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MEDICAL PSYCHOLOGY

methodical guideline for independent study of medical students

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CONTENTS

Subject and tasks of medical psychology and methods of examination of human mental state. Concept of mental health ... 3

Personality and a disease. Internal image of disorder ... 14

State of mental functions and a disease ... 25

Psychology of medical worker ... 41

Psychology of treatment and diagnostic process ... 53

Psychosomatic disorders in general clinical practice ... 67

Psychological peculiarities of patients with various diseases ... 77

Psychology of dependence, suicide, thanatology and euthanasia ... 92

Psychohygiene, psychoprophylaxis. principles of psychotherapy ... 111

List of questions for preparation of students for final modular control ... 126

List of practical works and tasks ... 127

SUBJECT AND TASKS OF MEDICAL PSYCHOLOGY AND METHODS OF EXAMINATION OF HUMAN MENTAL STATE. CONCEPT OF MENTAL HEALTH

Urgency: Doctor of any specialty in diagnostics of disease should take into account not only the patient's somatic state, but also be able to estimate the patient's individual psychological features. It promotes making trust relationships between a doctor and a patient, improves the quality of diagnosis of diseases and leads to overcoming of social and psychological factors playing a role in their onset and progressing.

General objective: to estimate the patient's mental state and level of their social-psychological adaptation with the methods of psychological examination.

Concrete objective:

1. To know the main tasks of medical psychology
2. To understand the place of medical psychology among other branch of medical science
3. To leam the concepts "mentality", "mental health"
4. To understand the principles and methods of psychological examination, to be able to interpret its results.

Use the literature:

1. Essentia! of medical psychology: manual for medical students, interns, [illegible] - Kharkiv: "Region-inform", 2003. - 188 p.
2. Summary of lectures
3. Graphological structure of the topic

Theoretical questions:

1. Definition, subject and tasks of medical psychology
2. Methods of psychological examination
3. Principles of directional psychological interview
4. Estimation of human mental health and levels of psychological adaptation
5. Criteria of health by WHO

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. Psychology is directly connected with philosophy and other sciences about man. It plays an important role in scientific cognition of regularities of developing the personality, his ideological, intellectual, ethical and aesthetic aims and values. 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. The general psychology gives the doctor methods giving an opportunity to notice slight changes in the **patients**

mental state, observe a course of disease step by step noticing positive and negative influence of methods of treatment.

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 place of medical Psychology in clinical medicine is determined by the object of research of these sciences, e.g. by sick person who has changed mentality in any disease. The basic points of contact of these sciences are the psychological peculiarities in doctor's behaniour, correction of mentality while treating the patient and psychotherapeutic influence. Medical psychology is connected with all medical specialties (therapy, surgery, obstetrics, gynecology, paediatrics, hygiene and others). It has some specific methods and thus it plays an important role in doctor's training in any specialty.

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 behaviour 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.Scchenov, 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.Zmchenko, L.I.Bozovich and others.

Before describing the methods used in medical psychology it is necessary to concentrate on the basic stages of experimental psychological examination.

On the preparatory stage the question (hypothesis) that should be answered is formulated. This question is mostly about differential diagnosis, the causes or factors which determine the specific character of one or other course of the disease, determination of individual psychological peculiarities of the patient's personality.

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

After the problem is formulated it can be found out how and to what extent all possible phenomena influence the event that is interesting for an examiner. Such a preliminary answer to the question about the character of the connection of events is a hypothesis. The main demand to hypothesis is the possibility of its checking. Some various hypothesis may arise while planning the examination; in this case they are checked consequently.

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.

The methods of clinical interview and observation are the main methods used by doctors and medical psychologists in their everyday practice.

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. The success of the interview depends on the examiner qualification that presupposes the capability to establish the contact with an examined person, to give him an opportunity to

express himself as freely as it is possible.

In the process of clinical interview, the patient's history and his complaints are taken. History taking permits to form an opinion about the character of the disease, its causes and development, peculiarities of its course and clinical manifestations. Taking a case history the doctor can reveal the neuropsychic state of the patient before the disease. He can also find out whether the patient was treated before and if so in what departments he was treated and how effective the treatment was. The case history allows the doctor to determine the attitude of the patient to his disease, the peculiarities of the psychological reactions to the disease. Interviewing the patient, the doctor both estimates the facts and has the opportunity to determine the psychological peculiarities of the patient. It is necessary to afford an opportunity for the patient to speak on his own about his life and disease. However, the interview with the patient should be guided by the doctor. It is very important to ask questions to the patient correctly and in the certain order and form. It is not possible to inspire the patient these or other sensations asking him questions (for example, it is sometimes enough to ask the patient whether he has pains in the heart region and he begins to feel them). Intimate questions about the patient's life should be asked with special delicacy. The doctor should take into account how attentively and thoughtfully the patient listens to his questions.

However, the patients that suffer from annoying sensations or pains can think that either a doctor did not examine them carefully or their disease is very serious and incurable. Besides, some of them try to stay sick after the recovery being afraid of reverting to their old healthy mode of life. In this case, we can say that the patient is aimed at the disease. Sometimes patients underestimate the severity of their disease and either they don't complain at all or alleviate the degree of its manifestations.

