

Kharkiv National Medical University
Department of Psychiatry, Narkology and Medical Psychology

WORKBOOK
MANUAL FOR INDIVIDUAL WORK OF
STUDENTS

MEDICAL PSYCHOLOGY

Student _____
Faculty _____
Curs _____ Group _____

2018

Копіювання для поширення в будь-якому вигляді частини або повністю можливо тільки з дозволу авторів навчального посібника.

Медична психологія: методичні рекомендації для самостійної роботи студентів // Г.М. Кожина, В.М. Сінайко, І.В. Лещина, К.О. Зеленська, В.О. Кощій, Л.Д. Коровіна – 2018р., 112 с.

Class №1. THE SUBJECT, OBJECTIVES AND METHODS OF STUDYING THE PSYCHOLOGICAL STATE OF A PERSON. CONCEPTS OF MENTAL HEALTH. THE STATE OF MENTAL FUNCTIONS AND DISEASE

Psychology is a science about the origin, development and manifestations of mentality. Psychology is subdivided into: general, individual and social. General Psychology is further subdivided into: age, medical, engineering, space, military and other.

General psychology is a science about regularities of development and practical realities of mental functions (perception, memory, attention, thinking, emotions, volitional sphere, consciousness) separately in their interaction, which makes the personality.

Medical Psychology is a field of psychology which studies regularities of developing and functioning mentality under conditions of the beginning and duration of the disease, treatment of the patients and using psychological factors in the process of treating, preventive and hygienic activities of the medical staff.

Medical Psychology is dealing with solving theoretical and practical problems connected with the restoration and maintenance of psychological health of the population, prevention of diseases, diagnosis of pathological conditions, psychocorrecting forms of influence the recovery, with solving of many problems of examinations, social and working rehabilitation of healthy and ill people and besides with study of psychological features of the professional activity of the medical worker.

The basic tasks of medical psychology:

1. Psychological evaluation of patient's specific features, changes of his psychological functions under various mental and somatic diseases.
2. Analysis of the influence of various mental and somato-neurological diseases on the mentality of children and adults.
3. Analysis of the role of mental affects in causes, duration and prevention of psychosomatic diseases, their psychopathological complications
4. Analysis of personal and professional psychological peculiarities in doctor's behavior and work with patients.
5. Studying of psychology interrelations between a patient and medical personnel in treatment process
6. Working out the principles and methods of experimental-psychological examination, correction and psychotherapy.

In Ukraine psychology develops as an integral part of the world psychological science. By the beginning of the 20-th century some scientific schools were formed: Kiev (G.I. Chelpanov, I.A. Sikorsky, S.A. Ananin), Odessa (I.M. Sechenov, I.I. Mechnikov, M.M. Lange, S.L. Rubinstein). Kharkov was one of the most important centres of developing experimental psychology in 20-30 years of the 20-th century. The history of the developing psychology in Ukraine is also connected with such well known scientists such as: L.S. Vigotsky, A.P. Luria,

O.V. Zaporozhets, A.Ya. Anphimov, K.K. Platonov, O.M. Leontiev, V.P. Protopopov, P.I. Zinchenko, L.I. Bozovich and others.

Experimental psychological examination includes the following stages:

- Preparatory (hypothesis formulation, selection of methods)
- Properly experimental
- Quantitative processing of the findings
- Interpretation of the received data and writing conclusion

Psychological diagnosis - is the revelation of some hidden causes of a visible trouble (L.F. Burlachuk).

In medical psychology the following methods are used:

- 1.Method of clinical directed interview.
- 2.Method of observation.
- 3.Experiment.
- 4.Psycho-diagnostic examination.

Method of clinical interview. The interview reveals the associations interesting to the examiner on the basis of the empiric data which were received at real two-way contact with the patient. This is the method of receiving information about the individual psychological peculiarities of the personality, psychological phenomena and psychopathological symptoms, inner picture of the disease and the structure of the patient's problem. It is also the way of psychological influence of the person, which is worked out directly on the basis of a personal contact between the doctor, the psychologist and the patient.

The principles of clinical interview are unambiguity, exactness and simplicity of formulations, adequacy, sequence, flexibility and impartiality of interrogation, verity of the information received.

Method of observation. One of the most typical ways of examination is observation of an object (a person, a group of people) pending the phenomena interested by an examiner will show themselves to be recorded and described. By means of this method mental processes, states and properties of sick and healthy are studied. Mentality is studied under natural living conditions, and this study differs from an experiment because a doctor or a psychologist is a passive observer that has to wait for those phenomena he is interested in.

Experiment. An experiment differs from observation because it presupposes the arrangement of a clinical situation which allows carrying out a relatively absolute control of variables which is impossible at observation. A variable is reality that can be changed in an experimental situation. One of the most important advantages of an experimenter over an observer is manipulation of variables.

An experiment can be divided into 4 types: laboratory, natural, establishing and forming.

Psycho-diagnostic examination. On the basis of the psycho-diagnostic examination the hypotheses about the dependences between different psychological description are checked.

Psycho-diagnosis is the science and practice of how to make the psychological diagnosis. The diagnosis as the main purpose of diagnostics can be made on various levels.

Level 1 is the symptomatic and empirical. On this level the diagnosis is limited by ascertaining of peculiarities or symptoms (signs).

Level 2 is etiological. It takes into account not only the presence of descriptions but also the causes of their development.

Level 3 is the level of the typological diagnosis which determines the place and the meaning of the revealed descriptions in the general picture of psychological human life.

Psycho-diagnostic methods. The main methods of psycho-diagnosis are testing and interviewing.

Testing. A test is a try-out, a task or a task system which helps to estimate the mental state or maturity of the examined.

Questionnaires are the methods containing a number of questions to be answered by an examined person in order to find out whether he agrees with them or not. There are questionnaires of an “open” type (answers are given arbitrarily) and of a “closed” type (answers are chosen from the variants given in the questionnaire). Besides there are questionnaires – surveys and personality questionnaires.

Personality questionnaires used for the evaluation of personality characteristics are divided into several groups:

- a) typological questionnaires worked out on the basis of personality type determination allow to refer the examined to this or that type which differs its peculiar manifestations;
- b) personality traits questionnaires which determine the expression of traits, i.e. stable personality signs;
- c) motives questionnaires;
- d) importance questionnaires;
- e) aims questionnaires;
- f) interests questionnaires.

A number of psycho-diagnostic methods for the examination of various areas of mental activity are in the table:

Area of psychological activity	Psycho-diagnostic methods
Perception	Sensory excitability Aschaffenburg’s test Reichardt’s test Liepmann’s test
Memory	Ten words test Memorizing numbers Story reproduction
Attention	Schulte’s tables Proof test Anfimov’s tables Counting by Kraepelin
Thinking	Classification, exception of notions, syllogisms, analogies, interpretation of

	proverb, generalization tests Association experiment Pictogram
Intellect	Raven's matrices Wechsler's test
Emotions	Spielberg's test Luscher's methods of colour choices TAT (Thematic Apperception Test) Hospital Anxiety and Depression Scale (HADS)
Personality	Rorschach's test MMPI Thematic Apperception Test (TAT) Dembo-Rubinstein's methodology of self-evaluation "Unfinished proposals"

The concept about mental health is the one of the most important in medical psychology. According to the Code of WHO, **health** is defined not only as an absence of illnesses or physical defects but as a state of complete physical, spiritual and social well-being.

There are the following components of health:

- 1) physical (physical activity, physical well-being, physical limits);
- 2) mental (mental well-being, control of behavior and emotional reactions, functioning of cognitive processes);
- 3) social (interpersonal communication);
- 4) role (ability to perform socially accepted roles at home and at work);
- 5) general estimation of health.

There are three interconnected aspects of health, necessary for correct planning of valeological measures and based on the appropriate levels of personality: somatic, mental and spiritual.

The spiritual aspect of health is a motivation for a healthy way of life, long and happy life, independent activity in formation and strengthening of person's health, careful attitude to life and health of others.

Mental health is:

- a) absence of prominent mental diseases;
- b) certain reserve of man's strength which makes him able to overcome unexpected stresses and difficulties in extraordinary circumstances;
- c) equilibrium state between man and environment, harmony between man and society, coexistence a notion of separate man about "objective reality" with other people's notion.

Mental health means absence of mental diseases, normal mental development and desired functioning of supreme parts of CNS. For children it means normal abilities to master knowledge and skills, answer the requirements of school system, follow the norms of behavior in relations with mates and teachers.

Normal development can be defined as harmonic, appropriate to age, normal functioning and intellectual activity, positive emotional state.

Commonly there are 5 groups of health:

1. Healthy persons with normal development and normal functioning.
2. Healthy persons with functional or some morphological deviations and reduced resistance to sharp and chronic diseases.
3. Patients with chronic diseases in a condition of compensation with the preserved functioning of organism.
4. Patients with chronic diseases in a condition of subcompensation with reduced functional abilities.
5. Patients with chronic diseases in a condition of decompensation with considerably reduced functional abilities of organism.

Important in medical psychology is the notion of human psychological adaptation. There are several types of adaptive states:

1. The state of "physiological adaptation" – a normal human being in changing environmental conditions with optimal mode of all functional systems.
2. The state of "tense adaptation" – in the event of the need to restructure, modify existing parameters of activity, requiring a certain tension in the relevant functional systems.
3. The state of "abnormal adaptation" occurs when reserve capacities of the organism are excessive, which can lead to the complete exhaustion of adaptive mechanisms and the development of maladjustment.

Basis mental sphere

There are three main areas of mental activity: cognitive, emotional and volitional-effector (motor-volitional). Cognitive activity is presented by the processes of perception, memory, and thinking.

Sensation and Perception (in general, the sensory sphere, perception) is the initial stage, the first stage of human cognitive activity.

In a state of fatigue, excitement, under the influence of strong noise and other adverse external influences physiological function analyzers and general psycho-physiological state can vary, with the result that there is dullness, deceptions and errors of perception with the erroneous actions.

Sensation – is the simplest mental act; it reflects some properties of the objects and phenomena of the environment as well as inner state of the organism which influence the analyzers (sense organs) of the person.

The physiological basis of sensation is a complicated activity of analyzers. They consist of:

- receptors which receive stimuli;
- afferent neural pathways that transmit signals to the relevant parts of the brain;
- the central parts of the cortical analyzers, that process incoming information.

Sensation reflected:

- the main external signs of objects and phenomena

-state of inner organs

Kinds of sensations:

1. exteroceptive (due to influence of the stimulant on the receptors, nerve endings on the surface of the skin and mucous membranes) – contact and distant;
2. interoceptive (caused by influence of the stimulant on the nerve endings which supply the inner organs and those located in the walls of the respiratory organs, gastrointestinal tract, etc.)
3. proprioceptive (associated with the signals which develop due to stimulation of the receptors located in the muscles, tendons, joints).

In clinical practice, when patient's sensitivity is reduced or completely disappears in one or more analyzers, it's becomes important property of sensations such, as **sensitization**. This is a compensatory increase of sensitivity as a result of interaction and training analyzers. Loss of vision or hearing, to some extent offset by the development of other kinds of sensitivity (tactile, olfactory, vibration).

A special role is played by *pain* – *subjectively severe, sometimes unbearable, sensation which is due to very strong destroying stimulants*.

Our observation suggests that sensations for pain are generalized and processed by the second signal system. Therefore, the patient's complaints are one of the signs of the disease, its character and the place of the lesion.

Pain warns about the danger. Experience of pain depends on numerous factors: concentration or distraction of the attention from the pain, expectation of pain, emotional state, personality characteristics, and socio-moral orientation. The physician should take this into account and seek to create the conditions that diminish the pain of the patient. It is important to be able to reduce the pain of patient, by suggestion. Individual system of mental parameters of sensations - is the sensory organization of the organism.

One of the necessary conditions for a normal human mental activity is a certain minimum level of irritants that enter the body. If a person *does not receive the required quantity of stimuli* in connection with the pathology of the sense organs, then he falls asleep or immersed in oblivion, and nothing of what happened with him during that period, does not remember.

The sensory isolation conditions in humans unusual mental states can arise, which initially have a functional, reversible. If time of isolation increased, these functional changes go into pathological - having mental illnesses (neuroses and psychoses).

Perception – is a mental process which consists in holistic representation of the objects and phenomena of the world at their immediate influence on the sense organs which is combined with the past human experience (representation).

But the perception – it is **not the sum of sensations**, and the hard work of analyzers connection.

Physiological basis of perception. Perception is called acting at the same time complex stimuli implemented simultaneous and coordinated activity of several analyzers and proceeds with the assistance of the departments of associative cortex and speech centers.

Representation – is animation of images perceived in the past, the traces of the past sensations and perceptions. In contrast to perception, representations are more generalized, their brightness is different in different persons, they consist of fragments, do not project to the outer space and appear in the subjective world of the person. Besides, unlike perceptions, they can be deliberately changed. In some cases representations can be especially bright and in the smallest detail correspond to the perceived image. The ability to reproduce accurately earlier perception in the representation is termed eudetism.

Methods of perception study. The sphere of sensation and perception is studied with observation, introspection, questioning and use of different examples. At specialized hospitals (neurology, ophthalmology, ENT), various equipment for investigation of acuity of sensation and perception in different analyzers are used. At psychological study, perception is examined with different charts and pictures (illustrations of objects, their outlines, pictures with superimposed outlines of the objects, schemes with visual illusions, pictures “figure and background”, “mysterious” pictures).

To examine the vision and visual perception special charts and technical means are used.

To study auditory, cutaneous and vestibular perception audiometer, Weber’s compasses are used. To study stereognosis (touching the object without looking at it), it is necessary to have different objects (models of cars, animals, house-hold utensils).

Memory – is a form of mental reflection of the reality and with its help earlier acquired data; knowledge and events are fixed, kept and recreated.

Processes of memory: 1) Memorizing (fixation) – acquisition of information; 2) Retention – the process of keeping information; 3) Reproduction – the process of getting information from the storage of memory; 4) Forgetting – forcing out the information which lost its urgency to the latent layers of memory or perhaps the complete destruction of all the information.

The volume of memorized information depends on the method of its preparation

Speaking 15 %	Visual 25 %	Both of them 65 %
---------------	-------------	-------------------

By the volitional activity memory participate divided into involuntary and voluntary:

1) Involuntary memory means memorizing and playback automatically, without any effort.

2) An arbitrary memory involves cases where there is a specific task, and strong-willed effort to memorize.

This form of memory plays an important role purpose. It is proved that involuntarily memorized material, which is interesting for a person who is of great importance.

By the nature of mental activity, memory is divided into motor, emotional (affective), imaginal, and verbal-logical.

The motor (kinetic) memory – memorizing and preservation, and if necessary reproduction of multiple complex movements. This memory is actively involved in the development of motor (labor, sports) and skills. All manual movement of the person associated with this kind of memory.

This memory manifests itself in humans first of all, and is essential for normal development of the child.

Emotional memory – memory for experiences. Especially this kind of memory is manifested in human relations. As a rule, what makes a person emotional distress, remembered them easily and for a long time. Pleasant events more firmly deposited in the memory than unpleasant. This type of memory plays an important role in human motivation, and this manifests itself very early memory: about 6 months.

Verbal and logical memory – a type of memory when a large role in the process of memory plays a word, thought, logic. In this case, a man tries to understand assimilate information, clarify terminology, to install all semantic links in the text, and only after that to remember the material. People with well-developed verbal-logical memory is easier to remember a verbal, abstract material, concepts, formulas. This type of memory, in conjunction with the hearing, have scientists, experienced lecturers, university professors, etc. The logical memory at its training gives very good results, and much more effective than just rote memorization. Some researchers believe that this memory is formed and begins to "work" later than others. P.P.Bonsky called her "daughter-story." She has a child already in 3-4 years, when they begin to develop the very foundations of logic. It develops a child with learning the basics of science.

The image memory – associated with storing and playback of sensory images of objects and phenomena, their properties, relations between them. This memory begins to appear by the age of 2 years, and reaches its highest point in adolescence. Images can be different: a man remembers the images of different objects, and a general idea of them, with some abstract content. Remember the images of helping the different analyzers. Different people have different analyzers are more active, most people have better developed visual memory.

Methods of memory study

The condition of the memory is studied by questioning the patient. It helps to find out whether the patient calls things by their right names (year, month, date), if he knows the place where he is and who is close to him, if he says his age, date of birth in a proper way.

When studying memory some experimental psychological methods have great importance: memorizing 10 words not associated in meaning, counting numbers, reproducing stories and others.

Thinking is a mental process which consists of generalized and mediated reflection of objects and phenomena of the world, their natural connections and relations. Thinking unlike perception exceeds the bounds of sensible cognition, expands its limits. Thinking is directly connected with the outer world and is its reflection through sensation and perception.

Classification of types of thinking.

By the character of the aids used:

- Visual aid is a material for thinking activity presented in a visual, specific form (plaster cast, laboratory equipment and others).

- Semantic aid is a material for thinking activity presented in a sense, symbolic form (operating with numbers, verbal description of the situation).

By the character of duration of the cognitive processes:

- Intuitive thinking is performed as "gripping" the situation, "provided" decision without information about the ways and conditions of its performance.

- Analytical thinking is performed by means of logical conclusions leading to the correct understanding the main principle of appropriateness.

Forms of thinking

Concept is an idea reflecting common, important and distinctive signs of subjects and phenomena of the reality. Concept includes everything that cannot be directly interpreted with the help of our sense organs.

Judgment is reflections of links between the subjects and phenomena of reality or between their properties and signs. Judgment is a result of somebody's expression about something. They affirm or reject any relations between subjects, events and phenomena of the reality.

Conclusion is a link between thoughts (notions, judgments) resulting in getting different judgment from one or several judgments withdrawing it from the content of initial judgments.

Induction and deduction are the means of making conclusions which reflect direction of thought from separate parts to general or on the contrary.

Basic mental operations

Analysis is apportionment of general into parts in thoughts or mental apportionment of its sides, actions and relations from general. In an elementary form analysis is expressed in practical apportionment of subjects in component parts.

Synthesis is mental joining the parts, properties, actions into the whole. Synthesis is not a mechanical unity of the parts and thus it does not result in their summing.

As a rule, analysis and synthesis are carried out together, render assistance to more thorough cognition of the reality.

Generalization is apportionment of general and essential typical for the definite number of subjects and notions.

Intellect

Intellect is a system of all cognitive abilities of the individual, that is ability for cognition and solving the problem which determines success of any activity.

Intellect includes experience, acquired knowledge and ability to its quick and expedient use in new situations which were not met before and besides in the process of solving complex tasks.

Methods of studying thinking and intellect

When talking to the patient one should pay attention to the speed of associations and their features.

A number of experimental psychological methods can be used for studying thinking and intellect: tests which provide for finding out the ability to generalize,

exclusion and making new ideas and conclusions, understanding proverbs, memorizing numbers and words, solving simple tasks.

Attention

Attention is observed as concentration of consciousness on a chosen object or phenomenon, as a result this object or phenomenon is reflected clearer. In contrast to cognitive processes (sensation and perception) attention does not have its own content. It characterizes dynamics of psychic processes.

Kinds of attention

Attention can be involuntary, voluntary and post-voluntary. Involuntary attention is caused by objects and phenomena, which influence a man with their brightness, force or dynamism. Voluntary attention is directed by a man with volitional effort according to conscious purpose.

Methods of investigating attention.

Change of a patient's attention can be noticed with a naked eye, but experiments and psychological research supplies more precise data. Studying stability of attention psychologists use a special table. Right checked column is covered with a stripe of paper checked the same way. Using only vision a patient is to follow each line and mark its ending with a corresponding number.

Researching volume and stability of attention they use a table on which 17 blue, and 29 red confetti are stuck in disorder. A patient is to count confetti not using a pointer.

Emotional sphere

Emotions are subjective feelings which tincture the whole psychic activity of the person and reflect his attitude to the surroundings and himself. These are feelings of pleasant and unpleasant things that accompany perception of the self and the surrounding world, mental activity, satisfaction of requirements, interpersonal contacts. This is one of the most important aspects of psychic processes.

Methods for investigation of emotions

In the process of a talk with patients it is necessary both to ask them about their mood and to assess external signs of their emotional state: facial expression, general expression, rate and timbre of the voice, contents of thoughts, color of the skin, state of the cardiovascular and autonomic nervous systems (rate and rhythm of the pulse, blood pressure).

Effector-Volitional Sphere

Effector-volitional sphere is known to be a composite psychic function, which carries out purposeful human activity according to definite motives, caused by inner needs and demands of environment. It consists of two main components: a) effector-motor (simple and composite movements, acts and deeds) and b) volitional (ability to conscious and purposeful human regulation of acts and deeds).

Biological (instinctive, lower) needs are based on instinctive mechanism, i.e. need for food (food instinct), self-preservation (instinct of self-preservation) and reproduction (sexual instinct). During formation, of personality, being influenced by bringing up and education, they acquire socially acceptable and conscious forms of satisfaction.

Social (higher) needs are those which appear in the process of educating personality and manifest as necessity of self-preservation, gaining a certain position in society, professional training, moral and ideological purposes, respect from neighbours and other ethic, aesthetic and intellectual demands. Satisfaction of biological and social needs occurs as a result of composite effectory-volitional and psychic activity of a man. These satisfaction and dissatisfaction are accompanied by corresponding emotions.

Methods of researching inclinations, needs and effectory-volitional sphere.

The following points matter for judging the state of inclinations and effectory-volitional sphere:

- evaluation of a patient's outlook, mimicry, pose, conduct, tempo of speech, reaction to questions during conversation;
- evaluation of subjective and objective anamnestic data of a patient's life and his disease;
- analysis of complaints and objective psychological and somatic-neurological symptoms of disease;
- data of experimentary-psychological, laboratory and other investigations.

Consciousness

Consciousness is the highest level of the reality reflection and the interaction between the person and the surroundings, it is characteristic of the mental activity of the person under certain historical conditions. His mode of life varied under the conditions of any social and economic stage is of great importance for his development. Consciousness is an integrative sphere of mental activity, the highest form of the objective reality reflection, the product of the continuous historical development with the beginning of consciousness a person managed to single himself out of the nature, to cognize and seize it.

Psychological essence of consciousness is the opportunity of a person to single him out of the surroundings, to determine his attitude to it, to organize his purposeful activity. All the types of human activity including requirements satisfaction are carried out under consciousness control.

Consciousness constituents

Ego consciousness (self-consciousness) is the ability to realize correctly the parts of the body and their correlation's, the body and the personality as wholeness (with all its feelings) and to single oneself out of the surroundings (mental function of personality reflection, autopsychic orientation). Therefore, consciousness structure can include such constituents as.

Consciousness of the object surroundings is the ability of the correct and adequate reflection and realization of the object surroundings and its associations, its attitude to the knowledge subject and also right orientation in place and time (mental function of the surrounding reality reflection that is allopsychic orientation).

Consciousness properties

Clarity is the presence of clear and logical perception of the surroundings and the proper orientation in it (consciousness of the surroundings, time, the place, etc.).

The presence of self: consciousness with memory keeping about the past and the present, arbitrary attention and thinking, adequate emotions and will, the ability to be aware of one's own actions and to control them.

Capacity is a definite number of associations (or feelings) which arise under the influence of different stimuli and are kept in consciousness now that is the consciousness inclusion of the surrounding situation and one's own feelings.

Content is the contents of associations which arise under the influence of different stimuli and are kept in consciousness for certain time (the content of thoughts, feelings, etc.).

Dreams are the result of incomplete inhibition of the cerebral cortex whose separate sections remain uninhibited. The quick change of dreams is caused by proper chaotic character of excitement and inhibition.

K. Jaspers formulated the signs of consciousness disturbances: estrangement from the surroundings disorientation, amnesia during the period of disturbed consciousness. Estrangement from the surroundings should be understood as the disturbance of analysis and synthesis of the events that happen. Disorientation is revealed in the incomprehension of where a patient is at the present moment, who surrounds him, he cannot say the date, his name, surname, patronymic, age, profession.

Consciousness and self-consciousness examination methods

Interviewing a patient directly or indirectly the questions which allow to find out how well he orients place, time and the surrounding people are asked. In particular the patient is asked about the time, day of the week, the date, the month and the year. He is also asked where he is, who he is speaking to, who is standing nearby.

The state of consciousness is determined according to the patient's ability to name his demographic data (sex, age, the date, the month and the place of birth, surname, name and patronymic), speak about his biography, characterize his professional, personality, nature and other peculiarities and traits.

Control questions:

1-What does medical psychology study?

2- Specify the methods used in medical psychology.

3- Specify the groups of health.

4- Give a definition of sensations, perceptions, and representations.

5- List the types of memory.

6- Describe the types of thinking.

Tests:

1. The method of observation includes:
 - A. Active interference of psychologist in the observed events
 - B. Tracking of changes which take place
 - C. Cooperating with inspected people
 - D. Relatively complete events control
 - E. Nothing suits

2. “Proof test” is used for research of:
 - A. Sensation and perception
 - B. Memory
 - C. Psychological properties
 - D. Thoughts
 - E. Attention

3. What psychic sphere does include the feeling of anxiety, tension, irritability?
 - A. Sensations and perceptions
 - B. Emotions
 - C. Attention
 - D. Thinking
 - E. Consciousness

Case studies tasks:

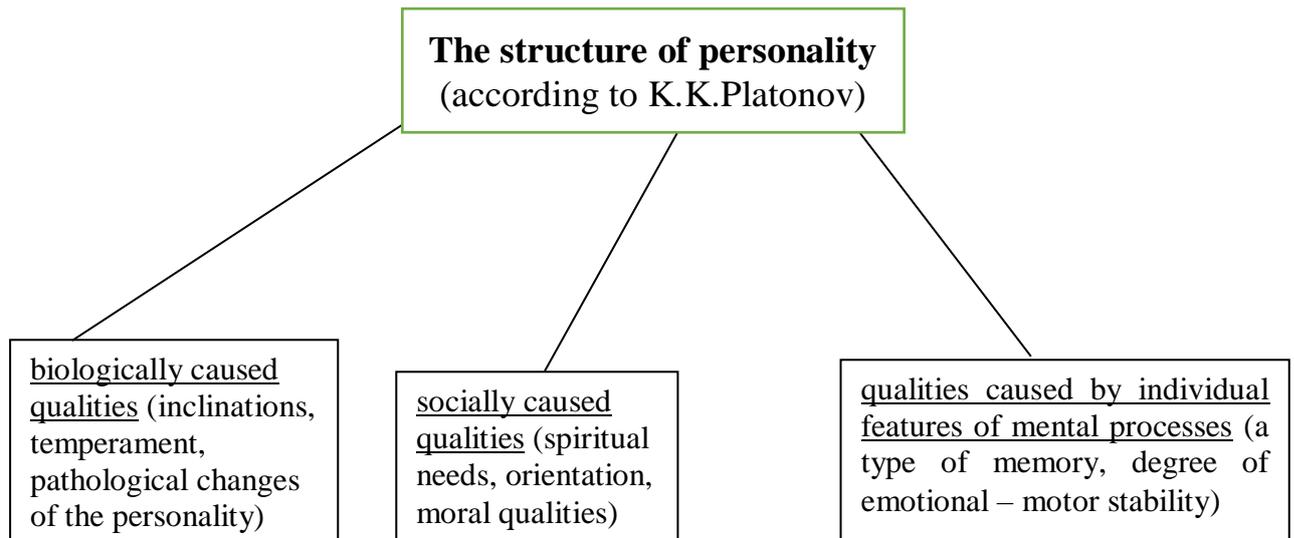
1. Patient T. got ill at the age of 48 years. There was a growing loss of memory, the patient loses or couldn't find different things. Had experienced difficulties to count money. Gradually increasing helplessness could not independently bathe and dress. Lost the ability to feed her independently: did not know what to do with a spoon. When trying to write something – she was drawing random scribbles. What psychodiagnostic methods should be used in this case first of all?

2. Demonstrating a thematic patient in the class with students, an assistant of the Department of Internal Diseases tries to establish contact with the patient, emphasizes respect for him. What section of psychology does include this aspect of the activity of a teacher of a medical university?

