifested as difficulty falling asleep and not sleeping deeply; a few patients showed excessive sleep. Weight loss is not necessarily proportional to loss of appetite, and a small number of patients may experience increased appetite and weight gain.

4.3 Treatment of depression

4.3.1 Treatment goals

The treatment of depressive episodes must meet three goals: (1) Improve the clinical cure rate, minimize the disability rate and suicide rate, the key is to completely eliminate clinical symptoms; (2) Improve the quality of life and restore social function; (3) Prevent relapse.

4.3.2 Treatment principles

(1) Individualized treatment; (2) The dose is gradually increased, and the minimum effective amount is used as much as possible to minimize adverse reactions to improve medication compliance; (3) A sufficient amount of full course of treatment; (4) As much as possible single medication, if the effect is not good, consider conversion Treatment, synergistic treatment or combination therapy, but need to pay attention to drug interactions; (5) Informed before treatment; (6) Close observation of disease changes and adverse reactions during treatment and timely treatment; (7) Can be combined with psychotherapy to increase efficacy; (8) Actively treat other physical illnesses, depression, anxiety disorders, etc.

4.3.3 Drug treatment

Medication is the main treatment for moderate or more depressive episodes. Currently, the first-line clinical antidepressants mainly include selective serotonin reuptake inhibitors (SSRI, representative drugs fluoxetine, paroxetine, sertraline, fluvoxamine, citalopram, and escitalopram)[12]. Serotonin and norepinephrine reuptake inhibitors (SNRI, for the drugs venlafaxine and duloxetine), norepinephrine, and specific serotonin antidepressants (NaSSA, for the drug nitrogen equality. Traditional tricyclic and tetracyclic antidepressants and monoamine oxidase inhibitors have been significantly reduced in application due to their large adverse effects.

4.3.4 Psychotherapy

For patients with depressive episodes with significant psychosocial factors, psychotherapy is often required at the same time as medication. Commonly used psychotherapy methods include supportive psychotherapy, cognitive-behavioral therapy, interpersonal therapy, marriage and family therapy, and psychodynamic therapy. Among them, the effect of cognitive-behavioral therapy on depression has been recognized.

4.3.5 Physical Therapy

In recent years, a new type of physical therapy has emerged—repetitive transcranial magnetic stimulation (rTMS) therapy, which is mainly applicable to mild to moderate depressive episodes.

4.4 Experimental analysis

Adopting drug treatment can alleviate the emotional and physical symptoms of patients with depression. In addition to psychological intervention treatment, which can obviously improve the patient's mood, it can also guide patients to correctly understand their own disease conditions and change their distorted understanding of themselves and the surrounding environment, so that patients better adapt to the environment, receive treatment in a pleasant mood, reduce depression, return to society early and return to society, and combined with drugs can play a synergistic therapeutic effect[13]. Therefore, psychological intervention is widely used in the treatment of depression. The results of this study show that the differences in HAMD and HAMA scores of the observation group and the control group after treatment at 2, 4, 6, and 8 weeks are highly statistically significant (P <0.01); the NOSIE scores at 8 weeks after intervention have significant differences Statistical significance (P <0.05). The effective rate in the observation group was 88.89%; the control group was 61.11%. The effective rates of the two groups were compared, and the difference was highly statistically significant (P <0.01), indicating that the clinical efficacy and social function rehabilitation effect of the observation group were significantly better than those of the control group. Drug treatment and routine care), that is, patients with depression and anxiety improved significantly.

This study also found that starting psychological intervention treatment when the patient was admitted to the hospital has a good effect, which indicates that psychological intervention for patients with depression can
significantly improve patients' awareness of their own diseases and improve patient medication compliance[14]. The more the patient understands the psychological knowledge, the more he can recognize his own personality defects and deficiencies, to calmly cope, reduce the feeling of helplessness and inferiority after the onset of illness, maintain an optimistic mood, and reduce the occurrence of depression.

Someone's research on patients with depression for 10 years found that 75% to 80% of patients have multiple relapses, so patients with depression need preventive treatment. More than 3 attacks should be treated for a long time, and even take medicine for life. Most scholars believe that the dose of maintenance therapy should be the same as the therapeutic dose, and they should be followed up regularly for outpatient visits. Psychotherapy and social support systems also play a very important role in preventing the recurrence of this disease[15]. Patients should be relieved or relieved of excessive psychological burden and stress as much as possible, help patients to solve practical difficulties and problems in life and work, and improve patient coping ability And actively create a good environment for it to prevent recurrence.

5. Conclusion

In summary, the author believes that psychological intervention treatment can help patients reduce the degree of depression as soon as possible, improve the patient's cognition, enhance the patient's self-confidence, improve the patient's treatment compliance, and promote the patient's early recovery. But the long-term rehabilitation effect needs further study.

References