Clinical interview is an important method of examination of a patient and interaction between the doctor and the patient, doctor's influence on the patient.

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.

The advantage of this method is that during the observation the natural course of mental phenomena is not broken. The disadvantage of the observation is that it does not allow to determine the cause of a certain mental phenomenon precisely, because it is not possible to take into account all interrelations of a mental phenomenon in the process of observation.

Observation is carried out under usual living conditions: in families, at

work, game, during studies, in a hospital ward. Independent activity, observation, reaction peculiarities of a patient, his relationship with other people are taken into consideration. Observation should be purposeful, that is follow some certain tasks. In medical practice it allows to estimate the patient's sleep, appetite, mood, psychic activity, etc.

Experiment. An experiment differs from observation because it presupposes the arrangement of a clinical situation which allows to carry 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 observer is interested in any interrelation of phenomena, but in an experiment under certain conditions it is possible to introduce a new element and to determine whether this or that change in the situation takes place. An examiner expects this situation as a consequence of the change made by him, but an observer has to wait for the change which may not take place. An experiment can be divided into 4 types: laboratory, natural, establishing and forming. The disadvantage of this method is that it is hard to arrange it in order an examined person not to know what is going on. Thus, an examined person can reveal constraint, diffidence, conscious or unrealized anxiety, etc.

Psycho-diagnostic examination. On the basis of the psycho-diagnostic examination the hypotheses about the dependences between different psychological description are checked. When their peculiarities are revealed in the sufficient number of the examined, it is possible to determine their interrelation on the basis of the proper mathematical procedures. The demands to both the psycho-diagnostic examination and the experiment arc the same: variable control.

Psycho-diagnosis as a field of psychology deals with the estimation of personality psychological characteristics. 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. Their systematic expression is tests and questionnaires whish are also called methods. The methods make it possible to collect the diagnostic information in the relatively short time, they give the general information about the person, about these or those **of** his peculiarities in particular (his intellect, anxiety, etc.), they allow to make a quantitative and qualitative comparison of an individual with other people. The information

received with the help of psycho-diagnostic methods is useful with regard to the selection of interference means, the prognosis of its efficiency, development, contact, effect of this or that individual activity.

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.

Psycho-diagnosis uses a number of experimental psychological methods or tests which help to estimate the functioning of both separate areas of mental activity and integrative formation such as temperament types, personality peculiarities, personal traits.

There are verbal (language) and non-verbal (picture) tests. Two groups of tests - standard and project - are usually distinguished.

The test directed toward estimation is called a standard test (maturity, creativity, aptitude tests).

However, there are tests that are not directed toward the estimation indices, but toward the qualitative personality peculiarities. Project methods belong to this group of tests. They are based on the fact that the personality is realized through various manifestation of an individual including some hidden unconscious needs, conflicts, feelings. Thus the main thing is subjective contents and attitude that a test can cause in an examined person, and it allows to make conclusions about the personality peculiarities.

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.

Questionnaires-surveys give an opportunity to get such information about the examined person that doesn't show directly his personality characteristics. They are biography, interests, aims questionnaires, for example.

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.

The analysis of psychological examination methods shows that they are not isolated, i.e. they can be the components of one another.

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

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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 Storv reproduction
Attention	Schulte's tables Proof test Anfimov's tables Counting bv 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
Personality	Rorschach's test MMPI Topical apperceptive test (TAT)

The last stage of experimental psychological examination necessarily contains a written conclusion based on the received data.

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 behaviour 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.

Corresponding to criteria of WHO, mentai 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 behaviour 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.

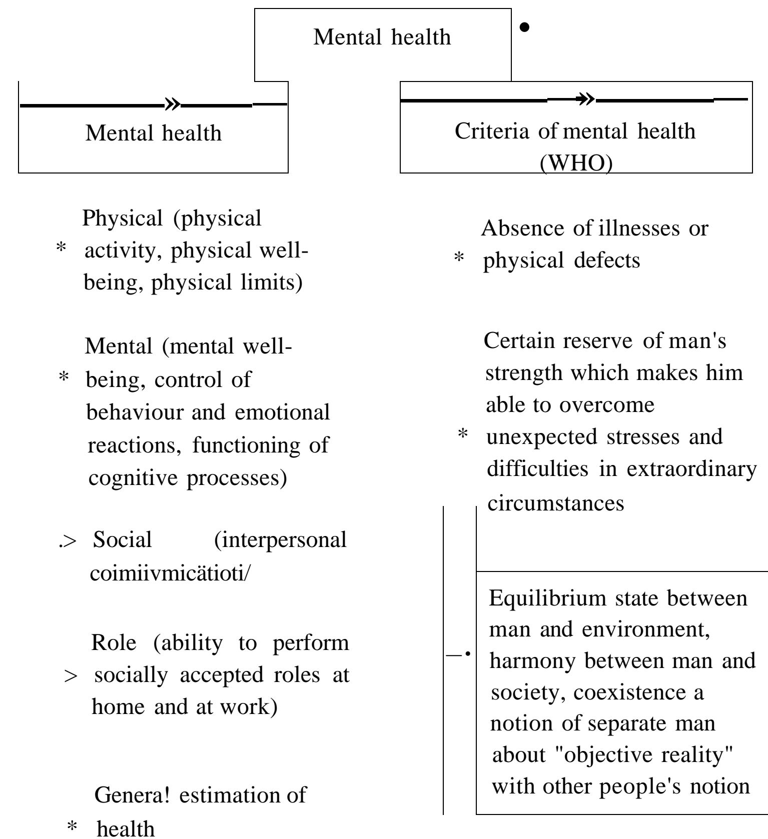
Methodical guidelines for the student's work at practical lesson.