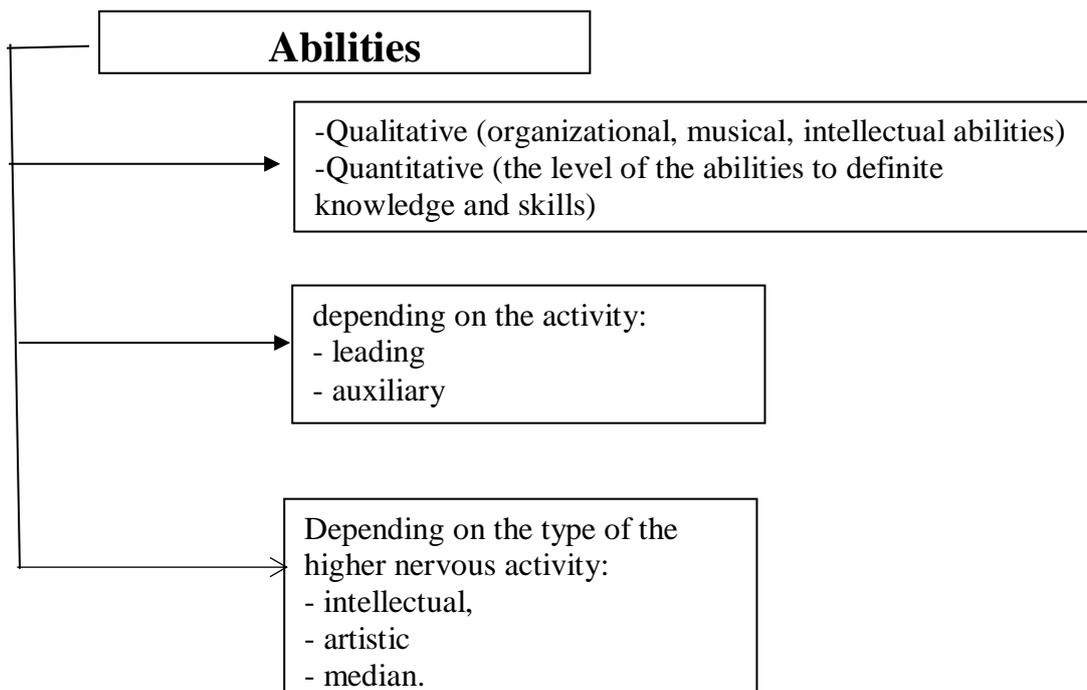
3. When examining a military university entrant, a suspicion arose that his intellect was insufficient. What methods can help in assessing his intellectual level?

Class №2. PSYCHOLOGY OF INDIVIDUAL DIFFERENCES. PSYCHOLOGY OF MEDICAL STAFF.

Personality is the most complex mental formation, in which are closely bound set of biological and social qualities. Changes of even one of these factors is essentially reflected in its mutual relation with other factors and on the personality as a whole. The variety of the approaches to study of the personality proceeds from the different concepts, they differ in conformity with various sciences which studies personality.



The sphere of individual-psychological feature of the personality includes abilities, temperament and character of the personality.



The temper is congenital individual characteristics of the personality, which determine the dynamics of mental activity and can be revealed in various activities irrespective of its content, purpose, motives. They remain constant in the older age.

Tempers were first described by Galen and Hypocrates. They divided all tempers into four types: choleric, sanguine person, phlegmatic, melancholic, which are characterized by the following:

a) *Sanguine person* – extravert, vivid, active, frequently tries to change the impressions, quickly reacts to the events, easily survives the failures. Sanguine person is a very productive person but only when the work is interesting to him.

b) *Phlegmatic* – introvert, slow, quiet, with stable desires and mood, does not express his feelings externally, persistent, well-regulated in the work. His slowness is compensated by the accuracy.

c) *Choleric* – extravert, quick, impetuous, is patiently devoted to the work, but he is unbalanced, can show stormy emotional fits, sharp changes in the mood. When they are involved in some work, they waste their strength and are quickly exhausted.

d) *Melancholic* – introvert, vulnerable, difficulty goes through even insignificant events, his sensitivity is increased, he is emotionally vulnerable.

The temper determines the individual style of activity that is individual scheme of means of action, which is characteristic for a definite person and individually reasonable. **The character** is a totality of individual psychological properties, which is revealed in typical for a definite personality means of action; they are revealed in typical circumstances and are determined by the attitude of the personality to these circumstances.

There are four systems of character traits, the traits manifest in:

a) attitude to the groups of people and separate people (kindness, sensitivity, exactingness, arrogance, etc.);

b) attitude to the work (diligence, laziness, conscientiousness, responsibility, etc);

c) attitude to things (neatness, untidiness, careful or careless treatment);

d) attitude to himself (pride, ambition, vanity, self-esteem, arrogance, modesty, etc.).

Individual features of the character are the degree of deepness of its properties, activity and strength of the character, stability of beliefs, plasticity. The character is formed on the basis of the types of higher nervous activity (temper) under the influence of education, upbringing, especially in the family.

Together with normal (socially adapted) there are accentuated and abnormal personalities. Accentuated personalities are not pathological, but marginal variants of the norm, hidden of excessive emphasizing of some traits of the character, which creates increased sensitivity to definite psychic influences at relative stability to the other, which is frequently observed in extreme emotional situations.

There are two classifications of character accentuation (by K. Leongard (1968) and A.E. Lichko)

Accentuated types of personality	Accentuated types of personality
---	---

by K. Leongard	by A.E. Litchko
Labile	Labile cycloid
Emotive	Labile
Demonstrative	hysteriod
Pedantic	psychoastenic
affective-exalted	epileptoid
Introvert	schizoid
Anxious	sensitive
Neurasthenic	Asteno-neurotic
Extravert	conformal
Timid	unstable
-	Hypertymic
-	cycloid

Psychopathies are marked character disturbances, which manifest by total pathology of the character causing social maladjustment (main sign of psychopathy).

Psychopathic development is determined by long-acting psychogenic factors.

Psychopathization of personality is deformation of the character due to some disease (drug or alcohol abuse, for example).

Individual psychological characteristics of the personality play a considerable role in development of various diseases, determine their course, development (prognosis) and success of therapeutic procedures.

Internal image of disorder means reflection of patient's disorder in his mind. Notion "internal image of disorder" (IID) was introduced to clinical medicine by Soviet therapist A.R. Luriya (1944), and at present time it is widely used in medical psychology.

IID is what the patient feels and experiences, his general feel, introspection, his idea of own disease, its causes, and everything the patient connects with his visit to doctor, huge inner world of the patient that consists of very difficult composition of perception and sensation, emotions, affects, conflicts, psychical worries and traumas.

IID has the following spheres: sensitive, emotional, volitional, and rational-informative:

- sensitive sphere of disorder internal image is specified by unpleasant (painful) senses caused by it.

- emotional sphere is shown with emotional feelings: fear, anxiety, hope.

- volitional sphere includes own efforts of the patient to overcome the disease: to seek for a medical attention, to have necessary examination and to get adequate treatment

- knowledge about disease, its assessment are rational-informative sphere of the internal image of disorder.

The attitude of the patients to their disease may be as follows.

1. Normal (harmonic), i.e. corresponding to the patient's state or the information given to him about the disease.
2. Scornful, when the patient underestimates the severity of his disease, is not treated and does not take any care of him, as well as demonstrates ungrounded optimism with respect to the prognosis of the disease.
3. Denying, the patient "does not pay attention to the disease", does not take medical advice, fights back any thoughts on his disease and reasoning about it; it also includes dissimulation.
4. Nosophobic, when the patient is disproportionately afraid of the disease, undergoes repeated examinations, changes his doctors; to a greater or less degree he understands that his fears are exaggerated but cannot fight them.
5. Hypochondriac, when the patient guesses or is sure that he suffers from a severe disease, or when he overestimates the severity of some less serious disease.
6. Nosophilic, connected with some calming and pleasant sensations during the disease; it proceeds from the fact that the patient should not perform his duties, the children can play and dream, the adults can read or be engaged in some of their hobbies; the family is attentive to the patient and takes more care of him.
7. Utilitarian, this is the highest manifestation of the nosophilic response.

It can have a triple motivation:

- a. receiving of sympathy, attention and a better examination;
- b. finding a way out of some unpleasant situation, as, for instance, imprisonment, military service, hated work, obligation to pay alimony;
- c. receiving of material benefits: pension, vacation, free time which can be also used with some economic benefit.

From this point of view, we distinguish the following types of reactions:

Aggravation is exaggeration of signs of the disease and subjective complaints;

Simulation is a pretense with whose help a person tries to create an impression that there is a disease and its signs;

Dissimulation means concealing of the disease and its signs. It often occurs in psychiatry in cases of psychoses.

Hospitalism (Latin "hospitalis" – hospitable; hospital – a patient-care institution) – scope of mental and somatic disorders, specified by continuous stay of a person at hospital with separation from relatives and home, it is characterized by social maladjustment, loss of interest to work and loss of work skills, decrease and deterioration of contacts with people around, tendency of disease chronicity.

Two main points can be identified in the IID structure:

- ✓ symptom of the disease as primary reaction of the organism to external and (or) internal change, disturbing homeostasis;
- ✓ protection from psychological symptoms as a secondary reaction, aimed at minimizing the negative experiences associated with the conflicts that threaten the integrity of the individual.

Premorbid especially premorbid state - (from the Latin PRAE -. Before and morbus - disease) body condition prior to development of the disease.

Classification of attitude to the disease, depending on the individual characteristics of the patient:

- ✓ Asteno-depressive, hypochondric, psychoastenic, hysteric and euphoric-anosognostic.
- ✓ Psychoastenic – morbid mental disorder characterized by extreme indecision, timidity, prone to obsessions.
- ✓ Euphoric-anosognostic – type of relationship, in which not only denied the disease, but also the mood of patients is unnecessarily raised.

Classification according to the activity levels of personality in its counteracting disease or its aggravation: passive-passive and active-positive (care in the disease), denying the existence of the disease, easily-expectant attitude, active resistance developing diseases.

Psychology of medical staff.

The success of the medical influence does not depend only upon the psychological peculiarities of the patient, but first of all is determined by the moral make-up of the doctor whose professional activity radically differs from that of any other specialist. The life makes great demands from the doctor as a specialist. First of all, they include a high professionalism, an aspiration for a constant enrichment of his own knowledge. The doctor must be a person of high moral standards whose authority is established by profound knowledge in his field, a personal charm, modesty, optimism, honesty, truthfulness, justice, selflessness and humanism.

A sincere and deep personal interest of the doctor in elimination of the patient's ailments gives rise to inventiveness in the forms of help. Confidence in the doctor often depends upon the first impression which develops in the patient during the first meeting with his doctor, the doctor's urgent facial expression, gesticulation, tone of his voice, expressions, as well as his appearance: if the patient sees that his doctor is untidy and sleepy for some reasons which are not caused by his work, he loses any belief considering that a person who is not able to take care of himself cannot care for others and be reliable in his work. The patients are rather inclined to excuse different deviations in the external manifestations and appearance of those medical workers whom they already know and in whom they already have confidence.

The medical worker gains his patients' confidence in the case if, as a personality, he is harmonious, quiet and positive, but not haughty, and if his manner of behavior is rapid, persistent and decisive, accompanied by humane sympathy and delicacy. Taking every serious decision the doctor must imagine the results of its effect on the patient's health and life. The necessity of having patience and control over himself makes particular demands of him. He must always consider various possible ways in the development of the disease. It is not easy for the doctor to combine in his work the necessary thoughtfulness and reasonableness with the required decisiveness and coolness, optimism with a critical attitude and modesty.

For the patient, an even-tempered personality of the doctor is a complex of harmonious external stimuli whose effect participates in the patient's recovery. The medical worker must bring up and form his personality, firstly, observing a direct response to his behavior (by the talk, assessment of the facial expression and gestures of the patient) and, secondly, in an indirect way, when his behavior is assessed by his colleagues. It requires some effort, a certain critical attitude towards him and a necessary measure of culture which must go without saying for the medical worker.

The patients' confidence in a younger medical worker with a less life experience and less skills becomes more perfect owing to his honesty, modesty and readiness to render help.

The patient loses his confidence and the medical worker loses his authority in the case when the patient gains the impression that the medical worker is a so-called "bad person". Such an impression may be created by the doctor's behavior if he speaks bad about his colleagues, treats his subordinates haughtily and toadies up to his bosses, displays vanity, lack of criticism, garrulity and malicious joy. The vanity is demonstrated, for instance, when the doctor does not apply to his more experienced colleague for consultation or exaggerates the severity of the disease for the patient in order to receive more recognition and admiration after the patient's recovery. More serious personal shortcomings of the medical worker may lead the patient to the suggestion that a doctor or a nurse with such streaks cannot be honest and reliable in serving their duties either.

There are psychological types of doctors:

1. **"Compassionate"** – tender-hearted, merciful, and easily responsive to the patient's sufferings.
2. **"Pragmatic"** – taking into consideration only the objective side of the disease in the work with his patients, does not pay any attention to the patients' sufferings.
3. **"Moralist"** – inclined to moral admonitions and indignant if the patient doubts or does not follow his doctor's recommendations.
4. **"Diligent"** – honest in his work, serious, assiduous, industrious and not inclined to joke with the patients.
5. **"Activist" ("public worker")** – prefers solving of various organizational problems and serving of social duties in the medical institution to work with his patients.
6. **"Dogmatic"** – strictly follows the mastered diagnostic and therapeutic directions and schemes, hardly apprehends any new things.
7. **"Technocrat"** – overestimates the significance of laboratory and apparatus data, does not attach any importance to the patients' sufferings and other subjective aspects of the disease.
8. **"Psychotherapist"** – tries to grasp the patient's sufferings, help him with a piece of advice or making him change his mind.
9. **"Sybarite"** – likes cosines and comfort, the patients irritate him with their complaints, he does not consider much their opinion and is inclined to the Bohemian mode of life.

10. **“Artist”** – inclined to demonstration of his knowledge and professional skills to the patients and their relatives, depending upon the conditions he plays parts of various doctors, namely: “hesitating”, “attentive”, “luminary”, etc.

11. **“Bored idler”** – a high self-estimation with a rather modest stock of knowledge, stereotyped diagnosis and administration of treatment, a scornful attitude towards his inquisitive colleagues.

12. **“Misanthrope”** – a doctor under compulsion: a lack of any calling for the doctor’s activity is displayed through the absence of such streaks as mercifulness, kindness, as well as through rudeness, a disgusted attitude towards the patients and malicious jokes.

Harmonic doctor’s personality should include all types except misanthrope, sybarite and bored idler.

The above scheme does not exhaust the whole variety of psychological types of doctors. It should be taken into account that formation of some or other type of the doctor is to a considerable extent dependent upon his upbringing.

Some prerequisites for establishing positive relationships between the doctor and the patient appear even before they come into direct contact. As a rule, the patient coming to the doctor knows about him more than the doctor about the patient. Reputation of the health service in general and the medical institution where the patient comes in particular is of importance too. Tension, dissatisfaction and anger of the patient who had to get to the doctor by an uncomfortable transport and, moreover, wait his turn for a long time at the reception room may often become inadequately apparent when meeting a nurse or a doctor who have not the slightest idea of the causes of this reaction and groundlessly explain it as a hostile attitude towards them.

It is also necessary to mention a possible action of “the transfer of the esthetic stereotype”. Beautiful people rather arouse sympathy and confidence, while plain ones stir up antipathy and uncertainty. In this way, the notion of beauty is associated with good features, and ugliness with evil. Despite the fact that this supposition is groundless, it subconsciously produces a rather strong effect: an outwardly attractive patient arouses more sympathy in the doctor even if in reality he requires less help than a patient whose appearance stirs up antipathy. And, on the contrary, the doctor acting esthetically positively arouses more confidence.

In making contact with the patient, the first impression created by the doctor on him is important. It is also influenced by the general atmosphere of the medical institution and behavior of all its workers: auxiliary personnel, administrative staff, the nurse on reception and registration of the patient. During the first contact with the doctor the patient must gain the impression that the doctor wants to help him. The doctor is obliged to control himself to such an extent that all common norms of the social contact were observed. It means that he must personally introduce himself to the patient, if the latter is not acquainted with him, and hold out his hand. Such behavior calms the patient, develops a feeling of safety in him and increases his consciousness of the personal dignity.

To give the patient an opportunity for a free and uninterrupted account of his sufferings, problems, complaints, troubles and fears is one of the prerequisites for developing a positive attitude. The doctor should not demonstrate that he is very busy, though it may be in reality. The doctor must “resound to the patient’s statements” with his own personality. If the patient is not given an opportunity to express his opinion to a necessary extent, he often complains that the doctor “has not listened to him at all” and he has not been examined in compliance with all the rules, though in reality all the necessary things were made. From the patient’s side, such cases reveal dissatisfaction that he is neglected as a personality. A talkative patient, an extroverted type achieves psychic ventilation easier; moreover, he even excites curiosity of the doctor in his account if it is entertaining. But actually the above psychic ventilation is more necessary for a concealed introverted type who conceals his problems, complaints and sometimes even signs of a disease as a result of tameness, shame or exaggerated modesty.

The work of the nurse who spends much more time in direct contact with the patient than the doctor is of great importance at in-patient medical institutions. The patient seeks for understanding and support from her. She must both professionally master the skills of caring for her patients and know the rules of the psychological approach to them, as a lack of knowledge of these rules often results in the fact that the patients express their “displeasure” and protest against the “formal” and “barrack” behavior of some nurses despite the fact that from the physical viewpoint the care for them was good. On the other hand, the development of relationships between the nurse and the patient is sometimes fraught with appearance of both a danger of not keeping a certain necessary distance and an aspiration to a flirt or helpless sympathy. The nurse must be able to manifest her understanding of the patient’s difficulties and problems, but should not seek to solve these problems.

Depending upon their character and attitude to the work, there are following individual types of nurses:

1. ***Practical type***, characterized by accuracy and strictness, sometimes forgetting the humane side of the patient. In a paradoxical form it may be sometimes manifested by the fact that she awakens a sleeping patient in order to give him some soporific.
2. ***Artistic type***, characterized by affected behavior; without any sense of proportion, such a nurse tries to impress the patient and be pompous.
3. ***Nervous type***; such a nurse is often tired, irritated and the patients do not feel calmness near her. She subconsciously tries to evade some duties; for example, out of apprehension to be infected.
4. ***Male type of the nurse***, with a strong constitution: she is resolute, energetic, self-confident and consistent. The patients characterize her behavior as “military”. In a favorable case, she becomes a good organizer and successfully trains young nurses. In an unfavorable case, such nurses may be primitive, aggressive and despotic.
5. ***Maternal type of the nurse***, a “sweet nurse”, often with a pyknic constitution.

6. *Nurses-specialists* who work, e.g., on an electrocardiograph or electroencephalograph; sometimes they have a feeling of superiority over the nurses working at departments; if they do not conceal this attitude, it may result in tense relations between them and other personnel.

Confidence is the main component in the patient's attitude to his doctor. Nevertheless, gaining of the confidence does not proceed only from the psychological aspect of the relations between the doctor and the patient, but it also has a broader social aspect. The doctor can gain the confidence of his patient and establish positive contact with him through satisfying his groundless demands. Development of such relations usually proceeds from the mutual satisfaction of the interests, where one side is presented by the doctor and the other one with the patients who may render him some service, but thereby affecting the effective and actually necessary examination of all the patients that in the first place must be performed from the viewpoint of their diseases, but not depending upon their social standing or abilities.

A psychological problem arises also in those cases when the doctor notices that his relations with the patient develop in an unfavorable direction. Then the doctor should behave with restraint and patience, resist any provocations, do not provoke himself and try to gradually gain his patient's confidence with calmness and understanding.

An important aspect of the doctor's activity consists in the **medical secrecy** which is defined as follows: the medical secret means any information which is not to be made public and includes data about the patient's disease and personal life obtained from him or revealed in the process of his examination and treatment, i.e. when the medical worker performs his professional duties. Not to be made public are also any data concerning the functional peculiarities of the patient's organism, corporal defects, bad habits, peculiarities of his mentality and, finally, his private property, circle of acquaintance, interests, hobbies, etc., rather than only the disease itself. The purpose of the medical secret is to prevent cases of causing the patient and other persons any possible moral, material and medical harm.

Medical mistakes: Medical practice knows cases when the doctor experiences diagnostic difficulties that sometimes result in medical mistakes. There are objective and subjective causes of these mistakes.

A medical mistake means a delusion of the doctor with absence of any negligence, carelessness or a thoughtless attitude to his duties. Medical mistakes are often caused by peculiarities in the doctor's personality and character, as well as by how he feels rather than by his insufficient professional training and qualification. This subjective factor accounts for 60-70 % of the total number of mistakes.

Sometimes mistakes are caused by the doctor's sluggishness, indecision, diffidence, and insufficient constructiveness of his thinking, inability to correctly and rapidly orientate him in a difficult situation, an insufficiently developed ability to correctly and logically compare and synthesize all the elements of the information obtained about the patient. Unwarranted caution taken by the doctor

may be extremely dangerous in situations when the patient's state requires prompt and decisive actions.

On the other hand, unwarranted self-confidence which is not supported by real evidence sometimes results in making "popular" florid diagnoses.

Such peculiarities in the doctor's character as optimism or pessimism may play a part in a wrong prognostic assessment of the severity of a disease. The doctor must always really assess the true situation and should not take the desired thing for the real one. Diagnostic mistakes may also result from the fact how the doctor feels, his asthenic states, the feeling of tiredness and sleepiness.

The paramount significance of personality peculiarities in the medical profession must be assessed during the professional selection for higher medical schools. If the applicant's individual personality peculiarities, interests and inclinations do not satisfy the demands of medical deontology he should not choose the profession of a doctor.

Concept of professional deformation. Every profession can favour a person's development and improve his personal qualities for the good of society. But profession also can cause deformations, change the character of person. In individual case deformations can only cause good-natured jokes (forgetfulness, absent-mindedness of professor), but in other case they can be an object of irony, sarcasm and satire (official, government bureaucracy).

The doctor also has a kind of power over patients, consequently, he is also can be endangered by deformation. As a rule, professional deformation develops gradually in the process of professional adaptation. Doctors, nurses and support personnel experience very emotionally all stages of medical assistance and pain of patients at the beginning of their professional activity, but gradually their emotional resistibility develops. Although the certain degree of emotional resistibility is required and reasonable, still, the medical persons should be able to realize a patient as a suffering person who deserves respect, the patient's personality should not be considered as an inconvenient addition to diseased organ to be examined. This is an integral part of not only human, but professional level of the doctor as well.

Professional deformations are the behaviour and expressions of medical persons, when under influence of habit the hard-heartedness to patients appears in such a rate that non-medical persons have an impression of callousness and cynicism.

The hospital doctor with professional deformation, who though diagnoses correctly with the help of machinery, makes unconsciously the impression of disinterest and indifference on the patient.

When projecting, the great attention is paid to purchase of diagnostic, medical and laboratory equipment and not to rebuilding of departments according to requirements of treatment-protective regime, that accent on creation of at least minimal intimate atmosphere for a patient.

Burnout syndrome.

Burnout syndrome: Syndrome of emotional burnout is the state of emotional, psychical, physical exhaustion that develops as a result of chronic unsettled stress at workplace. This syndrome is typical for altruistic professions, where the care of people dominates (social workers, doctors, nurses, teachers, etc.).

The first works concerning the burnout appeared in 70th in the USA. One of the founders of burnout idea is H. Fredenberger, American psychiatrist, who had an alternative service of medical assistance. In 1974 he described a phenomenon that he observed by himself and his colleagues (exhaustion, loss of motivations and responsibility) and named it with catchy metaphor – burnout. This is the syndrome of physical and emotional exhaustion, including the development of negative self-concept, negative attitude to work, loss of understanding and sympathy to clients or patients.

Main symptoms of emotional burnout are:

- Deterioration of relations with colleagues and relatives;
- Increasing negativism to patients (colleagues);
- Alcohol, nicotine, caffeine abuse;
- Loss of sense of humour, continuous feeling of misfortune and fault;
- Increased irritability – both at work and at home;
- Great desire to change the occupation;
- Absent-mindedness from time to time;
- Sleep disturbance;
- Sharp susceptibility to infection diseases;
- Increased fatigability, sense of fatigue during the working day.

In International classification of diseases of the 10th revision the burnout syndrome was described under the heading Z.73.0 as “Burnout – state of full exhaustion”. People with burnout syndrome usually have combination of psychopathologic, psychosomatic, somatic symptoms and signs of social dysfunction. Chronic fatigue, cognitive dysfunction (disturbances of memory and attention), sleep disturbances with difficulty of falling asleep and early awakening, personal changes are observed. Development of anxious, depressive disorder, dependence on psychoactive substances, suicide is possible. Generalized symptoms are headache, gastro-intestinal (diarrhoea, irritable stomach syndrome) and cardiovascular (tachycardia, arrhythmia, hypertension) disorders.

Persons with excessively high requirements to themselves are most of all exposed to the development of emotional burnout syndrome. They have an idea of a real specialist being an example of professional invulnerability and perfection. Persons of this category associate their work with assignment, mission, that is why the border between their job and private life is destroyed. Another three types of people, endangered to emotional burnout, are as well marked here.

1. **“Pedantic”**. The type main characteristics: honesty raised to absolute; excessive, morbid carefulness, desire for order in everything (even with harm to himself). These people are excessively attached to the past; their main symptoms of over fatigue are apathy, sleepiness.

2. **“Demonstrative”**. These people try to take priority over everything, try to be always in public. Therewith they usually have a high level of exhaustion when

performing ordinary, routine work. Over fatigue of people of the second type is expressed by increased irritability, anger. There is pressure increase, problems with falling asleep due to these factors. In this case it is recommended to drink a glass of warm milk and have a calm ant bath or shower in the evening.

3. **“Emotive”**. They are endlessly, unnaturally sensitive and impressionable. Their sympathy, tendency to take others` pain as own borders on pathology, self-destruction, accompanied by evident lack of strength to resist any unfavourable circumstance. People of the third type suffer from insomnia under stresses, increased anxiety is possible.

“Emotional burnout” syndrome includes 3 stages; each of them consists of 4 symptoms:

1st stage – “stress”. Its symptoms: self-dissatisfaction, "hopeless situation", experience of psychological-traumatic situations, anxiety and depression.

2nd stage – “resistance”. Its symptoms: inadequate, selective emotional reaction, emotional-moral disorientation, economy of emotions, reduction of professional duties.

3rd stage – “exhaustion”. Its symptoms: emotional deficiency, emotional remoteness, personal remoteness, psychosomatic and psycho-vegetative disorders.

Prevention and treatment of “burnout”

1. Determination of short-term and long-term aims. The first one not only provides feedback, indicating that the leader is on right way, but also increases long-term motivation. Achieving of short-term aims is the success that improves self-education rate. By the end of another working year it is important to add aims that give pleasure.

2. Communication. When leaders analyse their feelings and senses and share them with others, the possibility of “burnout” is considerably decreased, or this process is less expressed. That is why it is recommended for leaders to share their feelings with colleagues and look for their social support. If you share your negative emotions with colleagues, they can help you find a reasonable solution of your problem.

3. Use of “time-outs”. “Time-outs” are very important for provision of mental and physical wellbeing; they are the rest means from work and other loads. Workers of any sphere have a leave, a rest during holidays and on weekends. In our, rather difficult time, when the life speed increases more and more, new Ukrainian leaders work practically without breaks all year long, being under stress all the time.

4. Mastering of art and skills of self-regulation. Mastering of such mental skills as relaxation, ideomotor acts, determination of aims and positive endophasia favour the decrease of stress level that causes “burnout”. For example, determination of positive aims helps to balance professional activity and private life. When determining real aims, it is necessary to find time both for work and private life, which provides precautions of “burnout”.

5. Keeping of positive point of view. Find persons that will provide social support and, consequently, will help to keep positive point of view as for your activities.

6. Control of emotions arising from the fulfilment of planned work. Most of leaders know how it is important to control feeling of anxiety and stress when following professional tasks. But the end of work does not always remove the strong psychological feelings, especially if the work was not fruitful. Emotions often double and are shown in quarrels with colleagues and staff or, on the contrary, in depression that causes burn-out.

7. Keeping in good sport condition. It is a close connection that exists between body and mind. Chronic stress influences human organism that is why it is very important to keep in good sport condition with the help of physical exercises and rational diet. Incorrect nourishment, increasing or decreasing of body weight have negative influence on self-concept and lead to development of “burnout” syndrome. When you experience a stress, try to keep yourself in good sport condition that will help you keep in stable mind condition too.