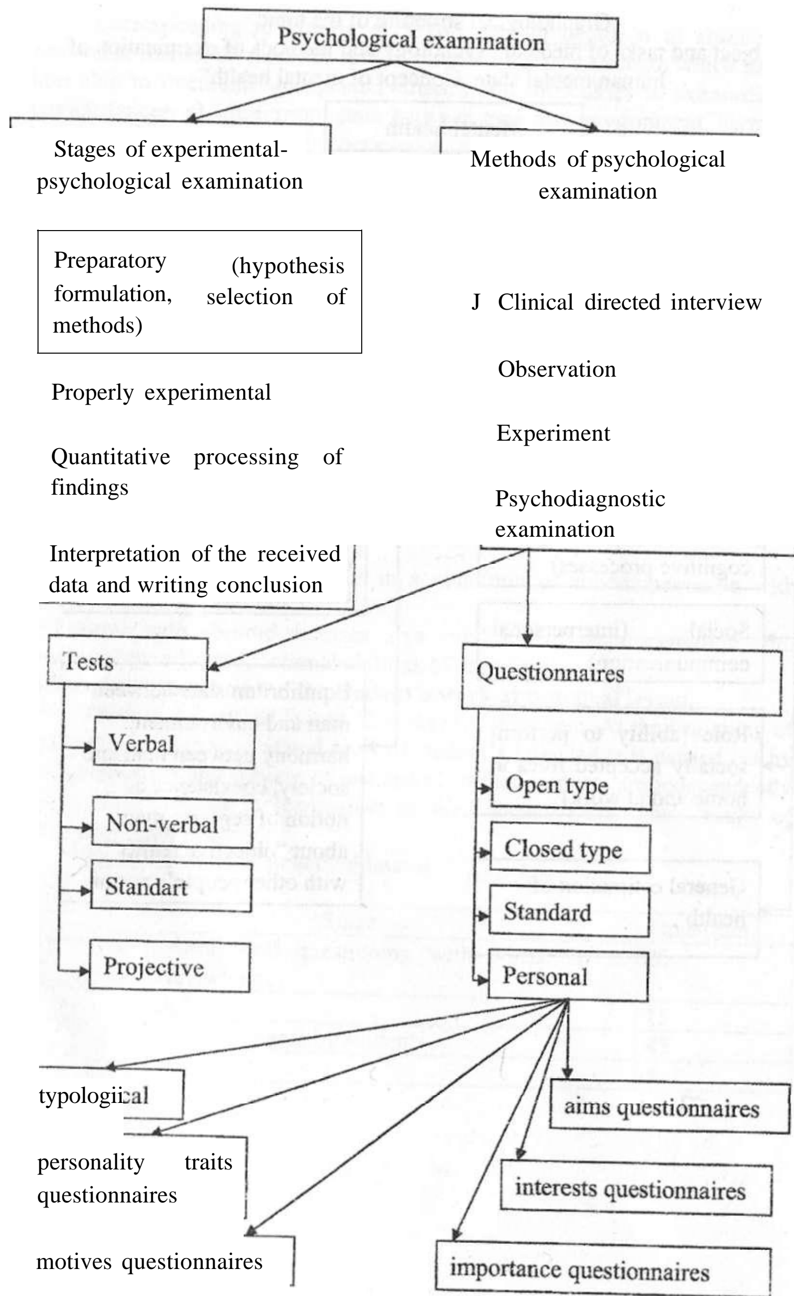
There is **1** practical lesson (2 hours) for this topic. At the beginning of lesson the estimation of initial level of student's knowledge is carried out by oral questioning and solving of test tasks. Further students **are** independently speaks with patients for estimation of their mental state. Then results of examination are discussed.

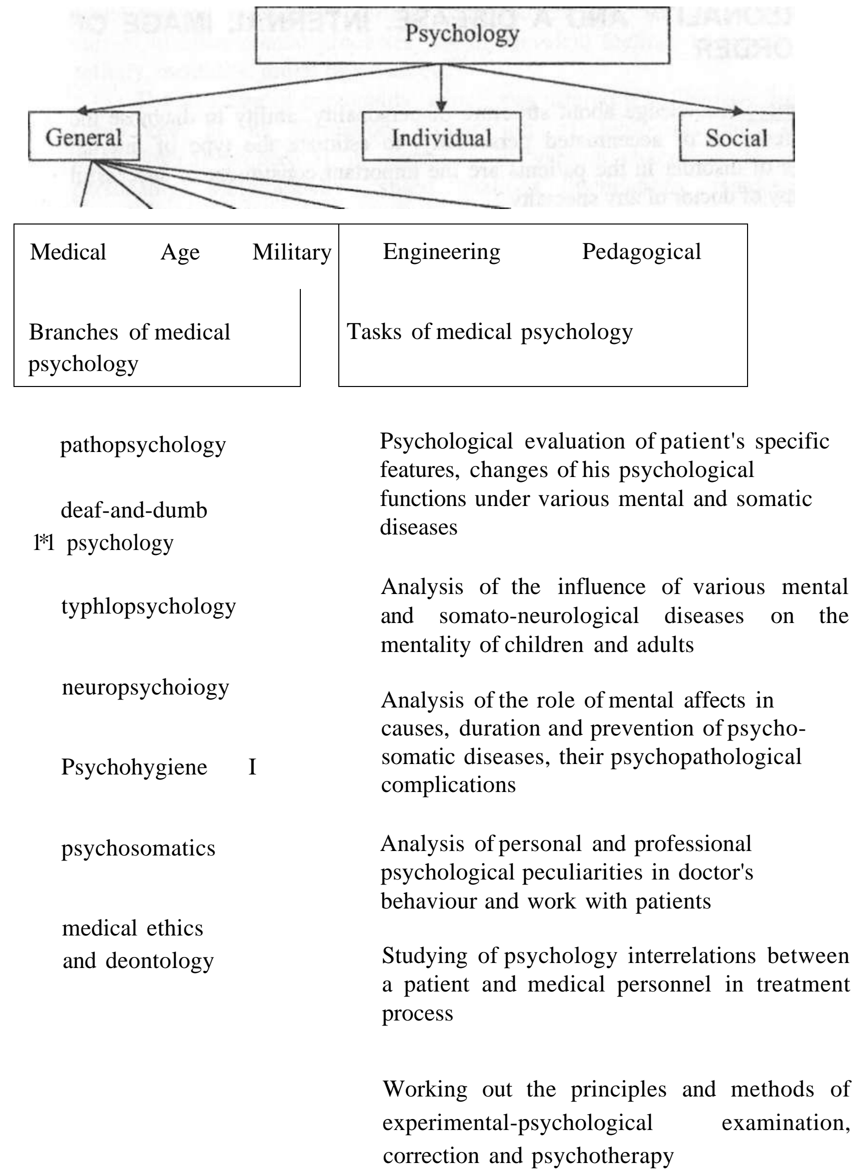
Planning sheet of practical lesson

No.	Stage	Time (min)
1	Initial control (oral questioning with correction of student's knowledge)	25
2	Test control	15
Í	Examination of patients by students	45
4	Conclusion	5

Graphological structure of the topic
"Subject and tasks of medical psychology and methods of examination of human mental state. Concept of mental health"




Psychological examination
Stages of experimental-psychological examination
Methods of psychological examination
Preparatory (hypothesis formulation, selection of methods)
Properly experimental
Quantitative processing of findings
Interpretation of the received data and writing conclusion
Clinical directed interview
Observation
Experiment
Psychodiagnostic examination
Tests
Verbal
Non-verbal
Standart
Projective
Questionnaires
Open type
Closed type
Standard
Personal
typological
personality traits questionnaires
motives questionnaires
aims questionnaires
interests questionnaires
importance questionnaires


Psychology
General
Individual
Social
Medical
Age
Military
Engineering
Pedagogical
Branches of medical psychology
Tasks of medical psychology
pathopsychology
deaf-and-dumb psychology
typhlopsychology
neuropsychoiogy
Psychohygiene
psychosomatics
medical ethics and deontology
Psychological evaluation of patient's specific features, changes of his psychological functions under various mental and somatic diseases
Analysis of the influence of various mental and somato-neurological diseases on the mentality of children and adults
Analysis of the role of mental affects in causes, duration and prevention of psycho-somatic diseases, their psychopathological complications
Analysis of personal and professional psychological peculiarities in doctor's behaviour and work with patients
Studying of psychology interrelations between a patient and medical personnel in treatment process
Working out the principles and methods of experimental-psychological examination, correction and psychotherapy

PERSONALITY AND A DISEASE. INTERNAL IMAGE OF DISORDER

Urgency: Knowledge about structure of personality, ability to diagnose the manifestation of accentuated personality, to estimate the type of internal image of disorder in the patients are the important constituent of successful therapy of doctor of any specialty.

General objective: to be able to communicate with patients, their relatives and colleagues taking into account their psychological features.