In order to avoid the syndrome of emotional burnout, try to plan, reasonably distribute all your loads, study to switch over one occupation to another; take conflicts at work ease; however strange it sounds – do not try to be the best in everything; remember: work is only a part of life.

Communication

Communication (personal contacts) is a complicated process of establishing relations between people resulting in mental contacts which include information exchange, mutual influence, mutual experience and mutual understanding.

Functions of personal contacts are as follows: information, regulation, affective. The following interrelated aspects can be distinguished in the process of communication: communicative (consists in information exchange), interactive (act exchange), perceptive (mutual understanding between partners).

Depending on the characteristics of the partners communication may be:

- interpersonal;
- individual-group;
- collective- individual;
- group.

The communicative aspect of personal contacts is associated with revealing specific features of information process between people as active subjects, that is with the account of the relations between the partners, their purposes, aims, intentions, which results in information transmission and enrichment of the knowledge, thoughts, ideas with which the communicants exchange. The means of the process of communication are different systems of signs, language, in particular, as well as non-verbal means: mimics, gestures, pantomimic, posture of the partners, paralinguistic systems (intonation, non-verbal elements of speech, e.g. pauses), the system of organization of the space and time of communication, eye contacts. A very important feature of communicative process is intention of its participants to influence one another and to provide the ideal presentation in the partner with influencing the behavior of the partner (personalization). An important condition of this is not only the use of a uniform language but also similar understanding of the essence of the communicative situation.

The interactive aspect of personal contact consists in construction of a common interrelation. Important are motives and purposes of the communication from the both parties. There are several types of personal contacts, concord, competition, and conflict. It is necessary to remember that concord, competition and conflict are not only interaction of two personalities. They take place between the parts of the groups and between the groups as a whole.

Interaction is observed in the form of feelings which can both make the people closer or separate them. The intensity of feelings influences the efficacy of the action of the members of the group and is one of the signs of social psychological climate in the group.

The perceptive aspect of personal contacts includes formation of the image of the other person which is achieved by "reading" the mental features and peculiarities of behavior by the physical characteristics of the person.

The process of communication requires at least two persons. Main mechanisms of learning the other person is identification (similarity), reflection (understanding how the subject is perceived by other persons), stereotyping (classification of different forms of behavior).

Reflection is understanding of the perception by the partner with contacts and correction of the own behavior depending on the behavior of the other person.

Stereotyping is perception, classification and evaluation of the partner's personality basing of definite ideas.

Identification is the process of learning the quality on the basis of which the personality can be classified.

Identification and reflection are mainly performed subconsciously that is why the mistakes in evaluation of the people are frequent, they form stereotypical ideas.

A number of effects develop in the process of interpersonal perception and cognition: priority, novelty, and halo.

One of the tasks of social psychology is working out the means for correction and optimizing personal contacts, development of abilities and skills of communication. Among a number of forms of teaching the art of communication, a significant place is occupied by psychological training (mastering communication skills with the use of different programs).

Personal contacts are the form of human activity. The human being is surrounded not only by the world of objects, but also by people. He is connected with the both. These interrelations are established and develop through the work, training, that is through activity. Common activity is not possible without personal contacts and information exchange that is without communication. The main characteristics of communication as a sort of activity are that through it the person forms his relations with the other people. Communication includes numerous mental and material forms of vital activity and is a need of a human being. Only mentally ill persons renounce real connections with people but with this they satisfy their need in contacts with pathological fantasies.

Joining into small groups, establishing contacts during common activity, people exchange information. Communication is always determined by the system

of social relations, but in dynamics in the structure of communication, it is impossible to separate the personal and social. Therefore, social and individual are closely connected in the language, one of the most important means of communication. The mechanism of language and its individual manifestation is speech. Language is a system of signs which have a definite importance and are used for transmission and storage of information. Speech (verbal language) belongs to the linguistic signs which are built according to certain grammar rules.

Non-linguistic signs are symbols, e.g. copies, the systems of traffic signs.

Besides verbal, there are non-verbal means of communication (the language of gestures, mimics, etc.).

In his activity the human being uses different types of speech:

1. Oral monologue speech, i.e. the speech of one person (speaker, lecturer, narrator).
2. Dialogic speech takes place as a conversation among several persons.
3. Written speech uses written signs and has its own construction characteristics.
4. Inner speech exists only in our brain; they are the speeches to him.

The functions of communication are various. An elementary function of communication is establishing mutual understanding at a formal level. This may be a nod, a smile, and a gesture.

Main functions of communication are social ones as we live in the society and solve collective tasks. We have service functions (manager, subordinate, doctor, pupil), vital functions (customer, neighbor), family functions (husband, wife, relatives).

To fulfill a social function means to do what is necessary at the definite place under the given conditions according to certain laws on the one hand and customs on the other.

Social functions are subdivided into those of management and control; they are connected with the organization of group activity.

The forms of interpersonal communication depend on the feelings of the person to his/her relatives, colleagues, and strangers. They work out their strategy of communication on the basis of these feelings. When forming the attitude to the work, the staff, and the other persons and to the person him/herself, emotional satisfaction with the contact is very important.

The function of personality self-actualization consists of trying to act together with the rest achieving the purpose or increasing the influence on the rest.

From the moment of the birth, the adults encourage the child to establish contacts. The need in communication develops in stages. The child uses different means to attract the attention of the adults before starting speaking (cry, smile, and gestures).

When the child is brought up properly, he/she gradually changes his mode of communication from aspiration to attract the attention of the adults to co-operation. At 2 months the child starts to smile in response to special interjections and words addressed to him, at 5-6 months he starts to babble. The first words are pronounced

at approximately 1 year. With the development of speech, communication becomes more effective.

An important component of the appearance (in addition to anatomical features) is functional signs: mimics, gestures, pantomimic, gait, voice which are a complex of signals and inform about mental processes and states of the person. The majority of people concentrate the attention on the face of the partner, especially the eyes. Contraction of the facial muscles changes the look which allows foreseeing the actions of the partner. The character of recognition of the emotional states can be of diagnostic significance. The clothes also influence the character of contacts. An old saying “the clothes makes the person” is important now. Without doubt the clothes, hair-do and manners influence the first impression about the person. A negative attitude can be formed if the partner’s clothes are not neat, and vice versa the person dressed neatly, with taste produces good impression. The clothes influence not only the partner, but also the person himself. He feels certain if well dressed. Fashion is also important. It dictates how to dress to look modern and smart. The fashion changes quickly that is why the person has to have his own style of clothes. The difference in clothes demonstrates generation gaps. The style of the clothes can underline the individual character of the person, to hide shortcomings and emphasize the advantages.

To establish normal interrelations between people, especially at work or at home, the culture of contact is important. It consists in the presence of tolerance, benevolence, respect, tact, and politeness. The moral qualities of the person, the level of his culture are evaluated according to his actions.

In different situations the culture of interpersonal contacts is based on definite rules which have been worked out for thousand years. These rules determine the forms of contacts, regulated by the society and are termed etiquette. It contains both technical aspects of contacts that are the rules about the outer side of the behavior and the principles, violation of which causes punishment and blame. Numerous rules of the etiquette have become the elements of culture of contacts at hospitals.

The outer side of service contacts regulates service etiquette. Thus, a component of medical ethics is observing the rules of decency, good form and behavior.

The person who knows the culture of communication exhibits it everywhere: in the family, at work, on holiday, in public places. The ability to convey the thoughts and feelings to other people, the ability not only to speak but also to listen, to show understanding and good-will sympathy and attention compose the culture of everyday communication.

A true culture of interpersonal relations is determined by ethical norms. A great role is played by self-estimation of the personality, attention concentration, and the ability to take the position of the partner.

One of important characteristics of the personality is self-estimation that is the ability to evaluate him and the attitude to the others. Self-estimation allows analyzing the actions. It depends on education and cultural level. If a person has no

desire to self-estimation, he cannot understand the rest and form interrelations; show such qualities as tact, and delicacy.

Communication begins with perception of one another. Important is attention concentration, which allows perception with the account of mental features. Communication will be effective if the first impression will cause the feeling of attraction. If it fails, the communication will be difficult. In any case communication must be established and maintained with the consideration of individual features of the personality of the communicants.

Interrelations can become richer if the people acquire the skills of communication and observe the rules and principles of cultured communication. Showing respect to a personal dignity and individuality of the personality allows improving the interrelations. "Treat the people as you would like to be treated" is the main rule of morals which should be the credo of any doctor.

Control questions:

1- Give the definition of character, temper and abilities.

2-Give the definition of psychopathy

3-List what can be his attitude to his illness.

4- What does the syndrome of burnout means? What are the stages of burnout syndrome?

5- Give a definition of reflection, stereotypization and identification.

Tests:

1. During the communication with the teacher student tries to correct his behavior and speech with the aim to make the most favorable impression. Identify learning mechanism used by a student in communication.

- A. Stereotyping
- B. Reflection
- C. Identification
- D. Perception
- E. Discussion

2. The surgeon on the planning meeting reports in detail about the status of the patient and about the progress of the planned operation. What kind of speech he uses.

- A. Dialog
- B. Monolog
- C. Written
- D. Internal
- E. None of these

3. A doctor with 40 years of experience clearly follows the diagnostic and therapeutic patterns over many years, is conservative and similar in his assignments, is not interested in modern medical and pharmacological publications, and does not accept anything new. Determine the type of the doctor.

- A. Dogmatist
- B. Hard-worker
- C. Moralist
- D. Technocrat
- E. Bored loafer

Case studies tasks:

1. Dr. A. works as a family physician for the third year. While studying at the university he has always been proactive, seek knowledge, he has been demanding of himself. He dreamed after graduation to work in a large hospital. He loves his work, willing to help patients, versed in complicated cases. However, in recent years he becomes so apathy. He believes that his work makes little sense for the people in the countryside "with standard diagnoses" that can cure "any bad doctor". Frustrated in their specialty. Periodically, I began to use psychoactive substances.

How would you describe the state of the doctor?

2. According to the words of his wife, patient N. (32 years old) suffered from a significant cough for 3 months, with hard-to-separate sputum, subfertility, bad appetite, having lost 5 kg of weight. Objectively - pale skin covers with the earth shade. The patient denies having any complaints and refuses to undergo the examination, "because he has a lot of work and do not have free time". What is the patient's attitude towards his illness?

Class №3. PSYCHOLOGY OF DIAGNOSTIC AND TREATMENT PROCESS. PSYCHOSOMATIC DISORDERS.

The role of the general group reaction of the medical team in relation to the patients is significant. There are patients who are sympathized by everyone, they are easy to cooperate with, and with others it is more difficult to work, people have negative feelings towards them, relationship with them are strained, and it can also cause a conflict. Psychological incompatibility can arise between a nurse and a patient, a patient and a doctor, relatives of a patient and a doctor, which greatly hinders effective treatment. If it is impossible to get the relationship back on track, it may be necessary to change the nurse or the doctor.

A good psychological atmosphere in medical institutions is determined by good friendly relationships between all those involved in the treatment process. This has a beneficial effect on patients, contributes to the effectiveness of therapeutic activities. Harmful influence is exerted by disputes with patients that nurses sometimes allow, showing their superiority over the patient.

The environment in which the patient is in the medical institution, the individual psychological features of the patients themselves, the attitude towards them is decisive in the treatment. Taking into account the psychological features of communication as a whole is an important condition for optimizing the joint activity of people and their relationships in the medical process.

When organizing the work of various medical institutions, it is necessary to take into account the basic principles of medical deontology and medical ethics.

Medical ethics is a set of principles of regulation and norms of behavior of a doctor and other medical workers, determined by the specificity of their activities (taking care of other people's health, treatment, etc.) and the social status.

Organizing the work of different medical institutions, one should proceed from the basic statements of the medical deontology and ethics.

The medical deontology and ethics is the whole complex of principles of regulation and standards of behavior for the doctor and other medical workers conditioned by the specific character of their activity (care for other people's health, treatment, etc.) and position in the society.

Deontology (the science about the due) is the teaching of behavior principles of the medical personnel contributing to creation of the necessary psychoprophylactic and psychotherapeutic situation in the diagnostic and medical process excluding negative consequences (it is a part of the medical ethics). The medical deontology and ethics also envisage a high level of training of the nurses, their accuracy and honesty in carrying out the doctor's administrations with regard for the age, individual peculiarities, disease and morbid state of the patients, tactfulness and a psychotherapeutic approach of the nurses and practical nurses in attending to the patients and work with their relatives.

The very atmosphere of the medical institution should dispose the patients to a frank and heart-to-heart talk, arouse their faith in recovery; as early as in the registry the patients should understand that everything at the polyclinic is directed to help them and alleviate their sufferings. It is necessary to calm the patient and

give him the feeling of confidence. One should exclude any conditions of strictness and ostentatious business-like efficiency. Visual aids at the polyclinic (stands, posters) must not arouse any feelings of fear and alertness in the patients or remind them of their diseases. The polyclinic should be comfortable and clean, the rooms should be located proceeding from the patients' comfort.

It is also very important to establish the protective regimen at the in-patient departments. Much depends upon the patients' contact with their doctor. It is necessary to start a conversation with the patient talking to him but not looking through results of his analyses; the doctor should thoroughly think over every word addressed to his patient and avoid using slangy words. The round of wards at the departments should be made every day and better at the same time; it is not recommended to ask and elucidate any intimate details in other patients' presence during the rounds, as these details are connected with the patient's life and disease.

The doctor should display great tact and delicacy in the case when he has to change the treatment administered by another doctor. It is prohibited to tell the patient that he was treated incorrectly as it may shake his faith in medicine on the whole.

Lack of satisfying the requirements of deontology and medical ethics results in development of iatrogenies.

Iatropathogeny, contracted to iatrogeny (iatros = doctor, gennaō = to do, to produce), is such a method of examination, treatment or carrying out prophylactic measures that results in causing harm to the patient's health by the doctor. In the broader sense of the word, it means the harm to the patient done by a medical worker. In this connection, the term "sorrorigeny" is used; it means the harm caused by a nurse (sorrow = nurse), like other fields use the term "didactogeny", or "pedagogeny", i.e. causing of harm to a pupil by his teacher in the process of training.

Somatic iatrogenic is distinguished, where the harm may be done by using drugs (e.g. allergic responses after administration of antibiotics), mechanical manipulations (surgical operations), irradiation (X-ray examination and radiotherapy), etc. Somatic iatrogenic which is through no fault of medical workers may result from an unusual and unexpected pathological responsiveness of the patient, e.g. to the drug which causes no complications in other cases. Sometimes they are due to an insufficient skill of the doctor, peculiarities in his personality, temperament and character, as well as his mental state, e.g. inability to focus his attention in cases of tiredness and haste. The cause of a harmful effect of some unsuccessfully chosen drug consists, first of all, in the person who administered it rather than in the drug itself.

Psychic iatrogenic is a type of psychogenic. The latter means the psychogenic mechanism in the development of a disease, i.e. development of the disease caused by psychic effects and impressions. Psychic iatrogenic includes a harmful psychic effect produced by the doctor on his patient through words and all means of contacts among people which have their effect on the whole organism of the patient rather than on his mentality only.

Below are mentioned possible sources of iatrogenic.

An incorrect provision of medical education and popularization of data of the medical science may become a collective source of psychic iatrogenic. In the process of sanitary-instructive work, it is prohibited to describe the signs of a disease without their purposeful selection and give a full objective description of the treatment. It is necessary to focus attention only on those facts and circumstances that can help persons without any medical education get a real idea of the disease and the necessary information how to prevent it. If the listeners have no medical education, the medical worker should not discuss the differential diagnosis even if they ask questions concerning their personal signs and complaints, but the whole picture of the disease and its treatment is unknown. Such explanations may be given during individual sanitary-instructive work with sick and healthy persons.

In the process of preventive medical examinations at factories, examinations of the men called up for military service, donors, sportsmen, expectant mothers (these measures are directed at promoting good health for the population) doctors may often reveal some accidental and insignificant abnormalities, e.g. unimportant deviations on an electrocardiogram, minute gynecological or neurological signs, etc. If the examinee gets to know about these deviations, their meaning should be immediately explained to him, otherwise he may think that they are very serious and it is for this reason that he was not informed about them. However it is better to do preventive examinations in such a way that the examination does not get any information about these insignificant deviations.

Mentality is affected by a “medical labyrinth”. The patient seeks for medical advice but is sent from one doctor to another, and everywhere he is said that he “should be treated by another doctor”, with different degrees of politeness he is not rendered any aid. The feelings of dissatisfaction, tension and anger begin to grow in the patient, he is afraid that for this reason his disease will become neglected and difficult for treatment.

The following types of iatrogenic are distinguished:

✓ **etiological** iatrogenic, e.g. iatrogenic due to overestimation of heredity; the doctor’s phrase “It is hereditary” causes hopelessness in the patient, the latter fears that the same bad fate will overtake the other members of his family;

✓ **organolocalistic** iatrogenic develops in the case where the doctor explains undiagnosed neurosis, i.e. a functional psychogenic disease, as an organic local process in the brain, e.g. thrombosis of the cerebral vessels;

✓ **diagnostic** iatrogenic, when an ungrounded diagnosis which later undergoes unsuccessful changes becomes a source of a psychic trauma for the patient.

Some words produce, so to say, a “toxic” effect on the patient; first of all, these are “infarction, paralysis, tumor, cancer, schizophrenia”. Therefore it is better to avoid these expressions. Sometimes iatrogenies are caused by unclear statements made by the doctor.

Even seemingly harmless statements made in the patient’s presence at an X-ray room result in his unexpected traumatism, particularly if they are pronounced with some significance or surprise.

✓ **Therapeutic** iatrogenic develops in the process of treatment. Its example can be provided by the use of some drug about which the patient knows that it did not help him in the past. Here a negative placebo effect is produced. Therefore prior to administration of any treatment it is recommended to check the case history how effective was the treatment previously used. As a rule, it is often forgotten because of a lack of time. Therapeutic iatrogenic is facilitated by a so-called therapeutic nihilism, i.e. a pessimistic viewpoint of the doctor on the supposed results of the treatment.

✓ The process of treatment may be characterized by **pharmaceutogeny**, i.e. causing of some harm to the patient by a lame statement of the pharmacist. Patients often demand from the pharmacist to explain the features and effects of the drug administered by the doctor. It is dangerous to use such statements as “It is too potent for you” or “It is no good at all, but I have got something better”.

✓ **Prognostic** iatrogenic proceeds from an unsuccessfully formulated prognosis of the disease. From this viewpoint, such cynical and openly traumatizing statements as, e.g. “You have only a few hours to live”, deserve censure. However both straightforward and peremptory optimistic statements are of a questionable value even in the case when the doctor believes that using them he will suggestively produce a positive effect on the patient. Such statements as “in a week you will be sound as a bell, upon my word!” may become false and will shake the patient’s confidence in his doctor in future.

Besides the above situations and circumstances, sources of iatrogenic may be also found in the medical worker’s (first of all, the doctor’s) personality; e.g. in his unwarrantedly peremptory statements, excessive self-conceit: an omniscient doctor. Such a personality easily suggests the patient his opinions and viewpoints. Personalities of the peremptory type easily substitute absolute confidence for a good possibility in their statements. But the opinion once formed does not enable them also to watch other potential features in the process of the development of the disease; the above features may become predominant, e.g. during the transition of the disease from the syndrome of bronchitis initially diagnosed as a common disease to a malignant process.

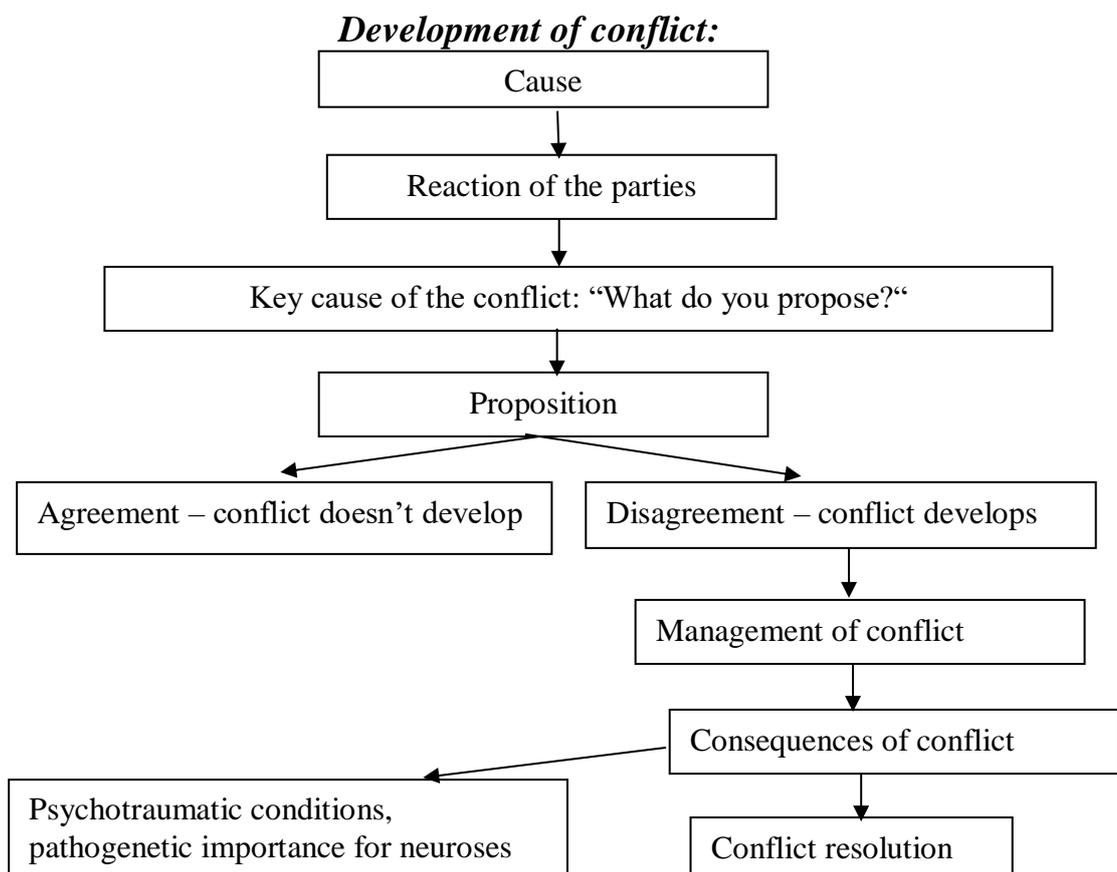
The diffident and doubting doctor, as a type of personality, is at the opposite pole. The patient often explains himself the way of the doctor’s behavior conformably to his disease, e.g. the doctor’s hesitations are regarded as proof of the severity or even incurability of his state. The doctor increases this impression by the fact that he “thinks aloud”, tells the patient about all possibilities of the differential diagnosis, does not complete a long line of auxiliary methods of examination and leaves the patient without any treatment for this time or gives him the initiative with respect to the kind of treatment, e.g. with such words as “If only I knew what to do with you!” The doctor should always be an artist in the correct understanding of the meaning of this word; he should be able to conceal from the patient a possible difficulty and, in the majority of cases, some temporary uncertainty about his diagnostic and therapeutic approach. The doctor’s subjective uncertainty should not affect his objective behavior.

The patient's personality may be another source of iatrogenic. A timorous, frightened, diffident, emotionally vulnerable and mentally inflexible patient is recognized by his tense facial expression, an increased sweating of his palms when shaking hands, often also by some fine motor tremor. He is inclined to timorously interpret our wordy or other manifestations, frequently even those ones that are not of any significance for us. We may be additionally surprised how such a patient understands our silence or a tired gesture of a hand that are regarded by him more important than words. The nurse may observe how such a patient restlessly walks at the waiting-room before his turn comes, how he lively participates in talks of other patients about diseases or quietly and with strained attention listens to them. Other patients would try to get insignificant details from the nurse before going to the doctor. It is necessary to tell the nurse that she should inform the doctor about such patients.

Sometimes the role of the patient's personality in the "iatrogenic impairment" can be so pronounced and decisive that the question is not of iatrogenic proper, but pseudoiatrogeny which is through no fault of the doctor. Pseudoiatrogeny develops in the cases when the patient cites such statements of the doctor which he has never made or isolates only separate parts from the doctor's explanation.

Conflicts in the medical environment.

Conflict is collision of opposite aims, interests, thoughts or views or the subjects of their interaction. The following stages of conflict can be distinguished: incubation, latent, open conflict, obvious conflict behavior. Varieties of conflict are intrapersonal, interpersonal, inter-group, inter-organization, inter-state, and international.



Classification of conflicts

- inner-personal conflict – confrontation between nearly equal in strength, but opposite in direction interests, needs, attractions of one person;
- interpersonal conflict – when two or more members of one group pursue incompatible aims and realize opposite values, or simultaneously try to reach the same aim, which can be reached by only one party.

Causes of interpersonal conflict

- reaction to obstacles when achieving basic aims of labour activity;
- reaction to obstacles when achieving personal aims that are not connected with labour activity
- reaction to behaviour that does not correspond to the norms of relations and behaviour of people in joint labour activity, which do not meet their requirements;
- peculiarities of team members

As any social-psychological phenomenon, the conflict can be considered as a progressing process. Most of psychologists find in conflict dynamics the following fragments

1. arising of pre-conflict situation
2. realizing of pre-conflict situation (impulse for conflict)
3. conflict behaviour (interaction)
4. settlement of conflict

Sometimes the conflict has more or less expressed positive influence on effectiveness of joint activity of the team where it took place, as well as on quality of individual work. Through open confrontation the conflict releases the team from sharpening factors, decreases possibility of delay and decay. Besides, it favours the development of understanding between the participants of joint activity.

Destructive functions of conflict appear in the following:

- conflict has negative influence on mood of the participants. For sometimes it can cause psychical isolation, the conclusion is that the conflict has negative influence on health – determines the development of neurotic reactions.

- in many cases conflict worsens relations between the participants. Arising hostility to another party, exacerbation and sometimes hatred break the mutual conflict relations and contacts, as to their quality and quantity. Sometimes as a result of conflict the relations of its participants not only worsen, but as well lead to break up. Research displays that in 56% of conflict situations the relations within conflict, in comparison with relations before it, worsened. Often (35% of conflict situations) the worsening of relations is kept after the conflict end.

- conflicts often have negative influence on personal development. They can favour the formation of disbelief of one of the parties in justice, persuasion that the leader is always right, the formation of the opinion that this team can not experience any innovation, etc.

Typical reasons for conflicts

1. Conflict circumstances of social interaction that lead to confrontation of their interests, opinions, aims create pre-conflict situation. Surely the confrontation of material and intellectual values of people is within their life activity. People,

who work in group (team), especially in conditions of isolation, solve numerous tasks together, cooperate with each other. In the process of regular interaction the interests of group members change from time to time. This confrontation of interests that weakly depends on their will creates objective base for possible conflict situations.

2. Management mistakes. Wrong decisions, for example, as for task fulfilment, labour and rest organisation, as well as wrong actions of leader and people are often the cause of conflicts.

People treat conflicts as negative phenomenon of everyday life. A conflict in team is more often considered as a symptom of problems and all strength of interested parties is taken to settle it as fast as possible, sometimes without preliminary serious analysis of arising opposites. But the conflict itself arises due to objective difference of talents and aims of those people, who interact, different people who are not similar to each other.

Methods of regulation of interpersonal conflicts (under K. Thomas).

Competition – business competition, desire for satisfaction of own interests to the prejudice of each other;

Adaptation - opposed to rivalry, sacrifice of own interests for somebody's sake;

Compromise – account of interests of both parties;

Escape – lack of desire for cooperation and achieving of own interests and aims;

Cooperation – search for alternative solution that completely satisfies interests of the both parties;

Prevention of conflict situations

Conflicts are not so bad themselves as the lack of control over them. Many conflicts can be prevented at the stage of their origin due to constant and deep analysis of relations system of the team, prediction of production changes influence, careful consideration by the interested parties of their words and actions, and in this way influence and management of interpersonal conflicts may be performed at the stages of their origin and development, with the purpose of prevention of conflict and settlement of opposition with one of non-conflict methods. Prevention of conflicts is by far less important than the ability to settle them. Moreover, it takes less efforts and time, as well as prevents even those minimal consequences that any conflict settled constructively has.