Concrete objective:

1. To know the structure of personality
2. To determine the tactics of behaviour during communicating with people who has accentuated personal features

Use the literature:

1. Essential of medical psychology: manual for medical students, interns, general practitioners /V.L.Gavenko, I.S.Vitenko, G.A.Samardakova et al. -Kharkiv: "Region-inform", 2003. - 188 p.
2. Summary of lectures
3. Graphologica! structure of the topic

Theoretical questions:

1. To estimate the typology of accentuation of personality and tactics of doctor's behaviour with patients who has accentuated personal features
2. Definition and the main types of attitude to disease and features of behaviour of patients with various types of attitude to disease
3. Diagnosis of main types of attitude to disease

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.

A personality in public sciences is considered as the special human quality, which he gets in social and cultural environment during joint activity and dialogue. A personality is in a broad sense determined as ensemble of mental organization of the human individual. A personality in narrow meaning is a level "of integrated individuality", on which the main vital elections are carried out, the decisions are accepted. It is the individual set of human properties (intellectual, emotional, volitional, moral - ethical etc.), features of his mental processes, which form stable unity and determined by social environment. Personality is a set of an inherent and acquired mental features, typical for the individual both determining uniqueness and originality of this individual.

The basis of the personality as carrier of consciousness and active

social essence, is made by abilities, temperament and character, features of current of other mental processes, set of prevalent feelings and motives of activity, mentality, moral purposes etc.

The structure of personality, which was offered K.K.Platonov displays complexity of its formation (connection of biological and social-psychological properties) in aggregate of various characteristics of the personality: a)biologically caused qualities (inclinations, temperament, pathological changes of the personality); b) socially caused qualities (spiritual needs, orientation, moral qualities); c) quality of the personality caused by experience (knowledge, habits, abilities, skills); d) qualities caused by individual features of mental processes (a type of memory, degree of emotional - motor stability).

In the recent years, both medical psychology and clinical psychiatry have demonstrated interest to researches of patients' personal features. It is explained by a number of circumstances: a) changes of the personality, having nosological specificity can be used at differential diagnostics; b) the analysis of premorbid personality properties is useful at finding the reasons of various mental and somatic diseases; c) the understanding of personal changes during disease enriches with representations about its pathogenetic mechanisms; d) the characteristics of the personality should be taken into account when working out the complex of rehabilitating measures.

The sphere of individual-psychological feature of the personality includes abilities, temperament and character of the personality. The success in acquiring knowledge, skills depends on the abilities of the person, but the abilities are not thee presence of this knowledge and skills. Abilities are possibility, not the real knowledge and skills, there are individual-psychological features of the personality, which can be conditions of successful realization of this activity. Abilities manifest only in activity, which can not be performed without these abilities. The abilities are seen in process of gaining of knowledge and skills. The highest degree of abilities development is talent, which unites the abilities, enabling the person to fulfill any job successfully, independently, originally. Biological grounds of abilities are the inclinations. Inclinations are morphological and functional features of the brain, sense organs and motions, which are natural grounds of ability development.

Qualitative (organizational, musical, intellectual abilities) and quantitative (the level of the abilities to definite knowledge and skills) characteristics of the abilities can be distinguished, depending on the activity there can be leading and auxiliary abilities. Abilities (intellectual, artistic, musical) are connected with the type of higher nervous activity, that is this or that signal system prevails (intellectual, artistic and median types). -The obligatory condition of ability development is education and upbringing beginning from the early childhood. The abilities are not inherited, but without inclinations it is difficult to develop high abilities.

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

Each type of temper has its advantages and disadvantages. Thus, a sanguine person is responsive but inconstant. Phlegmatic is self-possessed, restrained but dry and not sufficiently responsive. Choleric has a high potential of activity on the one hand, but is explosive, on the other hand. Melancholic is emotionally responsive, his feelings are deep, but he is reserved and shy.

LP. Pavlov worked out physiological foundation of the tempers, and distinguished the types of higher nervous activity according to such properties of main nervous processes (excitation and inhibition) as strength, balance, motility. According to him, a weak type is melancholic; strong, unrestrained — choleric, stt'ong, balanced, motile - sanguine, strong, balanced, inert - phlegmatic. 9

Besides this common for peop^e*and animals types of higher nervous activity, LP. Pavlov described three human types of signal systems. The people, in whom both signal systems take part in communication with the environment, are a mixed type. If first signal system prevails, this is an artistic type, second — intellectual. The so-called marginal types of higher nervous activity (weak, strong unrestrained, intellectual, artistic) have problems with coping with psychological difficulties, they may develop various morbid manifestations in stress situations.

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 arc revealed in typical circumstances and are determined by the

attitude of the personality to the Sc circumstances. Tnis is an mdlvldliai originality of the attitude to the person hlm/herself and t0 the othel, peculiarity of satisfying the needs, Work. The character is the temper (type **of** higher nervous activity) plus life experience, intellect, will, emotions and other mental processes.

Each trait of the character P Y ^ „ TT j r- "-presses the attitude of the person **to** definite circumstances in the reality ti J- r • n e ,,. X Depending on prevailing influence **of** different mental processes (thinking, attentlorij will> emotional attitude, accuracy and skil on the means of action, the following traits can be distinguished: intellectual, emotional, volitional. The traits can induce and decelerate actions. They are .requentty reveaied in difficult situations, form a complicated totality, which determines personality features. There are four systems of character traits, the traits manifest in-

a) attitude to the groups of people and separate people (kindness, sensitivity, exactmgness, arrogance, etc);
b) attitude to the work (diligence, hzia^ conscientiousriess, responsibility, etc);
c) attitude to things (neatness umidmess, careful or careless treatment);
d) attitude to himself (pride, ambition, vanity, self-esteem, arrogance, modesty, etc.).

Individual features of the character are ±e d of de ss of lts properties, activity and strength 0f the character, stability **of** beliefs, plasticity x u c character is termed **on** the basis of the types **of** higher nervous activity **(temper)** under he lnflueilce of gducati bringin& eSpecially m the family. This process tekes piace dun ^ whole life> but maintraits form by the age of 20-22. The most Unfavorable consequences for the character formation, when the person s eduCation - neglected! he is treated cruelly or spoiled, educated in hypocntical, Sanctlmomous conditions. As a result, the following types can be formed: good-natured, hypocritical, ambitious, cowed, malicious, inhibited.

The sphere of the personality trend includes purposes, interests, world-outlook, the system of values, morals, ideology, labor and social activity. Together with the abilities, temper and character they make up the complete characteristics of the personality, which determines its sociai importance. Trend is the system o, stimuli and value orientations, which determines selective attitude and active behavior of the person, that is trend is a stable system of motives which orient life activi ofthe ality.

Together with normal (socially there ^ mtmed and abnormal personalities. Accentuated personalities are not pathological, but marginal variants oi the norm, uaa... en of excessive emphasizing of some traits of the character, which creates Lb;*„ J • • -L * A C u- creased sensitivity to definite psychic influences at relative stability tu n ... V №e other, which is' frequently observed m extreme emotional situations.

K Leonard (1981) disti^,,^ ^ following variants of accentuated personalities: 1) emotive - anx,011Si timi(i compassionate) soft-hearted; 2.)

excitable - explosive, irritative, prone to impulse aggression but not bearing grudges; 3) epileptoid - excitable, vindictive, cruel; 4) demonstrative (with hysterical traits) - prone to self-appraisal and hysterical reactions, lying, trying to attract attention, demonstrative in communication, egoistic; 5) demonstrative sticking (with hysterical and paranoid features) - lying, self-confident, impudent, prone to slandering, ambitious, sensitive, hypocritical, vindictive, without ethic norms, 6) dysthimic (depressive) - constantly absorbed in their troubles, indecisive, prone to pessimism; 7) dysthimic sticking (paranoiac) - indecisive and preoccupied, they combine stinginess and suspicion; 8) pedantic (anancastic, psychasthenic) - timid, anxious, distrustful, conscientious; 9) sticking (paranoiac) - fanatic, non-flexible, vindictive, sure in their tightness ("I am always right"); 10) hypertimic - active, cheerful, optimistic; 11) affective-labile - emotionally unstable, with quick changes in the mood; 12) affective-exalted - those who heavily react to eveiything in the form of delight of despair; 13) extraverted personalities (open, amiable) and introverted (restrained, experiencing everything inside), various combinations of personality features are (temper, character, intellect) possible.

Character traits and their exhibitings are of great importance for successful professional work. Those medical workers have authority with patients, whose high professionalism is combined with positive characterologic lines. Patients usually prefer such character traits of the doctor as honesty, attentiveness, adherence to principles, ability to sympathise. All patients need positive emotional contact, warm words, sincere support.

Patients with disturbing-hypochondriac character traits attach importance to insignificant painful sensations, overestimate the pain, are afraid of inspection and treatment. The fear of possible negative result complicate course of disease.

Patients with hysterical character traits are inclined to a self-suggestion and exaggeration of the painful sensations. During hysterical reactions in such patients doctor should be balanced, not to show alarm and disturbing. It is recommended to talk to the patient easy, not raise his voice, not showing borings and an inattention to the patient's state. The doctor should remove by psychotherapeutic influences the patient's habit to react with hysterical reactions to various difficulties.

Sensitive patients concern manifestations of their illness with alarm. They suffer from change of the settled conditions of life. The doctor should concern such patients with excessive attention, convincing, that their painful sensations arc temporary and adjust them on recover.

Abnormal pathologic forms of personality development are oligophrenia, psychopathies, psychopathic development and psychopathization of personality.

Psychopathies are marked character disturbances, which manifest by total pathology of the character causing social deadaptation (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).

Personality reactions to difficult situations depend on the age. In young and medium-aged schoolchildren the following reactions are the most frequent; protest and opposition (active protest - disobedience, rudeness, aggressive behavior, desire to do everything to spite somebody; passive protest - infantile communication, false loss of the habits to be neat, selective mutism, escape from school and home, autoaggressive behavior); refusal (refusal from food, games, contacts, passiveness); simulation (long stable changes in the behavior associated with mimicking the behavior of the surrounding - scandal, alcoholozation, smoking, wearing some kind of dress, hair-do style,); anxiety and diffidence.