There are two main directions of conflict precautions, followed by leaders of any category. First of all it is observance of objective conditions that prevent arising and active development of pre-conflict situations. It is impossible to exclude pre-conflict situations at any team or group at all. It is not only possible, but necessary to create conditions by all means aimed at minimization of their quantity, as well as to try to settle them.

In whole, the subject preconditions of conflict precautions are in ability of every person to defend personal interests, avoid negative emotions influence on the partner of interaction and aggressive destructive counteraction to it. In turn, it is possible due to ability to control own psychical condition, estimate situation of

interaction, understand interests and desires of partner, find method for settlement of the problem that is adequate to the situation.

One of conditions of conflict precautions is ability of the leader and any person to estimate and control personal psychical condition, decrease own anxiety and aggression, to remove negative mood using appropriate autogenous training, physical training, when organising good rest, supplying pleasant social-psychological atmosphere at work, as well as the ability to do the complex of psychotechnic exercises for removal of fatigue and finding of internal stability.

Prevention of conflict situation at initial stages and, first of all, at the stage of origin, is most prospective. Herewith attention should be paid to external signs that are increasingly often point to the pre-conflict situation. They may include stressed coldness of communication, ambiguous expressions with underlying message, excessive impulsiveness and neglect.

Ways of settlement of interpersonal conflict situations are: evasion, evening-out, compulsion, compromise, solving of problem.

The pre-condition of conflict settlement is ability to interact. At the process of communication the given information can be lost or misrepresented, sometimes at an essential rate. Besides, the partner can watch the discussed problem from another point of view. These two reasons (not the real contradictions) can be the source of conflict. The set on understanding of the partner is always preferable.

Tolerance to non-conformity as well can prevent the development and aggravation of conflicts. If you have found that the partner is not right, it is not necessary to inform him about it. It is enough for you that your problem knowledge is more thoroughly in comparison with his, and you know this. It happens that for good it is necessary to tell to the partner he is not right, but in this case it is always necessary to do that in the presence of witnesses, insist on his public agreement of wrongness and confession. It is necessary to be firm as for the discussed problem, following the task requirements, as well as to be kind towards the partner on conversation. If you do not agree with idea, supposition, partner's decision, do not hurry to deny it at once. Think at first. First agree, and then say: "But maybe it is better to do..." or "And there is one more understanding..." With such an objection the partner is better to agree, because herewith he "does not lose his face".

Organisation of treatment process requires from all the participants (patients, relatives, doctors, middle and junior medics) the skills to communicate, prevent conflict situations that can cause a conflict, as well as to settle the conflict that happened.

One of conditions for prevention of conflict at hospital is a strict following of rules of deontology and subordination. E.g., at initial period of young doctors activity, when they master practical skills of medical work, the relations between them and chief personnel (head of department, head doctor) are similar to relations between teacher and pupils. When educational stage ends, the competition begins and, if it gains an unhealthy character, the conflict arises.

Psychosomatic disorders.

Psychosomatics (Greek: *psyche* - soul and *soma* - body) is a section of medical psychology that deals with the study of mental factors in the development of functional and organic somatic disorders.

The rapid spread and development of psychosomatic medicine was in the early XX century. At that time, millions of cases of so-called “functional” patients, “difficult patients”, whose somatic complaints had not been corroborated by objective research, were registered, and treatment with orthodox medications was ineffective. First of all, correction of affective states, affected interpersonal relations of patients, i.e. psychotherapy, psychological counseling, was necessary.

Among the changes in somatic state of health due to emotional impact, it is necessary to distinguish non-pathological psychosomatic reactions, psychosomatic diseases, the influence of the emotional state on the occurrence and course of somatic diseases, somatoform mental disorders.

In the International Classification of Diseases of the 10th edition, the term “psychosomatic” is not used for any diseases, so as not to give the impression that psychosomatic interrelations may not be relevant in other disorders.

The psychosomatic approach as a principle of therapeutic activity presupposes a holistic perception of a sick person, with all his personal characteristics, cultural norms and values, biological hereditary-constitutional features, the influence of the environment and interpersonal relations. In the late XX - early XXI centuries, the biopsychosocial concept of the disease is gaining increasing recognition in medicine, which is based on the principles of multifactoriality in understanding the causes of the onset and course of the disease. Thus, the psychosomatic approach for today is almost universally acceptable.

Psychosomatic diseases arise from stress caused by long-term and insurmountable psycho traumas, an internal conflict between the same in intensity but differently directed motives of the individual. It is assumed that some types of motivational conflicts are specific to certain forms of psychosomatic illnesses. Therefore, hypertension is associated with a conflict between high social control of behavior and the unrealized need of the individual in power. An unrealized need causes aggressiveness, which a person can not show through social attitudes. In this case, in contrast to neuroses, which are also based on intrapsychic conflict, psychosomatic diseases experience a double repression - not only an unacceptable motive, but also neurotic anxiety and all neurotic behavior.

There is a close system of somatopsychic and psychosomatic interrelations, which must be recognized and accounted for in the treatment of the patient. When considering the interrelations between the somatic and mental state, it is expedient to distinguish between the following types:

1. Psychological factors as a cause of somatic disease (as such psychosomatic diseases).
2. Mental disorders, manifested by somatic symptoms (somatoform disorders).
3. Mental consequences of a physical disease (including a psychological reaction to the fact of a physical disease).
4. Mental disorder and somatic disease, coincidentally coinciding in time.

5. Somatic complications of mental disorders.

Psychological factors play a role in the formation of various diseases, for example, migraine, endocrine disorders, malignant neoplasms, etc. Among them, it is necessary to distinguish real psychosomatoses, the emergence of which is determined by mental factors and the prevention of which should be directed primarily at eliminating and correcting emotional overstrain (psychotherapy and psychopharmacology), and other diseases, the dynamics of which is influenced by mental and behavioral factors, changing the non-specific resistance of the organism, but at the same time they are not the primary cause of their occurrence. For example, it is known that the influence of psychoemotional stress can reduce immune reactivity, which will increase the likelihood of diseases, including infectious.

Representatives of psychoanalysis approach the explanation of psychosomatic pathology, emphasizing the prevalence of emotional experience exclusion in patients with psychosomatic symptoms (a protective psychological mechanism that manifests itself in the subconscious exclusion of unacceptable thoughts or emotions from the mind), which then manifest themselves as somatic symptoms. However, in this case, organic pathology is ignored, and in practice one cannot neglect the fact that in the course of time, organic lesions develop in the patients, and only after the onset of the disease, it is not enough only for psychotherapy, but appropriate treatment with modern pharmacological means and sometimes surgical care is necessary.

Scientific explanation of psychosomatic interrelations is possible on the basis of the stimulus-response theory by I.P. Pavlov. Russian neurophysiologist P.K. Anokhin developed the biological theory of functional systems - the concept of the organization of processes in a holistic organism that interacts with the environment. The theory is based on the idea of a function as an achievement by the body of an adaptive result in interactions with the environment. In the light of this theory, any emotional reaction is considered as an integral functional system that unites the cerebral cortex, subcortical formations and the corresponding somatic components.

From the standpoint of neurophysiology, the central (thalamus, limbic system, activation and reward structures) and peripheral structures (catecholamines, hormones of the adrenal gland cortex, autonomic nervous system) are involved in emotional processes. Excessive stimuli over the force and duration alter the functional state of the central nervous system and the peripheral nervous system. Thus, functional disturbances and so-called "areas of the least resistance" can be occurred. There is a system of constant feedbacks, which determines the possibility of therapeutic, medical effect of the emotional factor.

The insoluble conflict of motives (as well as unresolved stress) ultimately leads to a reaction of capitulation, a refusal of search, which creates the most common precondition for the development of psychosomatic diseases in the form of masked depression. The defeat of these or other organs and systems is due to genetic factors or features of ontogenetic development.

The importance of understanding by a doctor the essence of protective

psychological mechanisms requires the reduction of their brief characteristics in this section. Protective mechanisms are subdivided into primitive, or immature (splitting, projection, idealization, identification), and more mature ones (sublimation, rationalization, etc.). However, neither the number of protection options (there are several dozens of them described), nor their classification, nor their names, are universally recognized.

One group combines protection options that reduce the level of anxiety, but do not change the nature of motives. These include suppression or ousting of unacceptable motives or feelings from the mind, denial of the source or the feeling of anxiety itself; projection or transfer of their desires or feelings to others; identification - imitation of another person with attribution to himself of his qualities; inhibition - blocking in behavior and consciousness all manifestations associated with anxiety.

In another group, the forms of protection are combined, in which mechanisms that reduce the severity of anxiety and, at the same time, change the direction of motives are triggered: self-aggression - the reversal of hostility toward oneself; reversion - polar treatment, or change of incentives and feelings to the opposite; regression - reduction, or a return to early, ateliotic forms of reaction; sublimation - the transformation of unacceptable ways of satisfying the needs for other forms - for example, in the form of creativity in art or science.

We shall consider 9 basic forms of psychological protection, regardless of their classification.

1. Suppression. By suppression it is meant the interference or exclusion from the consciousness of unpleasant or unacceptable events and phenomena, that is, the removal from the consciousness of those moments, information that cause anxiety. When neuroses, for example, the main events are often replaced, which served as its cause. In this case, there are such interesting psychological experiments. The examined people were given photographs that showed the specific situations of conflict, close to their experiences. It was expected that the subjects will tell their contents, but they “forgot” these pictures and set them aside. When, however, the reproduction of the relevant photographs was made in a hypnosis situation, the protection was removed and the photographs produced an effect adequate to their content. A similar mechanism of protection is in the background of a widespread phenomenon, when other people's shortcomings in behavior are noticed, and their own ones are being squeezed out. In other experiments, the examined people were offered tests for achieving definite success and when performing a task; they remembered only those tasks that they performed well, and “forgot” (i.e. suppressed) unfulfilled tasks.

2. Substitution is a reorientation from one anxiety-provoking and unpleasant experience of the object (topic) to another. This version of psychological protection can be represented by the following simple examples. After a conflict with a superior at work or a quarrel with a loved one, an individual rages anger on family members (often there is a rationalization, which will be discussed below). During a stirring conversation a person crumples a piece of paper. After hearing her friend's phrase “your boyfriend always leads you”, a woman throws the cat off

her laps.

3. Rationalization. In this case, we are talking about an attempt to rationally justify the desires and actions caused by such a cause, the recognition of which would lead to the loss of self-esteem. There can be many examples. If a stingy man is asked to borrow money, he will always explain why he cannot lend (from educational considerations, etc.); if any person is unpleasant, it is always easy to find in him a lot of shortcomings, although hostility can be connected not with them at all; a patient can explain his interest in the medical literature by the need to broaden his horizons.

4. Projection. Defense in the form of projection is the unconscious transfer of one's own unacceptable feelings and drives to another person, attributing one's socially disapproved motives, desires, motives, actions and qualities to people around. A striking example of this is the behavior of a young prosperous person who takes his mother to a nursing home and is indignant that the staff is indifferent or bad toward her.

The projection simplifies the behavior, eliminating the need for everyday life to evaluate its actions every time. We often transfer our behavior to other people by projecting our emotions on them. If the person is calm, self-confident, benevolent, then in his sight people around him share his benevolence, and conversely - a strained, frustrated person, unsatisfied with his desires, is hostile and projects this hostility to others.

5. Somatization. This form of defense is expressed by solving a difficult situation by fixing on the state of one's health (schoolchildren "fall ill" before tests - the simplest example). In these cases, the main value is the benefit from the disease, i.e. increasing attention and reducing demands from relatives. In more severe cases, this form of defense is of a chronic nature, as a rule, there is an exaggerated attention to one's health, an exaggeration of the severity of the disease up to the creation of own concepts of the disease, and a hypochondriac syndrome can be formed.

6. Reactive formation. In this case, it is about replacing the unacceptable tendencies by exactly the opposite. So, rejected love is often expressed in hatred of the former object of love, boys try to offend the girls they like, secret enviers often quite sincerely consider themselves to be devoted fans of the one to whom they envy.

7. Sublimation. With this form of psychological defense, unacceptable impulses are transformed into socially acceptable forms of instinctual needs that cannot be realized in an acceptable way and way of expression (for example, childless people get pets). For that matter, a hobby that some people have is a way of realizing the most improbable motives and drives. Egoistic and even "forbidden" goals can be sublimated by active activity in art, literature, religion, and science.

For instance, aggressive impulses can be sublimated in sports or political activity. But the actual psychological defense arise when the individual does not realize that his activity is determined by hidden impulses, which sometimes have a biological and egoistic basis.

8. Regression. In this case, we are talking about a return to primitive forms of response and behavior. Especially often this form of psychological defense is manifested in children. For example, when children are deprived of their parents, behavior that corresponds to the developmental delay is often observed: the child who started walking suddenly ceases to walk, or in the infant the enuresis that took place in infancy is resumed. It can also be mentioned the habit of sucking a finger in difficult situations (this feature sometimes manifests itself not only in children, but also in adults). Elements of psychological defense in the form of regression can also be observed in certain mental illnesses.

9. Denial. This form of defense is a protective mechanism by which unrealizable desires, motivations and intentions, as well as facts and actions are not recognized, but are rejected by unconsciously denying their existence, that is, in denial, the real phenomenon is considered non-existent. It should be emphasized, however, that negation does not include a conscious attempt to renounce or retreat, as in pretense, simulations, or lies.

In everyday life, most real situations often involve the use of several forms of psychological defense at the same time. This must be taken into account in the work of the doctor with both healthy and sick people.

The mechanisms of psychological defense described above are a part of psychological adaptation processes. **Adaptation** is a property of any living self-regulating system that determines its resistance to environmental changes. There is physiological, psychological, social adaptation of the individual allocated. Violation of adaptation to environmental conditions is called **maladaptation**. Unfavorable external influences (stress), which exceed the possibility of adaptation, are called distress.

In response to psycho-emotional stimuli, a variety of non-pathological psychosomatic reactions (visceral, sensory, etc.) arise. Psychosomatic reactions can occur not only in response to mental, emotionally significant influences, but also to direct effects of stimuli (for example, the view of a lemon). Representations can also affect the somatic state of a person. Psycho-emotional factors can cause such physiological disorders in different organs and systems of the body:

- a) in the cardiovascular system - increased heart rate, changes in blood pressure, vascular spasm;
- b) in the system of breathing - its delay, deceleration or acceleration;
- c) in the digestive tract - vomiting, diarrhea, constipation, increased salivation, dry mouth;
- d) in the sexual sphere - increased erection, weakness of the erection, swelling of the clitoris and lubrication (secretion of the genital organs), anorgasmia;
- e) in the muscles - involuntary reactions: muscle tension, trembling;
- f) in the vegetative system - sweating, hyperemia, etc.

Psychosomatic diseases are somatic diseases, in the emergence and course of which psychological factors play a determining role. The cause of psychosomatosis is affective (emotional) tension (conflicts, discontent, anger, fear, anxiety, etc.), provided that there are certain personal characteristics. These

diseases are often called “large” psychosomatic diseases, emphasizing the severity of the disease and the leading role of the psychogenic factor in their occurrence.

As a matter of fact, psychosomatic diseases are characterized by the following features:

Mental stress is decisive in provoking;

After the manifestation, the disease takes a chronic or recurrent course;

The first appearance at any age (but more often in late adolescence).

Historically, the psychosomatic image includes classic images of seven diseases, namely: essential hypertension; peptic ulcer; bronchial asthma; neurodermatitis; thyrotoxicosis; ulcerative colitis; rheumatoid arthritis.

Characteristics of psychosomatic disorders

Revealing psychological features which are responsible for development of psychosomatic diseases resulted in description of the features which are present in the patients with different diseases. These are reserve, anxiety, sensitivity. Below you can find descriptions of the patients with definite psychosomatic disorders.

Essential hypertension. Main properties of the personality, prone to development of essential hypertension, are intrapersonal conflict, interpersonal strain between aggressive impulses on the one hand and feeling of dependence on the other hand. Development of hypertension is due to the wish to manifest hostility at a simultaneous need of passive and adaptive behavior. This conflict can be characterized as a conflict between contradictory personal wishes (desire of frankness, honesty and sincerity in communication and politeness, avoidance of conflicts). At stress such person can restrain his irritation and inhibit the desire to answer the offender. Suppression of negative emotions in the person during stress which is accompanied by a natural increase in the blood pressure can aggravate the condition and promote stroke development.

At the beginning of hypertension disease the majority of patients can adequately evaluate their state, perceive the administrations adequately. Some suspicious patients think that increase in the blood pressure is a tragedy, catastrophe. Their mood is decreased, the attention is fixed on the sensations, the sphere of interests diminishes and is limited to the disease.

It is necessary to admit that there is no direct association between the level of the arterial pressure and probability of mental disorders development. When examining the mental state in hypertensive subjects with daily monitoring of the arterial pressure we determined the indices of the arterial pressure which can play a role in prognosis of mental disorders in this disease. These are high variability of the arterial pressure during the day and disturbances in the circadian rhythm of the pressure fluctuations: increase or absence of night reduction in the blood pressure level.

The patients with hypertension should be explained the causes of their state. They should know that the disorders of the nervous system are functional, temporary and with the proper treatment the function will be restored.

Coronary artery disease. It has long been considered that emotional stress can result in coronary artery disease. “Coronary personality” has been described in the literature. This idea is difficult to prove because only perspective studies can

distinguish psychic factors present before the heart disease and the consequences of the disease. In the studies performed in the 80th the attention was paid to several groups of possible risk factors which include chronic emotional disorders, social economic difficulties, fatigue, constant aggressors as well as behavioral pattern A. The most probable is pattern A which is characterized by hostility, excessive aspiration to competition, ambition, constant feeling of lack of time and concentration on limitations and prohibitions. When performing the studies devoted to primary and secondary prevention, main approach consisted in elimination of such risk factors as smoking, irregular diet, insufficient physical load.

Angina. Attacks of angina can frequently be induced by anger, anxiety, and excitation. The sensations survived during the attack can be horrified, sometimes the patient becomes too careful in spite of the doctor's efforts to make him get back to his ordinary lifestyle. Angina can be accompanied by atypical pain in the chest, edema due to anxiety and hyperventilation. In many cases there is discrepancy between the real capability of the patient to withstand the physical load determined objectively and their complaints on the pain in the chest and limitation of the activity.

A good effect is produced by conservative treatment together with the adequate exercise. Some patients benefit from behavior therapy administered according to an individual scheme.

Cardiophobia. One of psychovegetative syndromes which is frequently observed in medical practice is cardiophobia. Discomfort and unusual sensations in the left side of the chest, which first occur in the situation injuring the mental state, determine the increasing anxiety of the patients and fixation on the activity of the heart, which increases the belief in the presence of a serious heart disease and fear of death. At first increasing affective strain, anxiety and suspicion, fears as well as constitutional and developed peculiarities of the personality are the basis for development of acute cardiophobic attack. Vital unbearable fear experienced by the patients with cardiovascular disorders cannot be compared with the ordinary sensations in their intensity and character. Feeling of a close death is the only reality for the patient. The obvious fact that dozens of attacks did not cause infarction or cardiac failure does not mean anything. As it has long been known that it is dreadful to be dying not to die, the life of the patients which "died" several times is tragic. Especially important in this case is rational psychotherapy and suggestion. The life of the patient depends on their correct use and administration.

Apnea. This is caused by numerous respiratory and cardiac disorders and can increase due to mental factors. In some cases apnea is of purely psychological origin: a typical example is hyperventilation due to anxiety.

Asthma. This is thought to be caused by unsolved emotional conflicts associated with the relations of subordination, but the proofs for this are not satisfactory. In bronchial asthma contradiction between "desire of tenderness" and "fear of tenderness" are noted. This conflict is described as a conflict "possessive". Patients with bronchial asthma are frequently hysteric or hypochondriacal,

they cannot “release their anger to the air” and provoke attacks of suffocation. Besides asthmatics are hypersensitive, especially to odors.

Gastritis. In patients with gastritis and ulcer a specific character is formed in the childhood, these adult patients constantly need protection, support and guardianship. They respect force, independence and strive for them. As a result two opposite mutually exclusive needs (guardianship and independence) collude which causes unresolvable conflicts.

Ulcer. The patients with gastric and duodenal ulcer have specific features. They are often persons with explosive emotions; their thinking is categorical, frank. The other group of the patients is not prone to external manifestations of the emotions. They are frequently gloomy, distrustful people. Some authors associate ulcer with inappropriate for self-perception, need in protection.

Colitis. Ulcerative colitis was noted to begin after experiencing “loss of the object” and “catastrophe of experience”. Decreased self-estimation, excessive sensitivity to the failures and strong desire of protection and dependence are characteristic to these patients. The disease is often regarded the equivalent of grief.

Diabetes mellitus. Feeling of chronic dissatisfaction is characteristic for the personality of the patients with diabetes mellitus. But it is believed that in contrast to the patients with the other psychosomatic disorders there is no definite diabetic type of personality.

Neurodermitis. Eczema and psoriasis are considered to be neurodermitis of psychosomatic origin. The patients are passive, they experience difficulties with self-confirmation.

Diseases of the locomotor system. The patients with rheumatoid arthritis are characterized by “stiffed and exaggerated position”, they demonstrate high level of self-control. Characteristic is the tendency to self-sacrifice and exaggerated readiness to help the people. Their help has an aggressive character.

The approach to treatment of neurotic and somatoform disorders, when the complaints of the patients are associated with functional somatic diseases caused by mental disorders, is different. In this case the treatment is administered by a psychiatrist with the use of psychotherapy and psychopharmacotherapy.

Principles of the prevention of psychosomatic diseases

Therapeutic tactics in the treatment of psychosomatic diseases provide for the main role of specialists-somatologists and appropriate methods of therapy. However, psychotherapy plays an important role in the prevention of the onset of these diseases and at all stages of treatment and rehabilitation. In the prevention of psychosomatic diseases, an important role is played by the timely identification of personal predisposition and conducting long-term personality-oriented psychotherapy with the help of a specialist-psychotherapist. Doctors of general practice and family medicine should master and teach patients the skills of mental self-regulation, autogenic training to mobilize or relax in stressful situations.

Another approach is applied to the treatment of neurotic and somatoform disorders, when somatic complaints of the patient are associated with functional

somatic disorders, the main cause of which is mental illness. In these cases, treatment is carried out by a psychiatrist using psychotherapy and psychopharmacotherapy.

Control questions:

1. Give a definition of deontology.

2. Define the concept of iatrogeny, describe types of iatrogeny.

3. What is conflict? List the types of conflicts by K. Thomas.

4. Give a definition of the concept of psychosomatics.

5. List the forms of psychological protection.

Tests:

1. A surgeon at the time of open cholecystectomy damaged the patient's bile ducts. Developed pathology refers to:

- A. Somatic iatrogeny
- B. Organo-localistic iatrogeny
- C. Diagnostic iatrogeny

- D. Etiological iatrogeny
- E. Mental iatrogeny

2. A patient of 27 years old complains of increased irritability, weakness, rapid fatigue, arising during excitement and tension, headaches “as if a nail is being hammered in the head”, sensations of “lump in the throat”, laryngospasms, vegetative lability. A young expert in the history taking did not focus on the patient's psychotraumatic experiences, made a diagnosis, prescribed pharmacotherapy. The effect of this method of treatment was not observed, the patient felt worse. Developed deterioration refers to:

- A. Mental iatrogeny
- B. Organo-localistic iatrogeny
- C. Diagnostic iatrogeny
- D. Etiological iatrogeny
- E. Somatic iatrogeny

3. In a 40-year-old patient with a chronic somatic disease, a psychological examination revealed low self-esteem, excessive sensitivity to his failures and a strong desire for dependence and care. For patients with which disease are these personality traits most characteristic?

- A. Ischemic heart disease
- B. Thyrotoxicosis
- C. Ulcerative colitis
- D. Bronchial asthma
- E. Rheumatoid arthritis

4. A 14-year-old boy is teased as a “tomato”, as his face turns red when he’s worried. In what system do psychosomatic reactions predominate?

- A. In the respiratory system
- B. In the digestive tract
- C. In the sexual sphere
- D. In the muscles
- E. In the vegetative system

5. In a patient of 48 years old with a chronic somatic disease, a psychological examination revealed a demonstration of a high level of self-control, a tendency to self-sacrifice and an exaggerated willingness to help others. At the same time, “aggressive coloring of aid” is noted. For patients with which disease are these personality traits most characteristic?

- A. Ischemic heart disease
- B. Thyrotoxicosis
- C. Ulcerative colitis
- D. Bronchial asthma
- E. Rheumatoid arthritis

Case studies tasks:

1. A student of a medical university saw a colleague of her aunt during a demonstration of patients in a psychiatric class, and told her relatives on the same day that her colleague was in a psychiatric hospital. The student violated:

2. In a man after the X-ray study, a depressive symptomatology developed. He believes that his life is over, since a malignant tumor was found on the X-ray. It turned out that for the diagnosis of a malignant tumor he took the expression of a radiologist, who showed a part of the large intestine to his students with the words: "Here is sigma". What mistake did the doctor make? What consequences can it lead to?

3. In the therapeutic department of the Central District Hospital, a conflict situation occurred. The employees divided into several groups, often quarreling among themselves, complaining on each other to the chief doctor, the head of the department, which leads to a deterioration in the treatment process. What are the most optimal ways to create a favorable psychological climate in the department?

Class №4. PSYCHOLOGICAL FEATURES OF PATIENTS WITH SOMATIC DISORDERS. PSYCHOLOGICAL ASPECTS OF DEVIANT BEHAVIOR.

Revealing psychological features which are responsible for development of psychosomatic diseases resulted in description of the features which are present in the patients with different diseases. These are reserve, anxiety, sensitivity. Below you can find descriptions of the patients with definite psychosomatic disorders.

Psychological features of patients with diseases of the internal organs

In significant onset of disease, in patients there is a feeling of confusion, the fear of death. With prolonged course of the disease, the mood decreases, irritability, excitability appear.

Gerontology

In some therapeutic departments, more than 60% of patients are over 60 years of age. Improvement of living conditions and medical care, without a doubt, increases life expectancy. But the somatic life conservancy is not always associated with the positive mental content of it. Old people cannot adapt to the rapid changes and changes in their lives, and many things for young people are difficult and complicated, they are less able to understand. Despite the fact that they live in a family with the young persons, they are still relatively isolated, because they do not always understand the new conditions of life and work. But even more difficult is their position in cases where they live in full solitude. In the old lonely people, there can be such a paradoxical phenomenon that their illness will become the last means for establishing contact with people: a doctor comes to the patient, he can enter a hospital where he is surrounded by other patients, feels an interest in himself and compassion.

The boundary between the state of health and a disease in older people is more noticeable than at a young age. In the case of malaise, which is often repeated in old age, the relation to it plays a decisive role: will this inconvenience be experienced intensively, cause fear and uncertainty, or the person who is on the border between a state of health and a disease will be able to ignore his unpleasant feelings, more to live up to the impressions of events taking place in the world, to contacts with people around him, than with his body and fear for it. Older people living alone, with a lack of other stimulus reactions, focus on their somatic processes, intensively experience their feelings due to organic and neurotic reasons, and do the only thing that they think makes sense: they seek medical attention and require help.

Psychological features of patients in surgical clinics

In this specialty, great perfection has reached the technique, both in the meaning of actual surgical interventions, and in the meaning of equipment. Concentrating the attention of surgeons on the operation technique and its technical support sometimes leads to an inadequate assessment of the psychological state of

patients. In some cases, it creates a cold, impersonal atmosphere in which the patient does not feel well. With high churn of patients and the haste due to the urgency of work, it is not always possible to develop a psychological relationship between the medical staff and the patient. And patients often consider the surgeon to be some kind of ideal of a doctor - he helps with a quick vigorous intervention, which they passively take. In the surgical environment itself, in the behavior of surgeons, there are certain magic features in popularizing the outstanding achievements of modern surgery - one can speak of one of the forms of magic of the present time. In surgery, the patient is more than in any other specialty given to the doctor, especially in the state of anesthesia and during surgery. Psychological shocks experienced by the patient in these circumstances often lead to the fact that the patient during a conversation with a doctor before surgery often reports about his concealed vital problems.

For patients, surgical interventions (such as amputation of the extremities, in women - breast amputation in breast cancer, intestinal permeability in intestinal cancer, resection of the stomach in recurrent peptic ulcer, etc) are significant psychic traumas. Personal emotional experiences and the attitude of the patient towards his own physical condition often is of much bigger importance for his further personal life and work than the magnitude of organic defeat.

Sometimes patients refuse surgeries. Often, the reasons for failure are the following:

- ✓ The patient was scared by other patients who had experienced such an intervention, and when they talk about the troubles they “have heroically gone through”, they want to be at the center of attention and cause surprise.

- ✓ Such a surgery caused severe consequences, deformation or even death to a friend or relative of the patient.

- ✓ The patient underestimates and even denies his illness either by frivolity or in order to avoid fears and anxieties.

- ✓ The patient responds with fear for everything in life. Often, it is a question of psychopathic and neurotic subjects.

- ✓ Unpleasant impressions of past operations, for example, fear for narcosis, in which many are worried by the fear of feeling “falling into the bottomless abyss”.

An important step is the preparation for the operation. The surgeon must show interest and affection, establish what the illness and operation mean for life and future of the patient, and listen carefully to the patient about his fears and desires. Some patients are afraid of the unconscious state caused by anesthesia and helplessness in it, they feel fear that they will not awaken or suffocate, reveal their secrets or “say nonsense”, they will look ridiculous. Sometimes such mood exacerbates other patients, telling about their experiences that they have experienced. Some patients unjustifiably say that “anesthesia did not work” for them, that they were operated “in full consciousness”. Sometimes, due to unawareness, they take local or lumbar anesthesia for general anesthesia.

At the initial stage of anesthesia, the patients are highly susceptible to the expressions of the staff, which they memorize immediately, but are sometimes

perceived by them illusory and are referred to distorted after awakening, so that psychiatric iatrogeny can develop, in which the staff will not be blamed. Therefore, it is necessary to minimize the verbal contact between the medical staff during this period and during the operation. When awakening, patients have a high sensitivity to sensory stimuli such as noise, harsh light, olfactory stimuli that can cause nausea and vomiting. This should be taken into account when preparing the room, in which the patient will be in the wake of anesthesia.

Operation is a source of stress for patients since it is associated with the expectation of its outcome, sometimes patients are injured by postponing and changing the duration of the operation. And although after the operation, patients in most cases are unaware of their consequences, they are experiencing a sense of relief that "it's already in the past" that they "have returned to life", "avoided deadly danger". This may have a beneficial effect on the operation of the surgical placebo, especially in patients with inoperable tumors. However, in most cases, the sense of relief in such patients is short-term and it changes with an increase in symptoms, which is the result of both the disease itself and postoperative weakening of the body. If the disease develops further on the worse side, the patients unduly attribute this operation: "It's all the fault of the operation", "I shouldn't have agreed to the operation".

The postoperative flow is complicated by the following circumstances: poor patient contact with staff; the inability of the patient to express his condition; adverse life and family situations that may complicate the outcome of the operation; bad adaptability of the patient, his emotional immaturity, weak or unbalanced type of temperament, neurotic personality traits.

Older people adapt to changes worse, they are more afraid of death. Their wounds are healing slowly; postoperative complications happen more often and last longer (25% of the elderly have complications after surgery). They also have a brain disorder with a blood circulation and metabolism lesion. They miss their visitors more who should be allowed to come to them. Since they are very used to their stuff, the nurse should agree with the relatives of the patient, which items must be brought to the patient, for example, glasses, hearing aids. Despite the strict requirements of the hygienic regime in the surgical department, these requirements can be met at will.

Plastic surgery: in this specialty, two areas of psychological problems might be distinguished, although they are different in importance, but for the doctor are equally labor-intensive and complex. On the objective side, more serious are the states where the surgeon corrects the results of severe injuries and burns and should work with the staff or the psychologist to prepare the patient to sudden mental trauma, for example, at first glance in the mirror after plastic surgery on the face. Despite the fact that the person after a plastic surgery looks aesthetically better than the condition that was after injury or burn, the patient compares his appearance with that which was before an injury or a burn, and is disappointed and shocked.

Traumatology: traumatologists should take into account that the attitude towards the injury and the provision of assistance varies depending on whether the

trauma prevents some of the interests and requirements of the traumatized person or whether it facilitates them. For example, as a rule, athletes with minor injuries do not go to a doctor. Persons injured in a situation that they would like to hide from others, such as those who have fought and are afraid of punishment, adults who are in conflict with the police, hide their injury and thus avoid registration. Motivation in the period of injury also affects the trophic processes, on wound healing.

A significant psychological task of medical staff is to bring the injured patient to active rehabilitation, because only in this case it is possible to expect a favorable result.

Psychological features of patients of obstetric and gynecological clinics.

In adolescent girls, the appearance of bleeding during the first menstruation sometimes causes fear and neurotic reactions, so they need to be psychologically prepared. But even if the girl is informed, she can endure menstruation painfully. The girl, who gradually becomes a woman, catches up and plays this role and looks for appropriate examples. Most often this example is her mother. If her mother lives in a conflict marriage, the daughter takes the woman's role in double or even with a fear and disgust. But even in healthy women during the period of menstruation there are pains in the sacrum and abdomen, pressure in the genital organs, mental irritability and depression. With a negative mental experience of menstruation, these symptoms may be also exacerbated by dysmenorrhea. When dysmenorrhea, it is not easy to determine the fate of hormonal and mental factors, and in each such case, all individual characteristics should be taken into account. Similar phenomena are noted in the premenstrual period, so many women have irritability, fatigue and headaches. Premenstrual complaints in 60% of cases can be facilitated by the use of placebo, which indicates a significant effect of mental factors in their occurrence. This is often a tense expectation of menstruation, due to the fear of becoming pregnant. Amenorrhea, that is, the complete lack of menstruation, can be triggered by suggestion and hypnosis. It also develops in depression and in fear of unwanted pregnancy. In this case, there is a positive feedback, a "vicious circle": fears lead to amenorrhea, and the latter further enhances fear. The influence of other psychic factors on the development of these disorders is also described: during earthquakes, aviation raids, concentration camps, death of relatives, and even simply when moving. Sometimes amenorrhea is taken as "tendentious", that is, a purposeful symptom; girls in a campus are shy, seek to avoid attention and conversation, and this psychogenically suppresses menstruation. Conversely, menstruation as a "tendency" symptom may appear prematurely, for example, before an operation that women fear, so that menstruation for some time "saves" the patient from troubles.

When gynecological examination of women, it is necessary to remember the sensation of shyness that they feel. In the gynecological clinic, women often receive surgical intervention, so it is necessary to follow the same recommendations as in surgical departments. Particular attention deserves obstetric departments. The doctor should know about the experiences of women preparing

to become a mother, especially for the first time, concern for the outcome of pregnancy, fear of generic pain, and fear for the health of the child. Imbalance, emotional instability, increased vulnerability, shyness require maternal kindness, cordiality, sincerity of the staff. The delivery room should not be as close as possible to the reception office and predelivery room. It is necessary to observe the women who gave birth very carefully, since they may develop various mental disorders in the postpartum period.

The implementation of psychoprophylaxis and psychotherapy in obstetrics is associated with the names of I.Z. Velvovsky and K.I. Platonov, who developed a system for preventing the development of pain through the psychoprophylaxis preparation of pregnant women to childbirth and physiological psycho-hygienic management of pregnant women.

An important period in a woman's life is a climacteric one, when hormonal changes occasionally cause blood flow to the head, tachycardia, and other symptoms. But do not relate all disorders that appear in the menopause, only to hormonal changes. For a number of women, menopause is a stimulus-reaction to bring life's results to reflection on whether they are satisfied with their lives and that they can expect from the future. Many women do not know that erotic and sexual life can continue without changes after menopause and be even more harmonious, especially for those women who have been afraid of becoming pregnant. Incorrect doctor's statement that the disorder in the menopause is exclusively hormonal sounds fatal and can lead to iatrogeny.

Psychological features of patients with infectious diseases.

The fact of detecting an infectious disease and the need for hospitalization causes in the patient a sense of shame, the fear that they can become a source of infection of their loved ones.

At the prodromal stage of an infectious disease, an assessment of the patient's condition depends on the traumatic situation. At the stage of the onset of the disease, there are the symptoms of general toxicity, sometimes violations of consciousness. At the stage of recovery, different asthenic manifestations prevail.

In patients with especially dangerous infections, the burden of the disease, high contagiousness, dubious prognosis often cause acute psychological reactions resembling the behavior of people in situations of massive natural disasters.

Psychological characteristics of patients infected with AIDS.

The reaction of people to the diagnosis of AIDS - this most terrible disease, "plague of 20 centuries" - is a manifestation of psychological stress with a decrease in mood, ideas of self-prosecution, suicidal thoughts and tendencies. Patients have an obsessive fear of death, an idea of the very process of dying; some are worried about the possibility of infecting relatives by household. In the future, there may be a symptom of decreased intelligence. In people of a risk group that includes those infected with the AIDS virus and most susceptible to infection, there is anxiety, irritability, reduced capacity for work. They are focused on their health, read a lot of literature about this disease, look for their symptoms. Many people break their

sexual relationships. However, some people show outright anti-social tendencies, striving for the transfer of the AIDS virus to other people.

Psychological features of patients with tuberculosis.

Detection of tuberculosis, the need for prolonged inpatient treatment is perceived by some patients as a tragedy, as a catastrophe. They develop anxiety and fear that contact with them will be avoided by close people and employees. However, most patients correctly perceive the fact of the disease and the need for treatment.

Psychological peculiarities of patients with tuberculosis are characterized by sensitivity, sentimentality, emotional lability, exhaustion. Patients are asthenic, on this background, there are situationally caused affective manifestations, hysterical reactions.

The doctor should take into account these features of patients and adequately treat emerging conflict situations with those surrounding and staff as a manifestation of the disease. In these cases, it is necessary to prescribe sedation, and not to give redirection to the patient.

In some patients, in the background of asthenia, there is an elevated mood with talkativeness, motor activity, which quickly fluctuates with anxious tension or indifference.

A number of psychological problems also cause tuberculosis. Of great importance is the cooperation of patients in the process of treatment and their responsibility. In undisturbed and irresponsible patients, the condition often deteriorates because they do not adhere to the prescribed regimen and method of treatment. This circumstance increases the requirements for the organization of the regime and the individual psychotherapeutic approach to patients.

The psychological features of the relationship “mother - child – doctor”.

Working with children, taking care about them sick and healthy, correct assessment of their behavior, reactions requires special knowledge.

The psychologically difficult issue in pediatrics is the requirement for a differentiated approach to children of different age groups. A good pediatrician perfectly possesses a whole range of verbal and mimic expressions, through which he aspires to contact with sick children. A pediatrician who has his own children is in a better position because he can take advantage of already proven experience. The child's age is not a reliable indicator, indicating at what level the staff should contact the patient. There are a certain percentage of mentally disadvantaged children, retarded children, who eventually catch up with this lag, and children with accelerated development, which often slow down later, and thus equate their development with other children.

A child's disease is always a difficult situation for the whole family. The reaction of the child to the disease largely depends on the behavior of parents and forms of education. A child of preschool age has a fear of the fact of hospitalization, separation from parents. If children in the family were spoiled,

“idols”, then in the hospital they are helpless. Behavior of parents in difficult conditions often has an adverse effect on children.

In cases of emergency hospitalization, children may have a pathological reaction of protest, when the child cries, shouts, does not let his mother go. Such reactions can last from several hours to several days.

Great psychological difficulties arise in parents when they learn about a difficult, incurable, chronic childhood illness. Initially, there are reactions of distrust and parents get a consultation about the child from different professionals, hoping that the diagnosis is put erroneously. The results of the survey are often discussed in the presence of the child acting on the child negatively.

In prolonged ill children, parents of whom created special conditions for them, there is a tendency to hysterical reactions, the features of mental infantilism are formed, which impede adaptation to the conditions of the social environment.

In children's institutions, doctors, nurses should be able to engage with children, play with them, as the child calms down in the game. In the process of games the doctor examines personality peculiarities of the child, his desires and needs. The game distracts from unpleasant experiences.

It is advisable to gather children with the same level of development in one ward. It should be remembered that children, even small ones, always listen to the conversations of doctors and students in the ward, and then express their fears to their parents.

Sometimes in adolescence there are cases of simulation and aggravation, in order to attract attention, or as a protest against some kind of life troubles.

The most difficult moments are experienced by parents and staff in the disease of the child with sarcoma and leukemia. Medical personnel perceive the death of children more difficult than death of adults.

Psychological features of the work of doctors-dentists.

In dentistry, pain takes the first place, which usually leads the patient to a doctor. Here there is a vicious circle: fear of pain leads to the fact that the patients do not treat small carious processes, and the processes causing pain, as a rule, require more extensive and painful interventions. When delivery of care, the dentist usually takes into account the fact that sensitivity to pain is different in different age categories; this is also contributed by the refraction of the pulp, which comes with age. But it is necessary to take into account that there are individual differences in sensitivity to pain caused either by birth or acquired reasons. Extremely sensitive patients who cannot relieve pain by conventional treatments need to be treated gradually, take them repeatedly, and use all available means to reduce the pain. If the doctor has to cause pain, then he is obliged to act quickly, without hesitation, since uncertainty slows down the manipulation, reduces the quality and thus causes harm to the patient. It is appropriate to show to the patient that the doctor understands and fully assesses his pain, but excessive sympathy should not be expressed to the patient when the assisting doctor causes this pain himself. The fear of the patient before treatment and fear of pain greatly complicate the work of the dentist. Therefore, in some cases it is necessary to work

jointly with a psychotherapist and a psychiatrist. Pain and fear can reduce both psychotherapy and some psychopharmacological means.

Children with anomalies of the teeth suffer from speech disorders and may differ from other exterior and facial expressions - they look "silly". They suffer from the mockery of others and react to them in a distinct way: they experience a sense of inferiority or aggressiveness; sometimes they take on the role of "clown in the class". In order to compensate the child for these difficulties in the children's team and at school, parents sometimes overuse and overestimate the abilities and talent of their child, which in the future can lead to disappointments.

The psychological factor is also related to the causes of caries and its complications. Caries of teeth are more common in countries where there is the highest consumption of sugar and sweets. The fundamental importance belongs to the mode of feeding children, and the latter depends primarily on the parents, on the extent to which they allow the children to eat sweets, especially in the evening before bed. Parents and grandparents might be unprincipled in this case, even if they know everything about the proper nutrition of the child. Here is the motivation: "Give the child what we could not afford", the desire to keep this sympathy for the children, and sometimes also try to suppress the reproach of conscience in the fact that little attention is paid to the children. In some children and adults, sweets become a compensator for calmness in the face of personal troubles, failures and lack of purpose and meaning in life.

The environment where dental care is provided must meet the requirements of deontology and psychoprophylaxis. The waiting room should have a pleasant, as little as possible hospitalized appearance, to be provided with magazines. Patients who are in the waiting room and feel fear and tension do not pay attention to posters on sanitary and educational topics. In the doctor's office, it is appropriate to limit as much as possible the specific dental elements, such as, for example, the white color, the "exhibition of tools" with which the patient relates a number of possible experiences. An unpleasant effect is a number of armchairs set close together - it resembles a conveyor.

Psychological features of blind people

In the childhood of blind children, their parents try to exercise excessive care, creating a genuine environment for them, protecting them from difficulties, and constraining their initiative. This leads to the development of such features as timidity, indecision, tearfulness, propensity to fantasy, leaving the children's team.

Starting going to school is often accompanied by neurotic reactions, alertness, vulnerability, helplessness.

In the blind people, overpriced ideas of inferiority are formed, they feel bad among the sighted, forced presence in such a team causes autistic tendencies.

For example, after an injury, it is mentally easier to cope with blindness that arose suddenly for young people up to 20-30 years old than middle-aged and elderly people. The latter are constantly hoping for some kind of change, for some new scientific discovery. Complicated mental problems arise in married couples, where the blindness of both spouses is genetically determined. They concern the

question: to have or not to have children, the expectation that children will also be blind and all subsequent consequences, for example, the difficult education of the children of the blind people, the help of healthy children to blind parents and the consequent dependence of parents from children.

Psychological peculiarities of cloth-eared and deaf people

Personal reactions to hearing loss are polymorphic. Hearing aids are important in human life. Developing deafness causes concerns about inferiority, irritability, abusiveness, difficulty in communication, distrust, caution, suspicion. Because of the difficulty of contacts with others, relationship ideas can be developed, the patients think that people around them condemn, laugh at them. Treatment of such patients in somatic departments causes great difficulty. The patient tries to listen to what the doctors say and “hears” something terrible about his illness. Cloth-eared people usually conceal their disadvantage from other patients and are ashamed to say in the ward that they did not understand something. The doctor should hold a special conversation to dispel their suspicions and fears.

Psychological features of patients with facial injuries

A human person determines the impression he makes on other people, and also helps to create an idea of him. Mimicry determines the emotional state of a person. An aesthetic criterion for one's body is inherent in every person, but it is especially relevant to a person. People with a distorted face notice interesting and sometimes mocking looks of others; so they become supersensible, suspicious, offended. They are often afraid to go out into the street, meet people who knew them before. Some people leave and start to live in places where they have never been before.

A proper psychotherapeutic approach can greatly alleviate the suffering of such a patient and help him create a new vital dominant.

Features of communication with mentally ill people

The attitude to patients with mental illnesses should be the same as to other patients: correct, polite, friendly and merciful. While a conversation with these patients, it is necessary to carefully listen to their complaints, to treat these complaints, however absurd they may seem, as to the manifestations of the disease. It is inappropriate to use rudeness, neglect, ridicule over the sick. The doctor needs to get rid of the existing social prejudices of the mentally ill. It must be remembered that some patients lack consciousness of the disease and have to undergo urgent hospitalization in a psychiatric hospital and treatment without their consent, and often contrary to their requirements. This requires the doctor and the staff of the psychiatric hospital a great deal of patience. With relatives of the patients it is necessary to carry out soothing softening conversations, to convince them that it is necessary to have inpatient or outpatient treatment. At a psychiatric hospital, vigilance must be observed; attention should be paid to ensure that the patients do not commit any actions that endanger the health and life of the patient

and others. In communicating with mentally ill people, it is important to persuade them, and not to lie to them.

Psychological features of care for dying patients

A human is the only one of all living beings who knows about the inevitability of death. However, the person cannot understand this himself.

As psychological studies have indicated, a person usually dies as he lived. All those strengths, feelings, thoughts that were characteristic for his life, are inherent in his death. Not always, people are afraid of death. Exhausted by unbearable pains, depleted by chronic ailment, the patient whom painkillers do not help waits for the death as a release.

Most doctors and sisters who face death every day are struggling to protect themselves from the effects of this unpleasant phenomenon.

However, the doctor has not only to help the patient, but also to understand his experiences. Helplessness, the dependence of the dying man on others, his isolation must be taken into account in the organization of care for them. The will of the dying persons must be treated with respect. Activities at the patient's bed are dictated by his needs and opportunities for their implementation. Care of relatives and the attention of friends are necessary for such a patient.

It is often being discussed the question whether it is needed to tell the patient about the approaching dissolution. The patient's words cannot be always believed that the doctor can say everything, that he can take any "sentence". It is necessary to maintain the hope of the patient to recover. In medicine, there are not rare cases when in the so-called hopeless patients the condition was improved.

At hospitals, special attention should be paid to the issue of placement of dying patients in the wards. Death of a neighbor in the ward can be a shock to other patients, so it is very important to timely isolate the dying one. Care for such a patient in a small ward is more intense and does not harm other patients.

Also, relatives of the dying patient need care, compassion, attention. Doctors sometimes listen to unfair accusations in their address and should treat this patiently, striving to help those who suffered from misfortune.

Nowadays, it has sometimes been heard from young doctors the assertion that helping a person die means to do a humane act, saving him from suffering. However, a doctor, endowed with the necessary psychological qualities for his profession (humanism, compassion, honesty, dedication) will never agree with the justification of euthanasia. Until the last minute of the patient's life, the doctor must strive to extend this life, strive to ease his suffering by pharmacological and psychotherapeutic means. Neither the request of the patient nor the wishes of his relatives, even documented (statements, videos, etc.) cannot serve as justification for euthanasia.

Psychological aspects of deviant behavior.

Dependence is characterized by pathological inclination for an action or substance, as well as by sense of psychical and physical discomfort with impossibility to realize such an inclination. An individual becomes dependent not

under the external pressure or compulsion, but due to willingness to obey. Dependent person is able to easily find any object or subject of dependence in surroundings.

One of risk factors of dependence formation is psychical infantilism, which is psychological immaturity of the person with lack of “ego” consciousness. Behavior of such persons is characterized by childishness; the infantilism is shown as a protest, shocking behavior, seeking for peace and satisfaction out of reality, immaturity, uncontrollability of reactions. Infantilism is formed under the upbringing influence, hereditary factors, and organic diseases of brain.

Dependent persons in premorbidity are characterized by suggestibility and imitation, but cannot estimate their behavior critically, are credulous, complaisant to group influence, authoritarian control, they are easy to be convinced that this habit does no harm, "light drugs do not cause dependence", etc. The suggestibility has its special role in formation of group forms of dependence, for example, formation of religious, sport or musical fanaticism.

Dependent persons are inclined to imitating behavior, readiness to do the same things the others do. They are not able to plan the future adequately and in full. For example, the drug-addicts live today, this minute, they are not frightened by the influence on health that is made by drugs, and they do not follow own or somebody's negative experience.

They are notable for inflexibility of all mental activities; they strictly follow those life principles that are most significant for them. So, sport and music fans keep to specific clothes style, hair-cut, jewelry.

Dependent persons are characterized by naivety, simple-mindedness, spontaneity, extreme demands, emotions, they are not ready for compromises, are egocentric, fix attention on themselves only, their interests, their main need is to find pleasure. They have no self-control, it is difficult for them to wait and catch up. Such persons are inclined to risk, constantly look for difficult and dangerous ways of pleasure achievement. Side by side with the described features the dependent persons have fear of being left by people they are bound with their pathological passion, fear of being unable to manage with difficulties of life.

Dependence on psychoactive substances.

Psychoactive substances are such substances whose single taking causes various subjectively pleasant mental states: euphoria, an increased activity, a subjective feeling of comfort, calm. An abuse of psychoactive substances results in dependence (mental, and often also physical). A prolonged taking of these substances leads to a degradation of the personality, a decrease of cognitive abilities with a resultant affection of social adaptation.

Three groups of psychoactive substances are distinguished: alcoholic drinks, narcotics, toxic substances; therefore their misuse with dependence is respectively termed as alcoholism, narcomania and toxicomania.

Motivation of psychoactive substances use can be different. Someone takes these substances for relief or suppression of discomfort, these states are fear, anxiety, and depression. In case of hedonistic motivation the users of psychoactive

substances strive to take pleasure, experience the joy due to take. Others try to find extraordinary effect, “a fly to the unknown“. These sensations appear in case of use of marijuana, opium, cocaine, LSD, cyclodol, ethers and other substances. A number of psychoactive substances causes activating influence (ephedrine and its derivatives, marijuana, amphetamines, caffeine).

Quite often persons who take psychoactive substances believe themselves to be the special ones, weenies.

The most widespread form of dependence on psychoactive substances is nicotine addiction.

Use of tobacco is widely spread all over the world in spite of the fact that there occurred smokers' persecution in different times and countries. At first only men smoked, since the 80s of the 19th century women as well started sharing these practice. At present the average age of smoke-beginners has significantly decreased, and the number of female-smokers has increased. The smoking more and more extends on juniors, teenagers and even children.

The majority of smokers knows about the harm of smoking, but keeps on smoking. The habit to smoke is in everyday life of many people, has become a regular life necessity. One of the main reasons of smoking start is curiosity; desire to experience something new, which is strongly showed at the growing age.

Important place is occupied by the desire to follow adults, friends, recognized authorities, movie characters. Desire to start smoking is also caused by impressive advertisements that literally decorate our cities and that contain the warning as for harm of smoking with such subdued print, that it simply cannot attract any attention.

Often teenagers start smoking in order not to be a laughing stock among the friends.

Gradually the usual smoking becomes a complex conditioned reflex that includes the following components:

- elements of fetishism – beautiful and expensive smoking accessories;
- ritual elements – to play in hands with a lighter, cigarette, cutting of cigarette's end, first puff, making of smoke rings;
- taste sensations, analysis of individual satisfaction;
- satisfaction of tobacco smoke smell;
- reflex influence of tobacco smoke with its ingredients through respiratory system on internals;
- direct influence of nicotine on CNS;
- communication element – smoking as a group pass-time.

Desire to smoke quite often remains even through the continuous abstention terms (10-15 years).

Overvalued fascination

Overvalued fascination is a heightened interest to anything with passionate emotional attitude. In case of overvalued fascination all characteristics of common passion are increased to grotesque, subject or activity of passion becomes leading in person's life, they drive back or completely block all other activities.

Signs of overvalued fascination:

- deep and continuous concentration on object of passion;
- partial, emotionally rich attitude to object of passion;
- loss of inner sense of time spent on passion;
- ignoring of any other type of activities.

In case of overvalued fascination the “escape from reality” to any activity to the prejudice of another one and to personal harmony in whole take place.

Gambling (gameholism)

Pathological inclination to games of luck (gambling, gameholism). High comorbidity of this disorder with affective disorders and different types of chemical addiction is detected. Under statistics the risk of gambling is in 23 times more for persons who takes alcohol, in comparison with non-drinking persons. Start of gambling for men, as a rule, come on teenage, and for women – on the second half of life.

Characteristic signs of persons with pathological inclination to games of luck:

1. Constant passion and increasing of time spent at game situation.
2. Change of range of interests, exclusion of former motivations for game activities, constant thoughts about game, scrolling in imagination of the situations with game combinations.
3. “Loss of situational control”, which is expressed in inability of the game breakage using strength of will (both in case of great win and constant losses).
4. Presence of signs of “dry abstention”, which is expressed with the state of psychical discomfort, irritability, anxiety, uneasiness, depression in short time periods after the stop of game with difficult overcoming desire to continue.
5. Increasing of game participation frequency and pursuit for higher risk.
6. Increasing of ability to fall to temptation of the game restart, that is decreasing of game tolerance.

Gambling has 3 stages of development (R.L.Custer, 1984).

I stage – stage of win. This period is characterized with episodes of random game with wins; it is accompanied by excitement and euphoria. There appears desire to play more often, to raise stakes. The excitement that precedes the game increases. Game fantasies, causeless optimism and presentiment of great win come. Progressively the game takes place on slippery ground, when for a minute it is possible to lose everything or receive “the entire world”. Psychological dependence on game is being formed.

II stage – stage of progressing losses. At this period the physical dependence joins with already formed psychological dependence. Person’s life is concentrated on the game. The person can stop neither after the win nor after loss. Sense of euphoria that takes place at the period of stake and the result feeds the inclination. The social maladjustment grows, incl. financial problems, conflicts at work and in family, participation at risk activities appear, and legal breakings for gaining of money are possible. At the same time the psychological game skills decrease, thoughtless steps, unreasonable risks are present, quantity of losses increases.

Hierarchy of needs changes: need in game dominates, which drives back the basic physiological needs in food, sex and sleep. When trying to stop the game, the withdrawal syndrome appears; it is accompanied by serious dysphoric condition with headache and vegetative disorders, anxiety, stress, depression, sleep and attention disturbance, suicide thoughts. Depending on social, situational, personal and intellectual features, the second stage can last for 10-15 years.

III stage – stage of despair. The patient is socially decompensated, dysadaptated and is insolvent. It is marked with the compulsion inclination to game. Situation is not estimated in the reality: all personal and real estate possession is gamed away, financial crimes are committed. Criticism of self-condition and of everything that happens is lacking. Trying to stop the game causes severe abstention with expressed depressive disorders and attempted suicide, as well as with aggressive behavior. Anosognosia is shown. Patients seldom seek for medical care to psychiatrist, as a rule they are taken to him by relatives. First the psychiatrist consults them after attempted suicide.

Gambling has chronic and progressive character.

Computer dependence.

From 5% to 14% of Internet users suffer from computer dependence. Mostly these are teenagers and young persons. Important characteristic of dependent behavior of youngsters is the possibility of simple switch between addictions from one to another. Quite often at the same time they have some types of dependences. Computer dependence is highly co-morbid, with deviant forms of behavior, depressive and personal disorders, with different types of chemical addictions.