The following reactions are characteristic for teen-agers: emancipation, (increased desire of independence, getting rid of guardianship and control of the parents, teachers, etc.); grouping with the persons of the same age - with formation of informal groups of pro-social (actively support and protect the ideals dominating in the society), asocial (neglect the ideals dominating in the society) and antisocial (actively come out against the ideals dominating in the society) types; hobby-reactions (excessive, exaggerated hobbies); due to libido formation (onanism, early sexual life, transitory juvenile homosexualism, petting, etc.).

In elderly persons (aged 60-74), the rate of mental working ability decreases, the lose the ability to rapid switching of the attention, the condition of health becomes worse, they become anxious, sensitive to offence, inattention).

In old persons (aged 75-90), considerable difficulties with acquiring new material develop. The character becomes egocentric, some traits of the character become more prominent. The mood id gloomy, they are unsatisfied with their relatives, require increased attention, they are frequently hypochondriac.

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. Patients with somatic diseases are different from healthy persons in changes in the mental state accompanying the changes in the function of the inner organs. Such changes of the personality characteristics are various: reduction of the memory and thinking (intellectual functions), abilities to perform some activities, some traits of the character become prominent, pathological traits may develop (psychopathization). This should be taken into account when working with patients in order to prevent unfavorable emotional reactions, which aggravate the course of the disease and development of psychopathoiogical complications. In mental disorders, disturbances in the personality are connected with disturbances in the choice of the purpose and

purposefulness of the actions, appearance of pathological needs and motives. The attitude to the world, the other people, himself also changes. The ability to control, regulate and think critically is damaged. Any disease changes the perception and attitude of the personality to the events, creates a special situation among the close persons.

Reflection of internal image of disorder

Disorder has a great influence on every human life, changes his habitual way of life, character and possibility of communication with people around, as well as attitude to professional activities. When working with a patient, the doctor should take into account what symptoms are caused by this very disorder and in what way the patient assesses them. Under disorder influence, especially in case of chronicity, the character features of an individual change quite often.

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, 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.

Subjective sensations of the patient do not always correspond adequately to specific volume and severity of the objective pathologic process. For example, the patient with objective signs of scoliosis often does not have subjective unpleasant feelings. IID is also specified by the character of the disorder (sharp run or chronicity, necessary treatment and remedial measures, occurrence of severe pain, restriction of movement, unpleasant cosmetic effects), circumstances it runs by (that is the problems caused by it: "who will take care of the family?", "who will pay for the treatment?", "will my job be maintained?", "does the doctor say the truth?" and etc.) and premorbid features of an individual. In favourable domestic conditions the patients stand their disorder easier compared to standing it out of home. The character of hospital conditions where the patient is being treated is also important. Depressing influence is made by staying with dying patients, at

closed-type infectious or mental departments.

Certain role is taken by the cause of disease, namely whether the patient considers the person responsible for disorder himself or someone else. For example, in case of injury as a result of own fault the patient takes more efforts to recover than in situations when the injury occurred due to fault of someone else. Age of the patient is also important. In childhood the first place is taken by emotional side of disorder and attending situation: fear of pain, separation from parents. In middle age the fear of disorder consequences (e.g. because of job loss) is most valued. In old age the fear of loneliness when being ill, and fear of death prevail. An old person often identifies himself with persons of the same age who gradually die, compares their diseases with own ones, thinks over whether his turn has came. Fears and uncertainty of the patient are often increased by doctor's behaviour, who does not pay necessary attention To him.

In the process of IID formation important place is taken by sensitivity to pain, noise, unusual olfactory factors. The patients with hypersensitivity react to unusual irritators more painfully than others. At the same time on the contrary the patients with hyper-resistibility underestimate their complaints and neglect the examination and treatment. Emotional patients are more exposed to fear, pity, often hesitate between hopelessness and optimism. More restrained patients consider their disorder reasonably, but the doctor should take into account the fact that external display, especially verbal [illegible] patient.

Real assessment of disorder and situation itself also depends on medical knowledge of the patient. Attitude to disease, treatment and medical persons can be formed by upbringing in the family, personal experience, public health education, popularization of the latest medical information. Medical consciousness is shown originally when the doctor becomes a patient. Knowledge about diseases is the protection from perverted opinion of own pathology, and can help during individual disease prevention. On the other hand, the knowledge of ail possible complications, treatment schemes worries the doctor more than a non-specialist. Theoretically the health state of medical persons has to be better than of common people. Practically the situation is often a contrary one. Doctors as a rule underestimate the initial stage of disease.

Range of variants of disorder consciousness and patients' attitude to it is specified by variety of character features of people. Doctor has to realize the patient's attitude to his disorder, so that to find the appropriate psychological approach to him and to prevent the possible iatrogeny.

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 himself, as well as demonstrates

ungrounded optimism with respect to the prognosis of the disease.

3. Denying, when the patient "does not pay attention to the disease", does not take medical advice, fights back any thoughts on his disease and reasonings 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, which 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.

The utilitarian response can be more or less deliberate; it may be based on some slight or severe disease, but sometimes is observed even in a healthy person.