At present 5 types of computer dependence are classified:

1. obsessive surfing (net travel, search for information at data base centers and search engines);
2. addiction to on-line auctions and games of luck;
3. virtual acquaintances;
4. cyber-sex (ardor for porn-sites);
5. computer games.

Computer dependence is formed considerably faster than other addictive disorders: approximately 25% of patients have developed the dependence within half a year after the beginning of PC operation, 58% - within the second half, 17% - in a year.

There are a range of psychological and physical symptoms typical for computer-addicts:

- a) psychological symptoms: good feelings or euphoria at the computer; inability to stop, increasing of time spent at computer; disrespect to parents and friends; sense of emptiness, depression, irritability at the period of decrease or stop of Internet use; giving of untrue information to employer and family as for own activities; problems with work or education, use of Internet as a way of escape from problems or relief from painful emotions (feeling of hopelessness, anger, anxiety, depression).

b) physical symptoms: carpal tunnel syndrome (tunnel damage of nerve trunks of hand due to continuous overstrain of muscles); dry eyes; headache of migraine type; pain in back; irregular meals; neglect of personal hygiene; sleep disturbance, change of sleep regime.

Forming of computer dependence has three stages:

I stage – stage of risk of computer dependence development. Basic characteristics of this stage are increase of time spent for achievement of set aim and work at computer, loss of inner sense of time, taking of emotional satisfaction at computer, large expenses for computer activity, first signs of social maladjustment.

II stage – stage of formed computer dependence. Main features typical for this stage: emotional-volitional disorders and psychical dependence. Tolerance growth to computer, fixed thoughts about it and fantasy formation are shown. Dysactualization of main problems – sleep, rest, meals-connected, personal hygiene – is shown. Regimes of “sleep-wakefulness” and “rest-activity” are disturbed; time for computer operation is not only by day but also at night. Computer activity is performed instead of study, work, social and personal relations. On the one hand patients are completely oriented on the computer sphere, but on the other hand a kind of infantilism, practically full helplessness at the world of social norms and relations is present.

III stage – stage of total computer dependence. Both signs of psychical and physical dependence are shown. Efforts to control the work at computer are unsuccessful. At the structure of syndrome of compulsion inclination actualization the aggression, malignance, psychomotor agitation, depressive phenomena, lack of attention, involuntary “printing movements” of hand fingers dominate. The demonstrative and outrageous suicide behavior in case is possible, if people around try to limit computer activity. At this stage the following physical symptoms are evident: headache of migraine type, pain in spine, dry eyes, dumbness and pain in fingers (carpal tunnel syndrome). Social and family maladjustment is expressed.

Disorder of human eating behavior

Eating behavior of a person is characterized as harmonic (adequate) or deviant one, depending on variety of parameters, particularly on what place the process of eating resides in the individual hierarchy of values, on quantitative and qualitative indicators of nourishment, on aesthetics. Ethnic and cultural factors have essential influence on making of eating behavior stereotypes, especially at stress period. Eternal question of food importance becomes the question about connection between the food and life purposes (“eating for living or living for eating”), account of the role of eating behavior of people around for formation of some personal characteristics (for example, hospitality).

Eating behavior is a valuation attitude to food and eating, nourishment stereotype within casual conditions and stress situation, orientation to the idea of own body and activities as for shaping of it.

Taking into account the essential influence on assessment of eating behavior adequacy by trans-cultural features of a person, the significance of eating differs in

different cultures and people of different nationalities. E.g., in accordance with differential-analytic conception, the nourishment is one of the main components of Eastern psychological model of values, within it the own image of body beauty is created (as a rule, stout person with good appetite is considered to be more attractive and healthy), as well as created attention to the fact, in what way and amounts a child eats. Normal behavior under stress is characterized by high appetite and eating (“first have a meal, then let us talk about problems”) and so called “stress-eating”. At the sphere of domestic relations the high rate of hospitality is associated with provision of great amount of food. In Western psychological model the nourishment itself is not a value, and hospitality does not include eating as a necessary element. The value is ability to control over eating, orientation to other standards of beauty and aesthetics – slenderness, leanness, sport-like built, in contrast to the plumpness of Eastern model. In connection with trans-cultural differences the deviant eating behavior is sure to take into account the ethnic and cultural stereotype of eating behavior of people around.

Main disorders of eating behavior are: anorexia nervosa and bulimia nervosa. Their common parameters are the next: concern about control of own weight, misrepresentation of own body image, place change of nourishment in the hierarchy of values.

Anorexia nervosa is a disorder characterized by purposive reduction of weight, caused and fed by the individual himself. As a rule, refusal from food is connected with dissatisfaction by own appearance, seeming overweight.

Bulimia nervosa is characterized by repeating episodes of overeating, impossibility to go on without food even for short periods of time, and by unreasonable concern about weight control, which leads to taking of extreme measures for reducing of "fattening" influence of food consumed.

One more variety of eating behavior disorders is a **desire to eat inedible objects**. As a rule, such type of behavior occurs in case of mental diseases or serious pathology of character, although its manifestation is possible within delinquent behavior with the aim of somatic disease simulation for achievement of certain purpose.

Dysgeusia as a disorder of eating behavior occurs in case of a number of physiological conditions of a person. Particularly, within pregnancy the women have inclination for spicy, salty food, or for certain dish. Change of attitude to a number of products with the formation of changed eating behavior is possible in case of brain diseases.

Patho-characteristic types of deviant change of eating behavior include non-aesthetics (unaesthetic eating – champing, smacking at the process of eating; carelessness and untidiness; heightened fastidiousness even to relatives).

Stereotypes of deviant eating behavior also include speed of eating. There are two extremes: very slow and very fast, hurried swallowing of food, which can be caused by family traditions or temperament peculiarities.

Fanaticism

The passion for any activity that reaches the extreme intensity degree, with formation of cult and creation of idols, with complete obedience of a person and “dissolution” of individuality is called fanaticism.

The most common forms of fanaticism are religious, sport, music one. A person obeys personal interests to interests of confession, command, music collective. Such a person is not able to consider the words of cult figure critically and to realize the deviations of own behavior (isolation or leaving the family, ignoring of job). Most expressed social-psychological consequences causes religious fanaticism, when families, friendly and relative relations are broken, sharp change of life stereotype occurs.

The most favorable ground for formation of religious fanaticism is a sectarianism. Totalitarian religious sects use in their practice the strict psychological methods of influence that create at the person’s consciousness the state of heightened suggestibility due to physical and psychical exhaustion, social deprivation, use of trance state.

Influence characteristics of totalitarian sects on person are the following:

- formation of strict control over the will, consciousness and feelings of sect members (stern discipline, suggestion of sense of guilt before the organization, psychological pressure on those who want to go out);

- formation of psychological dependence on the leader and organization (suppression of ability to think critically, demand of break with persons of critical thinking, limitation of communication area to sect members, lack of spare time, private life out of the sect).

Specific risk group for religious fanaticism formation includes the persons who are in active spiritual search and strive for "complete and absolute Truth", and also the individuals with artistic type of higher nervous activity.

Different motives separate the person of reality, as well as subdue him to the idea and to the group leader. Among these motives there can be psychological problems, which an individual cannot cope with. Leaving for fanatic group is explained by rejection of responsibility for the made decisions. Another motive of group fanaticism behavior is the desire for leaving of monotonous, joyless reality.

Overvalued psychological ardors also include activities dedicated to worshipping of any mystical traditions, emotional involvement and following the traditions of psychic practice and esotericism, whose essence is the assurance that human activities, feelings and even consciousness are controlled by “mysterious powers”.

Co-dependence

People who suffer from different types of dependence seldom live in total insulation, usually they live with relatives. Dependence of one member of the family inevitably disturbs interfamily relations. Quite often one of members of such family becomes co-dependent. *Co-dependent person* is a person who is involved into the process of controlling of the behavior of another person, and does

not care about satisfying of own essential needs. It is the dependence on already a dependent person.

Co-dependent persons are characterized by:

➤ Low self-concept – there are numerous “I must”, “you must”, “how must I behave myself with my husband?” in the consciousness and lexicon of co-dependent persons. The co-dependent persons are ashamed of the behavior of their dependent relatives. Low self-concept determines their desire to help others so that to be needed by someone, and be loved.

➤ Desire to control the life of other people – the co-dependent persons think that they only know in what way other members of the family should behave themselves. They control others by different means – using persuasions, threats, compulsion, advice, stressing the helplessness of the people around.

➤ Desire to take care of others, to rescue them. Care about others quite often shapes grotesque forms which are beyond any reasonable limits. They consider themselves responsible for feelings and thoughts, actions and even destiny of the dependent members.

Many actions of the co-dependent persons are motivated by fear of facing the reality, of being left, by anxiety that the worst will happen, by the fear of losing control over life, and such fear limits the freedom of choice. Besides the fear, the co-dependent persons experience other feelings: anxiety, shame, fault, despair, indignation, sometimes rage.

The denial helps the co-dependent persons to live in the world of illusions, because the truth is so painful, that they cannot bear it. E.g., mother of a drug-addict, who takes drugs for many years, is sure he can leave it by himself, believes his promises and remorse.

The co-dependent persons denies the signs of co-dependence, which prevents them from motivating for overcoming of own problems, for asking for help, delays and worsens the dependence of the relative, keeps him in dysfunctional state.

Control questions:

1. List the psychological characteristics of patients in obstetric and gynecological clinics

2. What are psychoactive substances? List the groups.

3. Define the hobby. What are the signs of overvalued hobbies?

4. Give the definition of anorexia nervosa, bulimia nervosa.

5. What is fanaticism?

Tests:

1. What type of psychoanalytic response, as a rule, occurs in the patient in response to a diagnosis of malignant neoplasms?

A. Anozognostic

B. Aggressive

S. Indifferent

D. Euphoric

E. Suicidal

2. For children and adolescents, the most difficult psychologically are detected

A. Sexual disorders

B. Diseases that change appearance

S. Infectious diseases

D. Diseases of the respiratory organs

E. Cardiovascular diseases

3. A typical psychological reaction to the notice of the need for surgical operation is

A. Preoperative anguish

B. Preoperative stress

C. Preoperative frustration

D. Preoperative anxiety

E. Preoperative dysphoria

4. A boy 16 years of age suffers from stuttering. He repeatedly ridiculed and ignored peers. At the school with difficulty answered the questions. Becoming closed, showing reluctance to communicate with others, spend most of the time reading. What is the behavior of this boy associated with?

A. Fear of speech

B. Suspicion

C. Indecision

D. Vulnerability

E. Anguish

5. Psychological peculiarity of patients suffering from hearing loss is

A. Capriciousness

B. Vulnerability and increased anxiety

C. Impatience and breakdown

D. Fear and isolation

E. Emotional lability

6. The fear of death is characteristic for patients with

A. Acute period of myocardial infarction

B. Peptic ulcer

C. Hypertension

D. Bronchial asthma

E. Tuberculosis

7. A patient 22 years at the reception of a doctor feels a sense of shyness, stiffness, timidity, constantly trying to hide parts of the body under clothing. Reported that after the onset of the disease became irritable, little talk, inflammatory, there were thoughts about their inferiority. Described psychological characteristics are characteristic for patients with any disease

- A. Surgical
- B. Oncological
- C. Skin and venereal
- D. Infectious
- E. Diseases of the internal organs

8. At the reception to the GP there was a married couple. According to the wife, it became known that in the last time the man became tired when performing a not heavy work, irritating, there was a tendency to sentimentality, and became hypobulic. For which disease is characteristic of this psychological peculiarity.

- A. Peptic ulcer
- B. Myocardial infarction
- C. Hypertension
- D. Tuberculosis
- E. Bronchial asthma

9. 73 years old patient is in a therapeutic clinic. Whiny, during the day there are fluctuations of mood, with insignificant comments unreasonably offending, irritating. For any disease the data are characterized by psychological peculiarities

- A. Peptic ulcer
- B. Cerebral atherosclerosis
- S. Myocardial infarction
- D. Bronchial asthma
- E. Tuberculosis

10. 54 years old patient is being treated in the cardiology department said that a few days before admission he had a feeling of "uncertainty in the head," it was difficult to concentrate, there was a sense of impending danger, anxiety, and depression. For which disease these psychological features are characteristic.

- A. Peptic ulcer
- B. Cerebral atherosclerosis
- S. Myocardial infarction
- D. Bronchial asthma
- E. Tuberculosis

Case studies tasks:

1. The patient is 19 years old, her height is 168 cm, and her weight is 34 kg. 2 years ago, after the zestful remarks of a guy to observe a meager diet more often, for several days she did not take any food. When there was a feeling of hunger, she ate, but immediately caused a vomiting. She has kept the present weight for the last 6 months. She understands that she is exhausted, tries to increase her weight, but she cannot do it by herself, that's why she entered the hospital. Determine the form of eating behavior of the patient.

2. A 37-year-old man is a successful businessman. Following the advice of his friend, he visited the casino and from the first time won a considerable amount of money. Since that time he has spent all evenings at the casino, lost a significant part of his savings, was forced to sell a part of his property. If for some reason he cannot visit the casino, he becomes irritable, anxious, and restless. Determine the form of dependence.

Class № 5. PSYCHOLOGICAL ASPECTS OF SUICIDAL BEHAVIOR, DYING PATIENT AND EUTHANASIA. PSYCHOLOGICAL COUNSELING. REHABILITATION. FUNDAMENTALS OF PSYCHOTHERAPY.

Psychological aspects of suicide, thanatology, euthanasia

Suicide behavior

Suicide is an intended self-damage with fatal outcome. It is exceptionally human act and occurs in all cultures. People, who perform suicide, usually suffer from strong emotional pain and are under stress, as well feel the inability to manage their problems.

Suicide and attempted suicide are objects of specific interdisciplinary sphere of knowledge – *suicidology*, which for last years has been developing at many world countries. At the end of 20th century the suicides took the fourth place among most common causes of death. Within a year about 500 000 suicides occur, everyday more than 1 thousand people commit a suicide. Abrupt increase of suicides among people of 18-19 years is of special alarm. Such suicides make up 50% of all fixed suicides.

Suicide is a conscious, self-deprivation of life itself. The psychology of suicide is the psychology of hopelessness above all. The issue of suicide arises in circumstances where a person falls into a difficult life situation from which he cannot find other choice but to kill himself. All life events and psychological conflicts that lead to suicide cause powerful attack to the moral values of the person.

The growth of the number of suicides in recent years is explained by psychosocial maladjustment.

Suicidal behavior is dependent on many factors, it takes place on special extreme circumstances and is undertaken for different reasons and with different goals. Suicidology has long moved away from searching a single or dominant reason causes this behavior, as well as on whether to establish a common or "typical" portrait of a man committed suicide. The causes and forms of suicidal behavior are diverse, no single typical portrait of a man committed suicide.

Special attention should be paid to a suicide person in respect of influence of such factors as sex, belonging to specific social or ethnic group. It is quite evident that the grounds for suicide of a 12-year girl, who had a quarrel with mother, and of old sick and left woman are different. In one case it is an imitation of a sentimental film scene, which was recently watched, in another – a result of painful life drama.

Suicide behavior includes not only committed and attempted suicides, but as well suicide reactions, thoughts, threats, imitations, demonstrations of suicide intentions - until its extreme form - suicide attempts and completed suicides.

Basic psycho-traumatic situations, resulting in development of suicide behavior, are the next:

1. Short-time but sharp situations with acute affect to personality due to individual significance of traumatic influence:

➤ quarrel with a close friend or a spouse; sudden disappointment in respected person; serious financial difficulties, sudden loss of property.

➤ career crash; serious mistakes of own life experience that cause remorse; forced sharp change of life stereotype.

➤ statement of personal physical defects assessed as an ugliness; defects of character that are constant source for self-dissatisfaction.

2. Situations of powerful, continuous traumatic influences:

➤ contradictions of social and personal interests, conflicts of subordination, competition

➤ conflicts of family relations

➤ conflicts of sexual relations

3. Situations of slight but continuous traumatic influences:

➤ non-regulated work and life tempo, which requires constant switching, necessity of constant self-suppression in conditions of unfriendly family or office relations, high responsibility.

➤ forced stay at work that does not satisfy main interests of person; impossibility to perform favorite activity.

Suicide is seldom committed as a result of rational consideration of life circumstances, reasons for living or dying. Its basement is in psychological crisis; experience of all the range of negative emotions – despair, grief, fear, feeling of helplessness, fault, anger, desire to take revenge or break unbearable mental or body suffering.

Different interpretations of suicide behavior are evident, and in general can be represented by the following *motives*:

➤ “Protest” forms of suicide behavior arise in conflict situation, when the objective its link hostile or aggressive towards the subject, and the meaning of suicide is a negative impact on the objective link.

➤ “Revenge” is a specific form of protest, a form of causing of damage to hostile surrounding. These forms of behavior suppose the high self-concept and self-evaluation, active or aggressive position of a person, with change from hetero-aggression to autoaggression.

➤ Suicide behavior of “appeal” type – activation of outside help with the purpose to change the situation. Herewith the position of a person is less active.

➤ In case of “avoidance” suicides (avoidance of punishment or suffering) the sense is in avoidance of threat to personal or biological existence by means of self-elimination.

➤ “Self-punishment” can be determined as “internal and external protest of person”; the conflict basically is an internal one, with specific separation of “ego”, exteriorization and co-existence of two roles: of “Me-judge” and of “Me-the accused”. Herewith the sense of suicides of self-punishment type has slightly different nuances in case of “elimination of an inside enemy” (“from judge”, “from above”) and “expiation of faults” (“from the accused”, “from below”).

➤ In case of “refusal” suicides it is not possible to mark the divergence between purpose and motive. In other words, the motive is refusal from existence, and the purpose – self-deprivation of life.

Suicidal behavior is a consequence of social and psychological maladjustment person in the conditions experienced microsocial conflict. This is the result of interaction of environmental (situational) and personal factors. No specificity of conflict, on the one hand nor the specificity of personal characteristics – the other, they do not determine the character of one or another behavioral reaction, and simply "connection" of these two factors doesn't give system conception of this behavior mechanisms. To adequately understand suicidal behavior, it is necessary in each particular case to answer two questions: "what are the reasons" that person commits or intends to commit a suicidal act, and "for what" he wants to do it.

The answer to the first question requires an analysis of the objective conditions in which a person committed suicide found himself, the answer to the second question requires an analysis of subjective judgment of human committed suicide on the situation, it is important to understand what he wanted to achieve as a result of the implementation of suicidal threats or suicidal actions. In other words, the answer to the first question, it is necessary to determine the direct life situation of the patient, his position in the micro-social environment, the state of his health, mental status; and answering the second question, determine its internal motives, intentions, psychological bases of suicidal decision making.

Conflict circumstances, stressful situation (whether it be family quarrels and divorce, insult or professional failure, etc.), even if they involve the most significant spheres of the person, they do not uniquely determine the tactics of human behavior. Some persons, being in such circumstances, come to grips with the "enemy", other "cry for help", and others - are trying to avoid threats, and a fourth inclined to blame the incident itself or other, the fifth "become discouraged", putting himself under the "blows of fate". The form of human behavior in a traumatic situation depends on the characteristics of the individual.

The position of a person in a conflict situation is a semantic formation in which the individual's attitude to the situation and to himself (in this situation) is integrated with an assessment of the significance of the situation, a forecast of its outcome, which is the basis for choosing tactics of behavior. Once in a conflict situation, the person structures the holistic situation in the mind, first of all, separating from it the two main patterns: "I" and "not I", and places them relative to one another in subjective space. The final choice of tactics of behavior is directly determined by the position that is formed as a result of the process of self-determination and is accepted by the subject.

Not always the final position is unambiguously defined. It can be labile, ambivalent, contradictory, which is reflected in the line of behavior. Often the process of self-determination is minimized, and then the person immediately takes a position that directs his further actions. Finally, self-determination, acting for some as an arbitrary activity (free choice of position), for others seems to be a consequence of external coercion; in other words, the person either takes a position or gets into it. The existing semantic assessment of the situation as "hopeless" sharply limits the internal "field of vision" and blocks the search activity.

The following six characteristics characterize such a “losing” position of the individual.

1. Fixity of the position. The subject is not able to change the image of the situation, freely manipulate its elements in space-time coordinates.

2. Involvement, i.e. placing oneself in the point of application of threatening forces; a view of the situation “from within”, the inability to step back from the conflict situation, to distance it.

3. Narrowing the sphere of the position of the individual in comparison with the sphere of the conflict situation. Narrowing the semantic sphere of the individual occurs due to the restriction of ideas about one's own resources and due to the growing isolation from others.

4. Isolation and closure of the position. In the structure of awareness of conflict relations, instead of the adaptive position “we are they” there is a much more vulnerable confrontation “I am they”, indicating the alienation of the individual, the loss of connection with reference groups, the violation of identification.

5. Passiveness of the position. Imagining actively directed influences of the participants in the conflict, the person cannot present his constructive actions (attacks, protection, care, etc.) within the framework of the existing semantic image. Such passiveness of the position devalues any variants of decisions known to the person. In passive positions, knowledge and experience are not only actualized, but are also rejected.

6. Under development in the time perspective, the absence of the future are related to the above mentioned signs of a “losing” position. The future is presented only as a continuation or aggravation of the current situation. Such a position brings the subject close to suicidal behavior, but not yet sufficient for its occurrence.

The conflict situation develops into a suicidal crisis only when the main semantic structures are involved in its sphere - the person's value relations to life and death. Semantic images in this case go beyond the reflection of specific circumstances, cover a broader and more distant social situation, correlated with the notion of the future “me”. The process of self-determination and the formation of the position of the individual is developing at a higher level. In the structure of the actual semantic field, the situational position is reorganized into a life position, which while preserving the character of “losing” indicates not only the capitulation of the individual in this situation, but also its life crash. The passivity of the common life position, the blockade of remote prospects are equivalent to the impossibility of self-realization, which entails the loss of the value of life, this is already a specific ground for the origin of suicidal behavior.

Thus, ***suicidal behavior*** is any internal and external forms of mental acts directed by the concept of depriving oneself of life. It should be emphasized that the term “behavior” combines a variety of internal (including verbal) and external forms of mental acts. Internal forms of suicidal behavior include suicidal thoughts, perceptions, experiences, as well as *suicidal tendencies, which are subdivided into ideas and intentions*.

The listed number of concepts, on the one hand, reflects differences in the structure, in the subjective formulation of suicidal phenomena, and on the other hand, represents a scale of their depth or readiness for transition to external forms of suicidal behavior. It is advisable to use the three stages of this scale, separating a special, undifferentiated “soil” in the form of anti-vital experiences. These include thinking about the lack of value of life. There is still no clear idea of one's own death, but there is a denial of life.

1. *The first stage (passive suicidal thoughts)* is characterized by representations, fantasies about the death, but not about depriving oneself of life as a spontaneous activity.

2. *The second stage (suicidal ideas)* is an active form of manifestation of suicidal, i.e. the tendency to suicide, the depth of which is growing parallel to the degree of development of the plan for its implementation. The person thinks about the ways of suicide.

3. *The third stage (suicidal intentions)* involves adding the decision and the will component to thinking about suicide, which leads to a direct transition to external behavior.

External forms of suicidal behavior include *suicidal attempts and completed suicides*. A **suicidal attempt** is the purposeful operation of means of depriving oneself of life that does not result in death. Suicide attempts and suicides in their development have two phases. The first phase is reversible - when the person himself or with the intervention of others can stop trying. The second phase is irreversible, most often ending with the death of the individual (**completed suicide**). The chronological parameters of these phases depend both on the intentions of the person who is going to commit a suicide and on the method of assassination.

There are the following **variants of suicide behavior**:

1. *True suicide behavior*, which is characterized by well-considered, continuous and gradual (from one week to seven months) pre-suicide; in most cases the motives of suicide are conflicts (love, relations with parents, etc.), psycho-traumatic situations are marked by duration (on the average – of 1,5 year); but at the stage of internal readiness for suicide (some days-weeks prior) thoughts about death, not about suicide, are possible, of the kind “If I were run over by car”); just before the suicide there are depressive worries, feelings that the situation is unbearable, spiritual pain, despair, feeling of needlessness, tiredness; suicide attempts are made in loneliness, the means to be used are planned; psychological sense of this type of suicide – “protest” against the current situation.

2. *Affective suicide behavior* – in the majority of cases pre-suicide is a short-term one; suicide decision appears at the crown of affect, instantly, thoughts about suicide arise suddenly; more often a tool the finger was laid on is used. The severity of suicide is determined by severity of mental state and strength of affect, which at the moment of suicide weakens the consciousness; emotional state prior to suicide attempt is characterized by feeling of emotional pain, that the situation is unbearable, by excitement, fear, necessity of close spiritual contacts; suicide attempts are not always preceded by a certain reason; the reason can be represented

by events, interpreted by the person as an indicator of his life crash and even usual quarrels with an important person; suicide is committed in loneliness; the suicide does not think about consequences.

3. *Demonstrative suicide behavior*: the purpose of these suicide attempts is influence on attitude of important persons, motives are represented by conflicts; pre-suicide is a short-term one (from some minutes to an hour) with doubts in reasonability of autoaggressive actions; the autoaggressive actions are always preceded by a specific reason in the form of offensive shouts; state of the pre-suicide is characterized by non-depressive emotions: resentment, feeling of self-pity, the feeling that the situation is irresistible, aggression, fear of suicide (worries are not deep, and affect is not deeply expressed); the suicide realizes that his actions cannot cause death; the desire to attract attention to own grief and to take revenge: sometimes suicide is committed at the presence of important persons, often the relatives or even strangers are informed about the intention of suicide.

The basic psychological motives of suicidal behavior are: for a true suicidal behavior – avoidance, renouncement to fight, a way out of a difficult situation due to unsuccessfulness of repeated attempts to cope with it, and it is impossible to abandon their goals; for affective - the removal of emotional stress in a situation of long-term psychological trauma; for demonstrative – "cry for help".

Common psychological meaning all types of suicide is not the true desire of physical death, and in aspiration to eliminate of suffering.

Suicide it is a distress signal, the call for help that points to the desperate hopelessness conflict situation. In each case, suicide requires special therapeutic measures.

The course of medical treatment of the persons that are under threat of suicide does not include any causal therapy, which would be performed according to certain rules and would guarantee recovery of the patient. Purpose of treatment is to solve the problems that reason suicide, not to try to prevent the suicide at all costs. The person itself, who is "tired of life", can prevent the suicide.

Psychotherapy with patient aims at convincing him of presence of optimistic possibilities. About 70 % of persons that have had a single attempted suicide succeed in creation of new life purposes. Others repeat suicide attempts, half of them are fatal.

The first important therapeutic step is an attempt to get into contact with patient. The first question could be like this: "What made you feel so desperate, that you decided it is not worth to live anymore?" The display of sympathy and understanding of patient's hopelessness breaks the wall of patient's lost contacts and his isolation from people.

Direct ground for suicide attempt prior to committing it lasts from some minutes to some hours, seldom – days. It is important to know that ground, and if possible – reasons of preceded suicide attempts, so that to find the access to hidden problems of patient.

Motive, that is expressed consciously, is not absolute and single explanation of the suicide action. In all circumstances the crisis situation is a reason, on whose basement a new, unknown to the patient problematic develops. More often the

reason is a disappointment in partner or his/her loss. It is taken as painful and hurtful situation, and causes existential shock to the feeling of self-respect. The doctor creates an idea of crisis scope and strength of the patient's desire to die. In case of serious suicide crisis or sharp psychological states (of patients with endogenic depression, schizophrenia) the only proper decision can be a continuous observation of the patient or hospitalization in order to protect him from own suicide impulses. In case of psycho-reactive crises the doctor's position is strengthened by his respect to the desire of the patient. The person that is tired of life, easier gives preference to life, if he is under less pressure. The doctor should assess the depth of desire to die together with patient. Such conversation can be the first step towards life. This person wants his desire to be understood and taken seriously. Perhaps, there is no person who would like only to live or only to die.

More deep meaning of the desire to die is more often expressed in fantasies connected with alienation. Physical death is not the main purpose of the person, who committed a suicide. Realization of this fact helps to identify the real sense of crisis and to understand basic, deep difficulties of the patient.

After the contact with patient is reliably established, the scope and reason of crisis state are determined, the desire to die is expressed and meanings are understood, the restorative therapeutic work starts. The serious steps of psychotherapy of crisis states are to give the patient the possibility to realize own strength, ability to form his desires and aims, predict understanding and possibilities of solution of crisis situation in present and in the future.

In psychiatry it is a custom to determine the approaches to the suicide problem through the terms prevention, intervention and postvention, that are efforts as for prevention of suicide, active interference in process of the suicide itself (for example, at the process of phone or real consultation of the person with already shaped decision to commit a suicide) and treatment of suicide consequences of the patient (in case of survival) and/or his relatives.

Suicide prevention includes consultation (helpline, crisis centers, accounting of risk factors and suicide risk groups) with psychotherapy and medicament treatment.

Intervention means penetration into suicide process with the purpose to keep the suicide alive or to perform the blockade of his possible actions through psychological influence (for example, through anti-suicidal contract), emotional or spiritual support, formation of confidence relations and further work over strategy of positive changes in his state.

Postvention stands for prevention of consequences of autoaggression, as well as for overcoming of crisis of survived suicides and their close surrounding in order to ease the adaptation to reality they meet after the suicide attempt. Usually postvention is performed in presence or in absence of the suicide, or by phone.

Thanatology

Thanatology (Greek "thanatos" death + "logos" teaching) is a teaching about regularities of dying and caused by them changes of organs and tissues. It studies the dynamics and mechanisms of dying, direct causes of death, clinical,

biochemical and structural manifestations of gradual stoppage of organism activity. Knowledge of the basic regularities of thanatogenesis allows effective intervention at critical periods of the disease, especially in the condition of resuscitation.

There is general and private (special) thanatology. General thanatology - studies the most general regularities the dying process, private - especially thanatogenesis at certain diseases and causes of death, the cause and character of the onset of irreversible changes in some organs.

Interest to thanatology has increased within the last decades due to several reasons. First of all, due to the development of resuscitation science. Psychiatric and psychological aspects of “made-alive organism” of persons who experienced clinical death, terminal and other suddenly developed states, dangerous for life, caused heat discussions of ethical problems, and the psychiatrists, as well as neurologists, faced the problem of treatment, rehabilitation and restoration of mental activity of persons with post-resuscitation disease.

Since 1959, when the resuscitation specialists described for the first time the state of “brain death” that occurs in the process of resuscitation, discussions as for new concept of death, which identifies the death of person with the death of his brain, go on. This problem has gained special actuality since 1967, after the first heart transplantation was performed, for the majority of organ donors are patients with died brain. Transplantology was found at the center of thanatological, ethic and legal, social and philosophic problems that did not have definite answers and had different interpretations in different countries.

As a result, at the turn of 60-70th the bioethics appeared. On the basis of ethical and legal positions the specialists of this sphere solve different problematic situations arising at clinical practice (medical intervention to human reproduction, possibility of medical-genetic control, transplantation of organs, cloning of a human being and etc.).

Issues of thanatology are also studied in connection with the problem of euthanasia. The death is irreversible stopping of vital activity of an organism, inevitable natural end of existence of any creature. Modern science gives this very concept definition. Different interpretations of the definition are evident due to the fact that, e.g., some kinds of death are observed. There are clinical, biological (true), social death and brain death. The fact of “death” notion uncertainty itself produces for doctor’s very difficult ethic, philosophic, economic and legal problems, connected with the statement of death, range of resuscitation actions, euthanasia and taking decision as for continuation or stopping of medical assistance.

Psychological aspects of thanatology accent the dilemma whether to tell the death-sick patients about his diagnosis or not. At the present the majority of doctors agree that everything depends on psychological characteristics, life prerogatives and system of values of the patient. In any case, the information about fatal disease is psycho-traumatic for any person, it breaks his hope, and whether the person copes with such news or not depends on his personal features.

Modern industrial community creates the consumers' attitude of people as for life values, and our public system is not an exception, it is based on more wide

satisfaction demand of material and other needs. There appear specific norms that are to be gained by a citizen of certain social group; one can speak of a kind of “necessary standard”. Individual is presented with certain consumers' ideals (car, type of vocation), as well as personal ideals: beauty, sexuality, physical abilities. In such a way there is created an image of “right for life” for people, as well as sense of unrestricted right to consume life. The thought about death and inevitable end is put away to the shadow of social and psychological processes; here the following expression can be used: “I forgot about it like I forgot about death”. Signals on unexpected death or fatal disease of people who are “completely healthy” treat their mind as strong blows. Herewith people are suggested with an idea of nearly unrestricted abilities of science, and personal disappointment in this connection will be even deeper. Prolongation of human life does not improve health condition in older age lived passively in condition of retirement pension.

Medical assistance for persons of old age has usually supporting character, it postpones the inevitable end, often for a long time. Herewith people who are not engaged in work or another active occupations surely often recourse to a thought about the things that threaten their health and life.

Religious believes that are integral part of life style for really religious people cause certain “psychical antibodies” presence against sudden fear of disease and death. Cult of suffering and death in ceremonies and prayers («Memento mori — Remember about the death) forms out of thoughts about death, disease and suffering an integral part of psychical weapon of a human; the suffering becomes a merit that will be justly considered in other world.

Mental state of the patient with fatal disease is unstable and comes through 5 stages:

1st stage of denial and rejection of the tragic fact. Dominating expressions are “it is not with me”, “it is impossible”, “it is not cancer”. The patient develops anxiety and stress, fear of future. A kind of psychological protection is the denial of fatal disease, active examinations at different specialists with modern paraclinical methods of diagnostics. The patient considers the formulated diagnosis wrong; there occurs psychological substitution of the diagnosis to a disease that is not fatal.

Other patient, who has got to know about fatal disease, becomes indifferent, doomed, and inactive. Then they begin to talk about soonest recovery. This original psychological protection relieves painful worries and stress. But already on the first stage the dreams of the patients can contain symbols that point to a fatal disease (for example, an image of dark tunnel with a door at the end...).

2nd stage “protest”. When the first shock passes, and numerous examinations confirm the diagnosis, the feelings of protest and indignation appear. “Why did this happen to me?”, “Why others will live and I have to die?”, “why is it so soon? I have so much to do”, etc. This stage is inevitable, it is very difficult for the patient and his relatives. At this period the patient often asks the doctor about the time left for him to live. He has symptoms of reactive depression, suicide thoughts and actions are possible. At this stage the patient needs the help of a

qualified psychologist who knows logotherapy, help of family is as well very important.

3d stage – ask for postponement. At this period acceptance of the truth and awareness of the situation occur, with the only remark - "not now, a little more time". Many people, even not religious ones, turn to God with their thoughts and asks.

4th stage – reactive depression, as a rule it is mixed with the feeling of fault and offence, pity and grief. The patient realizes that he dies. At this period he grieves over his bad deeds, troubles and evil deeds done to others. But he is ready to accept the death, he is quiet, he finished with secular concerns and got deeper into himself.

5th stage – acceptance of own death. Person has peace and calm. With acceptance of the thought about close death the patient is not interested in world around, he is fixed and absorbed into own thoughts, when preparing for inevitable.

“Preparation for death”, that is preparation for own death and possibility of sudden death or unexpected fatal disease of the close persons, is obviously to be an element of mental hygiene.

It is may be supposed that the majority of patients die in calm death, if they have not realized their state in full. Considering that the dying person can be significantly exhausted physically and mentally, as a rule, he is not able to realize his future perspective. Often the patient is in drowsy, unconscious or comatose state.

The dying person is probably a psychological problem first of all for his surroundings, other patients. We try to relieve suffering of a dying person, for example, using symptomatic treatment, tactful behavior; when leaving, we would say: “See you tomorrow”; we allow frequent visits of relatives and friends, warning them not to disturb the patient too much. The dying person is placed at such a place, where his condition would not psychically traumatize other patients.

In modern bioethics literature there is actively being discussed the doctors’ promotion of death for hopeless, dying patients. One of main questions of bioethics is the problem of euthanasia.

Euthanasia

Euthanasia (Greek “ευ” – good + “θάνατος” — death) is the satisfying of the request of the death-sick patient as for forwarding of his death by any actions or means. For the first time the notion “euthanasia” was used by F. Bacon in the 17th century for description of “easy death”.

There are two types of euthanasia, namely *passive euthanasia* (intended stoppage of the patient supporting therapy by medics) and *active euthanasia* (introduction of drugs, or other actions that cause fast and easy death). Active euthanasia often includes a suicide with medical help (provision of patient with the preparations that shorten life).

The Netherlanders have become a pioneer state in the sphere of voluntary death. In 1984 the Supreme Court of the country admitted the voluntary euthanasia as acceptable. Euthanasia was legalized in Belgium in 2002. In 2003 euthanasia

helped 200 patients with fatal disease and 360 patients in 2004. Since April, 2005, in Belgium the pharmacies propose special sets for euthanasia that help to ease the procedure of voluntary death. The set costs about 60 euro and includes a single-use syringe with poison and other means necessary for injection. The set can be ordered only by the doctor in practice, who has to specify the exact dosage of poisonous substance. Order may be made after the address to one of 250 Belgian drug-stores that have the appropriate license. Under the legislation of Belgium, the euthanasia can be used for a person over 18, who suffer from an incurable disease. After several written applications that confirm the firm decision of the patient the doctor can perform euthanasia. In accordance with official statistics in 40% of cases the euthanasia is performed at patient's home.

In Ukraine euthanasia is forbidden by law. Surely, the statement of Hippocrates, set forth at his "Oath" – "I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect" – today is just a common ethic requirement to medics' behavior.

For quarter of a century the world watched the legal process over the follower of practical euthanasia – American doctor Jack Kevorkian, who stopped lives of 130 persons with the help of "death machine" invented by him. Some consider him to be a humanist, others – a murderer. His years-long litigation with courts of Michigan that justified him for some times was ended with conviction.

Still, euthanasia of 37-year president of USA Richard Nixon was publicly approved. After the first stroke he made an address to the attending medical doctors with request not to use forced methods of life keeping in case of the next cerebral hemorrhage, when he would not be able to express his will. President of France Mitteran stopped consciously to take medicines after the consultation with personal doctor and signing the testament; he had the final stage of cancer. The courageous action and desire of the famous patient to be the master of his destiny were marked by the press.

Analyzing the current situation, it should be recognized that those who believe that nowadays the topical issue is not about whether to allow or not allow doctors to use euthanasia, but about when and under what conditions it can be allowed and how to organize control over the legitimacy its implementation.

The right to refuse medical intervention is confirmed by the article of the Fundamentals of Legislation "The Rights of the Patient". This corresponds with international human rights standards, but it also creates the possibility of the legal use of passive euthanasia through the "cessation of life-support measures" explicitly prohibited by the Criminal Code. In cases of serious, life-threatening conditions, such forced inactivity of a doctor can be considered as the application of passive euthanasia, since there are two important signs of it:

- 1) the patient's request not to help him (after informing about possible consequences by the doctor in an accessible form);
- 2) failure to provide health care for life support or the cessation of artificial life-support measures.

L.N. Yurieva conducted a sociological study of 200 doctors-psychiatrists in 3 regions of Ukraine. Among the numerous questions aimed at revealing the socio-

psychological characteristics of doctors of this category, there was also the question of the attitude towards euthanasia. 46% of respondents were positive about euthanasia and only 5% do not accept it under any circumstances. 11% of psychiatrists had never thought about this problem, 25% of doctors were not ready to answer the question and 13% did not know what to answer.

The obtained results indicated that, contrary to officially proclaimed legal and ethical norms, doctors in different countries and different specialties show great interest in this problem, and some of them are inclined to allow euthanasia. However, despite this, currently in most countries euthanasia and “assisted suicide” are considered unethical, and every such case is widely publicized and evaluated by ethical committees in medical associations. An example is the history of Dr. D. Kevorkian. The facts that were publicized provoked controversial feedbacks from medical workers. Some experts estimated the suicide supported by the doctor as a more preferable way than active euthanasia. Their opponents stated a number of moral and ethical considerations against “assisted suicide”. The American Medical Association's Ethics and Litigation Council, having considered numerous opinions on this issue, issued the following decision: “In certain cases, a suicide assisted by a doctor may look merciful, but in connection with the possibility of harming the medical profession, it cannot be justified”.

Psychotherapy

Psychotherapy (Greek: “soul” + “treatment”) is the application of mental effects (primarily - with the help of words) for the treatment of the patient.

Psychotherapy is divided into general and special.

General psychotherapy is a set of measures of mental impact on the patient aimed at increasing his strength in the fight against the disease, and creating a protective and restorative regime that excludes the following psychic trauma and iatrogeny. In this case, psychotherapy is an auxiliary tool that creates a general background on which other types of treatment are performed (medical, surgical, physiotherapeutic, etc.).

General psychotherapy is closely related to medical deontology, forming a unified system of behavior of medical staff. Medical deontology focuses the doctor's attention on what he should and should not do, and psychotherapy equips him with methods using which he can achieve it. Psychotherapy includes the impact of the word, and the emotional and psychological climate that surrounds the patient. Broadly speaking, psychotherapy makes it possible to create positive life goals for the patient, creates favorable conditions around him, and organizes a regime. Psychotherapy contains elements of psychoprophylaxis and psychohygiene.

The main methods of special psychotherapy are rational, suggestive psychotherapy, autosuggestion, autogenic training, drug-therapy, etc. The development of effective methods and techniques of special psychotherapy and their theoretical justification constitute the subject of scientific psychotherapy.

Suggestive psychotherapy. Suggestion (infusion) is most fully manifested in the hypnotic state, so the method of suggestion itself is often called hypno-

suggestive. However, this is not true, since suggestions in the state of consciousness are one of the independent methods of psychotherapy. V.M. Bekhterev made a great contribution to the theory and practice of suggestion; in particular, he proposed a technique for suggestion distracting the patient from painful experiences. His disciple B.N. Sinani developed a system of targeted suggestions, which are based on trust and a positive emotional attitude of the patient to the doctor. To check and strengthen suggestibility in the state of consciousness, and especially in hypnosis, a fractional method is proposed that consists in successive brief immersions of the patient into a hypnotic state and awakenings in order to strengthen the sensations in the following states that are formed by suggestions. Also, methods of suggestive psychotherapy include hypnosis-rest according to Platonov and elongated hypnotherapy according to Rozhnov: the patient falls into hypnotic state for many hours in the first case, in the second case - for 1.5 - 2 hours. These techniques are used both for medical suggestion and for the purpose of protective-restorative therapy.

Rational psychotherapy (P. Dubois). This is a system of logical influence on the patient's psyche, free from suggestive and emotional components, the purpose of which is to dispel false ideas about the nature and severity of his condition. Rational psychotherapy contains techniques that take into account the nature of a person's morbid state, personality, and lifestyle. In any psychotherapeutic technique, there is a certain element of rationality. The leading elements are an explanation and proof, and the creation, together with the patient, of the necessary life plans. Thus, rational psychotherapy is a combination of logical beliefs with therapeutic re-education.

The influence of the doctor is essentially emotional, at times emotionally-stressful. During the session, the doctor's speaking should be free of doctrinal dryness, mentor tone and sentimentality. Words and phrases should be impressive, should interest and convince the patient that the doctor is right. Only by observing all of the above, it is possible to make the patient critically assess his bad thoughts, including phobic thoughts, and it will provide an opportunity to achieve therapeutic effect.

Autogenous training by Schultz is based on observations of patients who are in a hypnotic state, as well as their self-reports about the experience of this sensation. In this case, the tone of both the striated and smooth muscles is significantly weakened, it determines the possibility of influencing the somatic sphere.

Autogenous training is a special psychotherapeutic system of relaxation, which takes into account both the physiological state of the patient and the symptoms of the disease. The vegetative system of the body is involved (body temperature, sweating, heart beat rhythm, etc.). During the autogenous training session, regardless of its technique, the patient feels warmth and heaviness in the hands and feet, a pleasant coolness in the forehead area, warmth in the epigastric region. Some researchers consider autogenous training as one of the variants of self-hypnosis, bending in the approximation of the phenomena that arise in the autogenous training to the concentration of thought and self-immersion in the

world of own sensations, which is typical of Indian yoga. Schulz stressed the connection of his technique with yoga.

Modifications of autogenous training are common abroad (techniques of Lute, Kleinzorge, Klumbis, etc.). The original variants of autogenous training were offered by domestic psychotherapists A.S. Romen, P.S. Biliaev, M.S. Lebedinskyi, T.Y. Bortnik, S.S. Liebig, A.N. Svyadoshch, etc. A special variant of autogenous training called “psychotonic training” (A. Shogam and K.I. Mirovskyi) is recommended for persons suffering from hypotension, since they are contraindicated in traditional relaxation.

A.V. Alekseev generated the psycho-prophylactic variant of autogenous training – psycho-musical training, which is used, for example, in sports.

It should be noted tranquilizing influence of autogenous training on the emotional sphere. However, there should be no passive-indifferent calm, sleeping state; it is necessary to cultivate faithfulness full of positive emotions in one's own strength, as well as to the therapeutic possibilities of the technique.

Group or collective psychotherapy is an independent technique. It is based, on the one hand, on the fact that in the group in patients the suggestibility is raised and special conditions for interpersonal communication arise; on the other hand, group psychotherapy allows opening new opportunities for individual psychotherapeutic techniques. A doctor who supervises collective psychotherapy sessions builds his work with a group of patients (called therapeutic environment or therapeutic union) in a way to achieve the maximum therapeutic effect of patients on each other and the collective as a whole on each individual patient. This is the so-called principle of interaction or group psychotherapy by Kratochvil.

Foreign researchers use only the concept of “group psychotherapy”. The theoretical basis of most of the methods developed by them, for example, didactic group psychotherapy, inspiring psychotherapy, group analysis, family psychotherapy, psychodrama, is psychoanalysis and its modifications. Domestic researchers state that such a form of psychotherapy, in which the main therapeutic effect depends on the influence of patients on each other, is called collective and such psychotherapy, in which the therapeutic influence of the doctor on the group of patients prevails, is called group therapy. Domestic psychotherapists widely use various versions of collective and group psychotherapy for the correction of neurotic states and for enhancing the creative activity of the individual. In collective psychotherapy, the group methodology is used for therapeutic re-education, for therapeutic training, rehabilitation, for studying psychogenesis (using the methods of the “psychotherapeutic mirror” by Liebig, “bibliotherapy” by Kutanin, etc.), for targeted suggestion (in the form of suggestion or rational psychotherapeutic conversation with patients, they are in a state of wakefulness). Among more narrowly focused variants of collective psychotherapy, the activating, distracting, explaining and sedative variants are distinguished.

Family psychotherapy is a special variant of collective psychotherapy, which is aimed at correcting interpersonal relationships to eliminate emotional disorders in the family. Indication for its use is all kinds of behavioral disorders that are associated with emotional factors, anomalies of nature and other neuropsychic

disorders that are caused by various forms of family disorganization and inappropriate education. The goal of family psychotherapy is achieved by restructuring the nature of the relationship in the patient's family. Family psychotherapy involves the restructuring of disturbed family relationships in stages. At the first stage (diagnostic), there is a statement of the so-called family diagnosis, at the second stage - the elimination of family conflict. The third stage is reconstructive, and the fourth is supporting. There are modifications of the stages.

The variety of collective psychotherapy includes various medical clubs that pursue correctional and rehabilitation purposes. Heads of these clubs with the help of direct and secondary suggestive, rational and other techniques (for example, bibliotherapy, and music therapy) get a positive effect in working with patients with neuroses and alcoholism. Group psychotherapy includes the method of psycho-prophylactic analgesia of childbirth (K.I. Platonov and I.Z. Velvovskiy).

Group psychotherapy is especially effective at the maximum (definitely expressive) emotional impact on patients. This principle is based on the method of collective emotional-stress hypnotherapy, which is used for complex treatment of patients with alcoholism and neuroses, primarily to eliminate hysterical neurotic reactions and hysterical monosymptoms.

Narco-psychotherapy, or narcohypnosis, is a special method of psychotherapy, in which, together with the usual linguistic and psycho-emotional influence, inhalations of nitrous oxide or intravenous injection of barbamy (amytal sodium), hexenal, Pentothal and other barbituric acid preparations are used to increase suggestibility. Partial anesthesia leads to greater effectiveness of psychotherapy, in particular, in such a state patients more fully reproduce amnesic facts. It is preferable to combine sessions of narco-psychotherapy with extended sessions of hypnotherapy. Contraindications to narco-psychotherapy are hepatitis, cirrhosis, cardiovascular disorders.

Modification of the main methods of psychotherapy.

The method of exciting memories by Moro: the doctor focuses attention on the moments associated with the exciting views of the patient, and thereby achieves an increased emotional state, resulting in a change in the attitude to what is happening during the psychotherapeutic session, and to the personality of the doctor himself, which contributes to the therapeutic effect.

The method of Socratic dialogue by Kretschmer: this is the effectiveness in working with intellectual patients, for whom a well-organized discussion in the form of a well-reasoned interview is important.

The technique of therapy by ignoring (refuting) is oriented towards repression and refutation of painful and exciting experiences. For the most part, the therapeutic effect is carried out in a categorical, imperative form.

There are a number of effective techniques for patients with infantile-hysterical personality. *The method of imagotherapy* (I.S. Volperg, 1972) is a kind of game psychotherapy. The patient participates in improvised dramatizations, where he reproduces the represented image, which produces a positive therapeutic

effect on it. Imagotherapy is successfully used in children's and adolescent psychotherapy.

Pathogenetic psychotherapy (the system of psychogenetic analysis of V.N. Miasischev with co-authors). With the guidance of a doctor, the patient analyzes his life in detail, discovers biographical moments that could cause pathological symptoms and, based on this knowledge, is willing to develop such personality traits and behaviors that would help him overcome neurotic or other symptoms.

The therapeutic tactics of domestic psychotherapy is based on its combination with pharmacotherapy, hormone therapy, physiotherapy, occupational therapy, resort factors and other medical measures for the purpose of mutual potentiation of methods.

The drug effect depends to a large extent on the secondary psychotherapeutic, severe influence of the doctor who prescribes the medication. B.E. Votchal believed that 60% more effective treatment is associated with the psychotherapeutic effect, which is created by the mechanisms of hetero- and autosuggestion. Psychopharmaceuticals (antipsychotics and antidepressants) are effective in combination with the methods of both individual and collective psychotherapy. The exacerbate effect of psychopharmaceuticals and emotional impact, as well as additional reflexotherapy, physiotherapy, occupational therapy, therapeutic exercises, increase the overall effect of psychotherapy.

In modern psychotherapy, various concepts, theories and directions of different approaches, methods and techniques are used. Each of the approaches has its own idea of the features of the mental world and the leading mechanisms for the development of neuropsychiatric disorders. Below there are several separate psychological schools and their psychotherapeutic techniques.

Classical psychoanalysis (Freud and followers of the Austrian school). Psychoanalytic psychotherapy has the purpose of realizing subconscious painful experiences. Main methods: free associations and interpretation of dreams.

Psychosynthesis (R. Assagioli and others). Practice is based on the idea of integrating a complete personality with its constituent parts - subpersonalities. The main method: immersion in a special (semi-hypnotic) state of consciousness, as well as meditation. Meditation is a method of self-regulation through attention management and its concentration in a single object or process.

Positive psychotherapy (N. Pezeshkian). The main goal is to mobilize the patient's abilities and potential for self-help, preventive educational activities. Basic methods: the patient as a psychotherapist and therapy of the social environment.

Neuro-linguistic programming: NLP (R. Bendler, V. Grinder). The theory is based on the fact that a person receives information through five organs of perception (modalities): visual, audial, kinesthetic, olfactory and gustatory. The sequence of using the modality of a person for processing information is a strategy of the individual in his vital actions. Human subjective experience depends on the individual characteristics of the strategies used and the degree of development of each modality. The goal of NLP is to teach the ability to allocate the strategies and

modalities of their communication partners and apply them in the optimal ratio for themselves. The main method: work with modalities.

Logotherapy (V. Frankl) is the direction of this theory to get the meaning of life. The absence of the purpose of life is associated with “existential frustration”. The main therapeutic technique is the paradoxical intention (to wish for something instead of being afraid of it, for example: “I want to be anxious”). Logotherapeutic approach is based on the concept and anti-concept: the patient with the help of an alternative concept can see the situation in a different way, and thus it acquires a new meaning for him.

Non-directive (client-centered) psychotherapy (K. Rogers). The main emphasis is the acceptance of the patient as a person, regardless of his behavior at the moment. The main therapeutic method is the present (congruent) attitude and behavior of the therapist.

Gestalt therapy (F. Perls). The main task is to free a person from eroticizing emotionally unreactive, behavioral, unfinished situations. The main therapeutic principle is “here and now”: teaching the patient to live in the present, to see and feel what is really happening around.

Transactional analysis (E. Berne). “Transaction” in a specifically psychoanalytic meaning means to make a psychological agreement between two persons, and in a broad sense - as any element of relationships. The work is carried out with three basic states (“roles”) of “I”: “Father”, “Adult” and “Child”. The leading therapeutic technique is to teach us to distinguish these states of our “I”.

Indications for psychotherapy

The main techniques are used primarily for neurasthenia along with general restorative treatment. With characteristic for neurasthenia headaches and insomnia, hypnotherapy is indicated, with psychogenic impotence and frigidity - explaining conversations, self-hypnosis with autogenous training and hypnosuggestion sessions, hypochondriac syndrome - rational psychotherapy, autogenous training and hypnosis.

With the obsessive-compulsive personality disorder, rational psychotherapy is indicated, the aim of which is to convince the patient of the unreasonableness of his fear and to teach the autosuggestion system according to one of relaxation techniques of autogenous training. Symptoms of “mental cud”, agoraphobia and claustrophobia, cardiophobia, carcinophobia, as well as many other obsessive disorders, are best suited to autogenous medical treatment. Also, despite categorical denials to psychoanalysts, suggestion is effective.

Hysteria requires a particularly well-considered system of influence. While hysterical somatic vegetative monosymptoms (astasia-abasia, sensory organs disorders, contractures, amaurosis and slirdomutism) can be eliminated in one or more hypnosis sessions, then changing hysterical forms of response and behavior requires multifaceted and laborious work. It is required to reorganize the attitudes and views of the patient on life, his attitude towards it. The necessary complex of psychotherapeutic influences with obligatory involving family psychotherapy, with the purpose to develop healthy vital positions, contributing to the processing of an

egoistic stereotype, in particular in psychopathic persons of a hysterical type with a tendency to antisocial behavior. It should be taken into account the pathomorphism of hysteria due to social factors (light hysterical reactions prevail, and moderate severity).

In the hysterical reaction and reactive states caused by conflict situations and severe experiences as a result of the loss of loved ones or their illness, receptions of distracting and protective psychotherapy (hypnosis-rest and prolonged hypnosis) are also indicated. Hysterical and obsessive states can be combined with other neurotic disorders, so the doctor often treats patients with mixed symptoms, which should also combine therapies.

In psychopathy, psychotherapy solves corrective and educational problems with the help of labor therapy and environmental impact, as well as with the help of healthy social attitudes. Heterogeneous and autogenic psychotherapy is used, hypnosis is of primary importance. With expressed psychopathy, the psychotherapeutic effect is combined with psychopharmacological treatment (Seduxen, Elenium).

The psychotherapy of alcoholism and drug addiction is the obligatory background, without which one should not rely on the success of any other therapy. Starting from preventive anti-alcohol conversations and ending with the treatment of severe forms of alcoholism and drug addiction, psychotherapy should be an independent therapeutic factor and a mean of potentiating medical, conditioned reflex, sensitizing, labor therapy and other types of treatment. The explanation of the medicinal effect, the sessions of suggestion in a state of wakefulness and hypnosis (the method of collective and emotionally stressful hypnotherapy of alcoholism), autosuggestion and autogenic training are of great importance. The system of re-education by work acquires a rehabilitative value for the personality of such patients. It is also effective to apply the system of psychotherapeutic dispensaries for the treatment of patients with alcoholism, where creative work and material interest are used while using collective rational and hypnosuggestive psychotherapy, as well as the positive influence of a healthy environment.

Psychotherapy increases the therapeutic capacity of endogenous and organic mental illnesses as a mean, helps to conduct other therapeutic measures and potentiates their action.

In the case of schizophrenia, at certain stages of the disease with a low-prograde course without psychosis, psychotherapy acquires the main therapeutic value, becomes a support that helps patients to maintain their capacity for work, adapt to the environment and do not apply for inpatient care. In schizophrenia with delusions of hypnotic and physical influence, the use of hypnotherapy is contraindicated.

In the treatment of epilepsy, psychotherapy helps to comply with the regime. Psychotherapy is an integral part in the system of medical activities for many mental illnesses of late age.

Open wide opportunities for the use of psychotherapy in somatic diseases. With cardiovascular pathology, psychotherapy helps in the prevention of angina

pectoris, hypertension, and the treatment of all stages of myocardial infarction. The role of psychotherapy in the complex of therapeutic measures with bronchial asthma is universally recognized. Multifaceted possibilities of psychotherapy in gastroenterology, for example, with peptic ulcer of stomach and duodenum, gastritis, colitis.

In surgery, psychotherapy was introduced by S.I. Spasokukotskyi, S.S. Yudin, N.N. Petrov, A.V. Gulyaev, S.L. Doletsky, L.A. Durnov, etc. Psychotherapy is indicated both in the preoperative and postoperative period. Its role in pediatric surgery is very important. For anesthesia during the operation, various types of narcohypnosis have been developed, for example, a combination of anesthetics with a hypnosuggestive effect, which makes it possible to obtain an analgesic effect with a significant reduction in the anesthetic. With dental interventions, painful hypnosuggestion is successfully used to alleviate pain. Treatment of phantom pain is sufficiently effective.

Psychotherapy can be used by obstetricians-gynecologists for violations of lactation, dysmenorrhea, amenorrhea, menorrhagia, and vaginismus. The hypnosuggestive effect is especially effective with unquenchable vomiting of pregnant women and with the elimination of ancestral pain.

Dermatologists use psychotherapy in the treatment of neurodermatitis, psoriasis, lichen acuminatus, erythema nodosum, warts, etc.

In pediatrics, psychotherapy is used in the system of general educational, correction influence, as well as for the treatment of urinary incontinence, stammering, pathological habits (finger sucking, nail-biting, trichotillomania, etc.)

A special place belongs to psychotherapy in the system of medical measures carried out in sanatorium-and-spa institutions. The combination of heliotherapy, balneotherapy and thalassotherapy with other methods of physiotherapy and mechanotherapy, therapeutic exercises, mineral water treatment creates the conditions for the effective use of psychotherapy, which increases the effect of these methods. It is necessary to combine psychotherapy with psycho-hygiene and psycho-prophylaxis. In this case, special importance is acquired by preventive measures, the purpose of which is not to allow the development of subclinical neuropsychiatric disorders in a clinically pronounced pathology.

Psychological counseling

Psychological counseling is a relatively new professional sphere of psychological practice, which is a kind of psychological help. This direction comes from psychotherapy and is directed at a clinically healthy individual, who alone cannot overcome worldly difficulties. In other words, the key task of this method lies in helping individuals to find a way out of the existing problematic circumstances over which they cannot win without assistance, are unable to recognize and change inefficient behavioral patterns for making crucial decisions, resolving current life difficulties, achieving their goals. On the target direction, problems of psychological counseling are divided into corrective effects, and tasks aimed at achieving the client's personal growth, self-development and life success.

Fundamentals of psychological counseling

Consultation is a set of activities aimed at helping the subject in solving everyday problems and making crucial decisions, for example, regarding family and marriage, professional growth, self-improvement of the effectiveness of interpersonal interaction.

The purpose of this method of psychological support is to help individuals in comprehending what is happening on their life path and achieving the intended goal, based on an informed choice in resolving emotional problems and interpersonal difficulties.

All definitions of psychological counseling are similar to each other and include several important positions.

Psychological counseling contributes to:

- the conscious choice of the individual to act according to his own discretion;
- learning new behavior;
- development of personality.

The main element of this method is the “consolatory interaction” that occurs between the specialist and the subject. The emphasis is on the responsibility of the individual, in other words, counseling recognizes that an independent and responsible person is able to make decisions under certain conditions, and the consultant's task is to create conditions that encourage the willful behavior of the individual.

The goals of psychological counseling are borrowed from various psychotherapeutic concepts. So, for example, followers of the psychoanalytic trend see the task of counseling in the transformation into conscious images of repressed information to unconscious, helping the client in recreating the early experience and analyzing repressed conflicts, restoring the basic personality.

Predetermining the goals of psychological counseling is not easy, because the goal depends on the client's needs and the theoretical orientation of the consultant himself. Below there are several universal tasks of counseling, which are mentioned by practitioners of different schools:

- to promote the transformation of behavioral responses for a more productive life of the client, increase the level of satisfaction with life, even if there are certain indispensable social restrictions;
- to develop skills to overcome difficulties when facing new daily circumstances and conditions;
- to ensure the effective adoption of important decisions;
- to develop the ability to make contacts and maintain interpersonal relationships;
- to facilitate the growth of personal potential and self-realization.

The approaches of psychological counseling are characterized by a common system model, which combines six consecutive stages.

At the **first stage**, problems are investigated. The psychologist establishes a contact with the individual (report) and attains a mutual trust: the psychologist listens attentively to the client, who narrates about his everyday difficulties, expresses maximum empathy, ultimate sincerity, care, and does not resort to

evaluation and manipulative techniques. The consultant should choose incentive tactics that help the client's in-depth consideration of his problems, and note his feelings, the content of the replicas, non-verbal behavioral reactions.

The next stage is a two-dimensional definition of the problem situation. The consultant is committed to an accurate description of the client's problem, emphasizing both emotional and cognitive aspects. At this stage, there is a clarification of problematic issues until the client and the psychologist do not equally see and understand them. Problems are formulated by specific concepts that allow them to comprehend their causes, and in addition, often point to possible ways to resolve them. If there are ambiguities and difficulties in identifying problems, then it is necessary return to the previous stage.

The third stage is the identification of alternatives. At this stage, potential solutions to problems are being established and discussed. The consultant, using open questions, encourages the subject to list all possible alternatives that the latter finds suitable and real, facilitates the finding of additional options, but does not impose one's own decisions. During the conversation, it is recommended to write a list of alternatives in order to facilitate their comparison and comparison. It is necessary to find such options for solving a problematic issue that the subject could apply directly.

The fourth stage is planning. Critical evaluation of selected alternatives is carried out there. The consultant helps the subject to understand which options are appropriate and show themselves realistic in accordance with previous experience and today's readiness for change. Drawing up a strategy for realistic solution of difficult situations is also directed at understanding by the client that not all difficulties are solvable: some of them require the costs of a temporary resource; others can be partially resolved by reducing their destructive and disorganizing impact. At this stage, in the aspect of problem solving, it is recommended to envisage, by what methods the subject will be able to verify the realism of the solution preferred by him.

The fifth stage is activity itself, that is, a consistent implementation of the strategy for solving problems is taking place. The psychologist helps the client build activities, taking into account the circumstances, emotional and time costs, as well as the possibility of failure in the implementation of goals. The individual must realize that a partial failure does not yet become a complete failure, therefore, one should continue to implement a strategy for resolving difficulties, directing all actions to the ultimate goal.

The last step is to evaluate and maintain feedback. The subject together with the psychologist at this stage evaluates the degree of achievement of the goal (that is, the level of resolution of the problem) and sums up the results achieved. If necessary, it is possible to detail and refine the decision strategy. In the event of the appearance of new or detection of deep-seated problems, one should return to the previous stages.

The model described reflects the content of the consultative process and helps to better understand how specific counseling flows. In practice, the counseling process is much more extensive and is often not always guided by this

algorithm. In addition, the selection of stages is conditional, since in practice some stages are connected to others, and their interdependence is much more complicated than that presented in the described model.

Types of psychological counseling

Due to the fact that people belonging to different age categories need free psychological assistance and are in a relationship characterized by a variety of problems, psychological counseling is divided according to the problem situations of clients and their individual characteristics into species, namely individual psychological, group, family, psychological-pedagogical, professional (business) and multicultural counseling.

First of all, individual psychological counseling (intimate-personal) is allocated. This type of counseling is addressed by individuals on issues that deeply affect them as individuals, provoking their strongest experiences, often carefully hidden from the surrounding society. Such problems, for example, include psychological disorders or behavioral deficiencies that the subject wants to eliminate, difficulties in personal relationships with relatives or other significant persons, all kinds of fears of failure, psychogenic illnesses that require medical help, deep dissatisfaction with themselves, problems in the intimate sphere.

Individual psychological counseling simultaneously requires a consultant-client relationship, closed from third parties, and trusting, open relationships for interaction between them. This type of counseling should be conducted in a special setting, as it often reminds confession. Also, it cannot be of an episodic or short-term nature, due to the content of problems, for the solution of which it is purposeful. In the first turn, individual counseling assumes a great psychological pre-adjustment of the psychologist and the client himself for the process, then a long and often difficult conversation between the consultant and the subject, after which there is a long period of searching for solutions to the difficulties described by the client and directly solving the problem. The last stage is the longest, since most of the problematic issues of an intimate-personal orientation are not immediately solved.

A variety of this type of counseling is age-related psychological counseling, which includes issues of mental development, the characteristics of upbringing, and the principles of teaching children of different age subgroups. The subject of such counseling is the dynamics of development of the child and adolescent psyche at a certain age stage of formation, as well as the content of mental development, which is a significant difference from other types of counseling. Age psychological counseling solves the problems of systematic control over the course of the formation of children's mental functions for optimization and timely correction.

Group counseling is aimed at the self-development and growth of participants in the process, liberation from everything that is on the path to self-improvement. The benefits of the described type of psychological assistance before individual counseling are the following:

- group members can learn their own style of relationships with the environment and acquire more effective social skills, in addition, they have the opportunity to conduct experiments with alternative forms of behavioral response;
- clients can discuss their own perceptions of others and receive information about their perception by the group and individual participants;
- group reflects, in some way, the familiar environment for its participants;
- as a rule, groups offer participants understanding, assistance and help, which increases the participants' determination to study and resolve problem situations.

Family counseling involves assisting in issues related to the client's family and relationships in it, relating to interaction with other close associates. For example, if the individual is concerned about the upcoming choice of a life partner, the optimal construction of relationships in a future or current family, the regulation of interactions in family relations, the prevention and correct solving intra-family conflicts, the relationship of spouses between themselves and relatives, the behavior of divorce, the resolution of various current family problems, then family psychological counseling is needed.

The described type of psychological assistance requires consultants to know the essence of intra-family problems, ways to solve difficult situations and methods for their resolution.

Psychological and pedagogical counseling is in demand when it is necessary to cope with difficulties that are associated with teaching or raising children, when it is necessary to improve the pedagogical qualification of adults or teach the management of different groups. In addition, the psychological substantiation of pedagogical and educational innovations, the optimization of means, methods and training programs are relevant to the variety of counseling described.

Business (professional) counseling, in its turn, is characterized by as many varieties as there are professions and activities. This type of assistance considers issues that arise in the course of occupations by subjects of professional activity. This includes the issues of vocational guidance, improvement and formation of individual skills, organization of work, increasing efficiency, etc.

Multicultural counseling is aimed at interacting with individuals who perceive a different social environment, but at the same time try to cooperate.

The effectiveness of advisory assistance to clients differing in cultural-mediated characteristics (sexual orientation, gender, age, professional experience, etc.), and besides, the possibility of understanding these clients and their requirements is interrelated with the cultural characteristics of the psychologist and the manners adopted in a certain social culture organization of practices of psychological counseling.

Conducting a consultative work requires a number of personal qualities and specific characteristics from a counselor-psychologist. For example, an individual practicing this technique must necessarily have a higher psychological education, love people, be sociable, astute, patient, good and responsible.

Psychological counseling techniques

Specific techniques that the consultant applies at each stage of the counseling procedure and within these stages are called counseling techniques. They are universal, successfully applied at any stage of counseling, and specific, which are most suitable for a particular stage of the process.

Techniques should be considered in accordance with the stages of the model of psychological counseling.

The first stage (the beginning of the work and the first procedure) is marked by the meeting of the subject with the consultant. The techniques applicable to this task include greeting an individual, guiding him to the place, choosing place in the room by the individual, choosing place in the room by the counselor, methods of establishing psychological contact.

Welcoming techniques are implemented through standard phrases, for example: "It's nice to meet you", "I'm glad to see you".

The technique of "guiding a potential client to the place" is appropriate when the subject is first consulted. It looks like this: the consultant is going ahead of the individual, shows him the way and lets him take the lead when entering the office.

Establishing a positive attitude of the client is the second procedure of this stage. The main technique here is the establishment of rapport. It can be installed by everyone that is capable of producing a favorable impression: a neat appearance, observance of the communication zone, a benevolent facial expression.

The third procedure is the release from psychological barriers. The client feels excitement, which special techniques will help to remove. For example, it is acceptable to let him stay alone for a while, to turn on calm, unobtrusive music, which will also help create a favorable climate.

The second stage is the collection of information. The first procedure covers the diagnosis of the client's personality, in which the following methods are used: observation, conversation, and interview.

Clarifying the nature of the problem and determining the resources of the client is the second procedure. Applied techniques: dialogue and listening.

Activating the client's memory is the third procedure. Used techniques: help in the formulation of statements and the identification of genuine feelings, psychological support of the subject, provoking the client, saturating the pauses. In order to assist the subject in determining true feelings and their conversion into verbal form, methods of active listening are used.

The technique of "saturation of a pause" involves the use of pauses by the consultant. He can fill them with a question or a metaphor or "keep a pause".

The technique of "provocation" is based on questioning the client's words. Its goal is to help the subject see a difficult situation from a different side.

Stage three is the formulation of a strategy. The first procedure involves defining probable solving problem situations. With this purpose, the following techniques are applicable: advice, informing the individual, persuasion and clarification.

The technique of “advice” involves sharing an opinion of the consultant and a further joint discussion.

The technique of “informing” speaks for itself. It is also important that the information communicated by the consultant conforms to such requirements as objectivity, availability, concreteness.

The technique of “persuasion” is a logically stated argumentation that proves the correctness of the proposition expressed.

The technique of “clarification” is a detailed and concrete explanation of the consultant's judgment regarding the client's problem.

The second procedure is the coordination of the action plan. Applicable techniques: finding multiple solutions, specifying the expected result, stimulating questions, establishing an algorithm for solving.

Before developing a specific strategy, you need to maximize the likely solutions. For this, the Diltz technique is excellent: to offer to the subject to come up with incredible ways to solve the problem issue. There must be at least twenty assumptions.

Psychological counseling of children and parents also has differences in the practiced techniques, related to child immaturity and lack of independence.

Stages of psychological counseling

Nemov developed a consultation model that includes the following basic stages of the psychological process: *preparatory, tuning, diagnostic, advisory, control stages*.

Getting to know a potential client from information about him obtained from others, for example, from a specialist in psychological counseling, who received the application for consultation from a future client, as well as from a record in the registration journal, occurs at the *preparatory stage*. In addition, this stage involves the preparation of a consultant for consultation. It lasts 30 minutes in average.

The second stage of psychological counseling is the meeting of the subject with a consultant. The psychologist gets acquainted with the potential client and is set up for joint interaction with the client. The duration of this stage is not more than 7 minutes.

At *the diagnostic stage*, the consultant listens to the client's confession, clarifies the problem, based on its analysis. The key content of this stage is the narration of the client about the person and the problem. This narrative is called confession. In addition, the described stage may include a subject's psychodiagnosis, if necessary, to clarify the individual's problem and find the optimal solution. It is impossible to precisely establish the necessary time for the passage of this stage, since its establishment depends on the nature of the problem and the individual characteristics of the client.

The advisory stage involves the formulation by the client and the consultant of practical recommendations for solving the problem. At this stage, the developed recommendations are refined, concretized, and detailed. The average duration is up to 60 minutes.

The control stage includes the establishment of standards for monitoring and evaluation of the practical implementation of practical advice received by the client. The average duration is up to 30 minutes.

Medical rehabilitation is the process aimed at restoring and compensating the functional capabilities of the human body, as a result of a congenital defect, a disease or injury using the medical and other methods.

The main goal of medical rehabilitation is to prevent disability, restore and prolong active life, social integration and ensuring an acceptable quality of life. The maximum task is to achieve the full level of social and consumer services; the minimal task is to increase the patient's ability to self-service.

Principles of medical rehabilitation:

- a) early onset;
- b) continuity;
- c) step-by-step approach (stationary stage, polyclinic stage and sanatorium-resort stage);
- d) succession;
- e) complex nature of rehabilitation;
- f) individual approach.

In the organization of medical rehabilitation, there are 2 directions:

1. Integration of rehabilitation in the treatment process.
2. Establishment of a medical rehabilitation service (since 1993), in which it has been allocated 2 types of institutions:
 - non-specialized (they are organized at the regional level, these are multi-disciplines of medical rehabilitation);
 - specialized (they are created by nosology at the regional and national level).

Rehabilitation: definition, types.

Rehabilitation is a set of measures of various nature aimed at reducing the impact of disabling factors and conditions that lead to physical and other defects, as well as ensuring that the disabled person can achieve social integration. This is an interdepartmental notion (not only doctors should be involved in rehabilitation).

The main types of rehabilitation:

a) medical rehabilitation is the process aimed at restoring and compensating by medical and other methods the functional capabilities of the human body, impaired due to a congenital defect, past illnesses or injuries;

b) medical and professional rehabilitation is the process of restoring the working capacity, combining medical rehabilitation with the definition and training of professionally significant functions, the selection of a profession and adaptation to it;

c) professional rehabilitation is the system of measures that provide an opportunity for the disabled person to get a suitable job or keep the old one and move ahead in the work (service), thereby contributing to its social integration or reintegration;

d) labor rehabilitation is the process of employment and adaptation of a disabled person at a specific workplace;

e) social rehabilitation is the system of activities that ensure the improvement of the living standards of disabled people, creating equal opportunities for them to participate fully in society.

Rehabilitation directions:

1) rehabilitation of patients is aimed at preventing a defect, preventing disability;

2) rehabilitation of disabled people is reducing the severity of disability, adapting the disabled person to the domestic and labor environment.

Levels of the prevention of disability:

a) primary prevention of disability - reducing the incidence of functions impair that hamper life and limit working capacity.

b) secondary prevention of disability - restriction of the degree of functions impair or reverse development with existing diseases, congenital or acquired defects.

c) tertiary prevention of disability - prevention of the transition of arising or congenital functional disorders at the level of disability to permanent defects, leading to the increase in disability and incapacity for work.

Control questions:

1. Give a definition of the concept of suicide.

2. What kinds of suicidal behavior do you know?

3. What is euthanasia?

4. Give a definition of euthanasia.

5. Give a definition of psychotherapy. List the main methods.

6. Give the definition of rehabilitation.

Tests

1. Satisfaction of the request of a death sick person to accelerate his death by any action or means is called:
 - A. Euthanasia
 - B. General thanatology
 - C. Suicidology
 - D. Reanimatology
 - E. Criminology

2. Dynamics and mechanisms of dying, the immediate causes of death, clinical, biochemical and morphological manifestations of the gradual cessation of the life of the organism are studied in:
 - A. Ethanasia
 - B. Tanantology
 - C. Suicidology
 - D. Reanimatology
 - E. Criminology

3. What type of suicidal behavior is characterized by a short pre-suicide; a suicidal decision occurs instantaneously, the thought of suicide appears suddenly; most often the first mean to hand is chosen, suicidal attempts are not always preceded by a specific occasion; the suicider usually does not think about the consequences of his actions, there is a discrepancy between the ultimate goal of suicide (death) and its psychological meaning?
 - A. True
 - B. Affective
 - C. Demonstratively blackmailing
 - D. Protest
 - E. Calling

Case studies tasks:

1. A patient with a hypertension that is forming against a background of prolonged overstrain at work is recommended by the doctor to conduct treatment with a psychotherapist. What method of psychotherapy would you recommend to this patient?

Questions and tasks for monitoring the knowledge and skills of students:

1. Definition, subject and objectives of medical psychology.
2. Methods of psychological research.
3. Principles of making a purposeful psychological conversation.
4. Definition of mental health and levels of psychological adaptation of a person.
5. Health criteria of the World Health Organization.
6. Influence of the features of age and chronic diseases on the person's personality.
7. Definition and typology of personal accentuation, tactics of behavior of a doctor with patients with accented personality traits.
8. Definition and classification of the main types of attitude towards the disease, features of the behavior of patients with these types of attitude towards the disease.
9. Diagnosis of the main types of attitude towards the disease.
10. Principles of psychotherapeutic correction of attitude towards the disease.
11. Influence of the disease on the cognitive processes of a person.
12. Influence of a patient's intelligence characteristics on the medical process.
13. Influence of the disease on the emotional-volitional sphere of a person.
14. Influence of the disease on the emotional state, nosogeny.
15. The role of volitional powers of an individual in the medical process.
16. Changes in the will and behavior during illness.
17. Consciousness, self-awareness, their levels.
18. Psychodynamic approach in medicine.
19. Criteria of undisturbed consciousness. States of consciousness in a patient.
20. Requirements for the personality of medical workers.
21. The concept of "duty of care" and "medical secrecy".
22. Medical mistakes: reasons and types.
23. Psychological types of doctors.
24. Professional deformation, "emotional burnout syndrome" and ways to prevent it.
25. Rules of deontology and subordination in the medical environment.
26. Types and features of communication in a medical environment.
27. Psychological features of the stages of the diagnostic process.
28. Principles of a doctor's communication with patients and their relatives.
29. Mechanisms of the emergence of conflicts.
30. Classification of conflicts.
31. Structure of the conflict.
32. Techniques of communicating with combative persons.
33. Features of the choice of the strategy of behavior in a conflict situation.
34. Basic rules for communication between a doctor and a patient.
35. Communication of a doctor with patients of different age groups.

36. Communication of a doctor with the patient's relatives.
37. Communication in the work collective.
38. Psychosomatic approach as a principle of therapeutic activity.
39. Emotional stress as a factor of etiopathogenesis of psychosomatic disorders.
40. Influence of psychological factors on the course of somatic disorders.
41. Theories of psychosomatic relationships.
42. Mechanisms of psychological protection of an individual.
43. The concept of adaptation and maladaptation, distress.
44. Classification of psychosomatic disorders. Non-pathological psychosomatic reactions.
45. Principles of the prevention of psychosomatic disorders.
46. Psychological changes due to diseases of the cardiovascular system.
47. Psychological changes due to bronchial and pulmonary diseases.
48. Changes due to diseases of the digestive tract.
49. Psychological characteristics of patients with infectious diseases, tuberculosis, AIDS.
50. Psychological characteristics of patients with endocrine, nervous and mental diseases.
51. Psychological changes in sick women in a gynecological hospital.
52. Psychological features of women during pregnancy and childbirth.
53. Features of the psychology of sick children and elderly people.
54. Psychological features of patients in a surgical hospital in the pre- and postoperative period, in orthopedics and traumatology.
55. Psychological characteristics of dentistry, ophthalmology, otolaryngology patients.
56. Psychological features of patients with oncological pathology.
57. Influence of congenital and acquired physical defects on the human mentality.
58. Psychological aspects of dependence on psychoactive substances, overvalued hobbies (gambling, Internet addiction), dependence of eating behavior.
59. Types of suicidal behavior, features of suicidal behavior in somatic patients and in patients with addictions.
60. Psychological aspects of dying and death.
61. The concept of “psychohygiene” and “psychoprophylaxis”.
62. Psychohygiene of the labor of a medical worker.
63. Principles of psycho-prophylaxis of work, life, family and sexual relations.
64. The role of a general practitioner in the prevention of nosopsychological manifestations.
65. Social and professional rehabilitation, its main sections.
66. Psychological and social rehabilitation of persons who became invalids during military service and other persons who suffered in the performance of duties of military service (official duties) in Ukraine.

67. The main modern methods of psychotherapy, the principles of psychotherapy.

68. Indications and contraindications for carrying out individual methods of psychotherapy.

69. Psychological aid in crisis periods.

70. Psychological features of medical care in emergency situations.

List of practical skills

1. Independently conduct a directed psychological conversation with patients, make a psychological history of illness and life, and evaluate the psychological state of the patient with the formulation of the conclusion of the experimental psychological examination.

2. Be able to identify accentuations of personality, as well as to conduct a differentiated psychocorrection of identified personality traits.

3. Determine the type of internal picture of the disease and the type of patient's attitude towards the disease.

4. Form an adequate attitude towards the disease in a patient and maintain it throughout the treatment and diagnostic process.

5. Differentiate the psychological features of patients with various somatic diseases, determine the need for psychological correction, taking into account the individual characteristics of the patient.

6. Give psycho-hygienic advice to a patient of a somatic profile.

7. Develop tactics of communication with patients and their relatives, taking into account the principles of medical ethics and deontology.

8. Evaluate and correct the patient's relationship with the medical staff.

9. Make an analysis of professionally important qualities of a doctor.

10. Be able to implement measures of primary psycho-prophylaxis of the syndrome of emotional burnout in a medical environment.

11. Know the basic diagnostic algorithms of states of dependence (chemical, Internet, gambling) and codependence and be able to apply them in practice for prevention and correction.

12. Know the main ways of psycho-prophylaxis of suicidal behavior and be able to identify suicidal tendencies in a timely manner.

Рекомендована література

1. Медична психологія: державний національний підручник / І.Д. Спіріна, І.С. Вітенко, О.К. Напреєнко та ін. – Дніпропетровськ: ЧП «Ліра» ЛТД, 2012. – 444 с.
2. Medical psychology. State National Textbook / I.D. Spirina, I.S. Vitenko, O.K. Napreenko et al. – Dnipropetrovsk: 2015. – 376 с.
3. Загальна та медична психологія (практикум) / Під заг. ред. проф. І.Д. Спіріної, проф. І.С. Вітенка. – Дніпропетровськ, АРТ ПРЕС, 2002. 176 с.
4. Любан-Плоцца Б. Терапевтический союз врача и пациента / Б. Любан-Плоцца, В. Запорожан, Н. Пряев. – К.: АДЕФ - Украина, 2001. - 292с.
5. Медична психологія/ За редакцією академіка С.Д. Максименка. Підручник. – Вінниця: Нова Книга, 2008 – 520 с.
6. Айві А. Цілеспрямоване інтерв'ювання і консультування. – К. Сфера, 1998.
7. Булах І.С., Кузьменко В.У., Помиткін Е.О. Консультативна психологія: підручник / І.С. Булах, І.М. Бушай, В.У. Кузьменко, Е.О. Помиткін, Ю.А. Алексєєва; Нац. пед. ун-т ім. М.П. Драгоманова, Ін-т соціології, психології та соц. комунікацій. – Вінниця: Нілан, 2014. – 484 с.
8. Васьківська С.В. Основи психологічного консультування. – К.: Четверта хвиля, 2004. – 256 с.
9. Вітенко І.С. Сімейна медицина. Психологічні аспекти діагностики, профілактики і лікування хворих / І.С. Вітенко, О.О. Чабан, О.О. Бусло – Тернопіль: Укрмедкнига, 2002. – 187с.
10. Діагностика, терапія та профілактика медико-психологічних наслідків бойових дій в сучасних умовах (методичні рекомендації) / П.В. Волошин, Н.О. Марута, Л.Ф. Шестопалова та ін. – Харків, 2014. –79 с.
11. Кюблер-Росс Э.О смерти и умирании. – К.: София, 2001. – 320 с.
12. Медична психологія. Навчальний посібник, рекомендов. МОНУ для студентів ВНЗ / Пшук Н.Г., Маркова М.В., Кондратюк А.І., Стукан Л.В. – Вінниця, 2010. - 136с.
13. Медична психологія: Підручник / І.С. Вітенко. – К.: Здоров'я, 2007.
14. Медична психологія : підручник / С.Д. Максименко, Я.В. Цехмістер, І.А. Коваль, К.С. Максименко ; за загальною ред. С.Д. Максименка. – 2-е вид. – К. : Слово, 2014. – 516 с.
15. Москленко В.В. Соціальна психологія. – К.: Центр навчальної літератури, 2008. – 688 с.
16. Особливості діагностики, терапії та медико-психологічної реабілітації вимушених переселенців з зони бойових дій, хворих на посттравматичний стресовий розлад. Методичні рекомендації / Спіріна І.Д., Леонов С.Ф., Рокутов С.В. та ін. – К., 2015. - 28 с.
17. Філоненко М.М. Психологія особистісного становлення майбутнього лікаря. – Київ: Центр учбової літератури, 2015. – 334 с.