The utilitarian response can be manifested with different forms of the patients' behaviour: aggravation, simulation and dissimulation.

Aggravation is exaggeration of signs of the disease and subjective complaints. This exaggeration can be completely deliberate, but sometimes is rather caused by emotional motives of a deeper origin, e.g. fear, distrust, feeling of solitude, hopelessness, suspect that the doctor does not believe him. Transitions from the deliberate aggravation to a less deliberate one are sometimes rather unostentatious, and in some cases even hardly perceptible.

Simulation is a pretence with whose help a person tries to create an impression that there is a disease and its signs. It occurs less frequently than aggravation. As a rule, it is used only by very primitive persons in whom its revealing can be relatively easy, or, on the contrary, by well-experienced, pushful and irresponsible persons. A great risk for the malingerer is incurred by the fact that he strives for a certain benefit, this aim being revealed sooner or later. If he does not reach his aim, e.g. receives a pension promising him a well-to-do life with a possibility to earn extra money, this circumstance cannot be concealed from surrounding people and revision of the case will put an end to the simulation. The doctor should not be in a hurry to make a conclusion about simulation until he absolutely makes sure that his suspicions

are correct. In this case, a less experienced doctor must always consult his more experienced colleague. Substantiation and argumentation of simulation are particularly important in case of drawing a written conclusion about it. Substitution of the wording "a deliberate production of signs" or "an attempt of a deliberate affected representation of a disease" for the word "simulation" in a medical conclusion is more expedient.

Dissimulation means concealing of the disease and its signs. It often occurs in psychiatry in cases of psychoses. As far as other patients are concerned, it is mainly observed in the diseases resulting in some objective or subjective disadvantages for the patient, e.g.: in tuberculosis it is a prolonged staying at a sanatorium, syphilis is accompanied by notification about the disease and revealing of the focus of the infection, surgery is fraught with a possible operation. The greater is the extent of saving the patient from the fear of the forthcoming examination, treatment and consequences of the disease, the more successful is prevention of dissimulation.

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 characterised by social dysadaptation, loss of interest to work and loss of work skills, decrease and deterioration of contacts with people around, tendency of disease chronicity.

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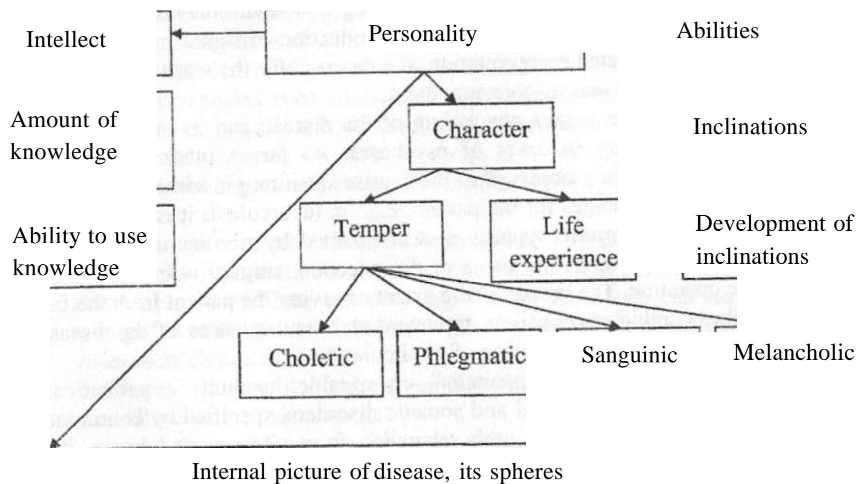
There is 1 practical lesson (2 hours) for this topic. At the beginning of lesson the estimation of initial level of student's knowledge is carried out by oral questioning and solving of test tasks. Further students are independently speaks with patients for estimation of their mental state. Then results of examination are discussed.

Planning sheet of practical lesson

No.	Stage	Time (min)
1	Initial control (oral questioning with correction of student's knowledge)	25
2	Test control	15
3	Examination of patients by students	45
4	Conclusion	5

Graphological structure of the topic
"Personality and a disease. Internal image of disorder"



Internal picture of disease, its spheres

Sensitive
Volitional
Emotional
Rational-informative

Attitude to disease

». Harmonic

Anosognosia

Dissimulation

J Nosophilic

Simulation

Nosophobie

Aggravation

Hypochondria

Hospitalism

Scornful

Depressive

Urgency: Every somatic disease influences on patient's mental state in some cases accompanying by psychological changes and in other cases leading to mental disorders. Ability to estimate the patient's psychological features, take into account change of his psychological processes is important factor of successful diagnostics and treatment of the disease.

General objective: to estimate the patient's mental state and level of their social-psychological adaptation with the methods of psychological examination.

Concrete objective:

1. To make a conclusion about level of patient's intellectual development
2. To explain the influence of the disease on human cognitive processes
3. To analyze the influence of emotions on human health
4. To explain the influence of the disease on human consciousness and self-consciousness

Use the literature:

1. Essentia! of medical psychology: manual for medical students, interns, general practitioners /V.L.Gavenko, I.S.Vitenko, G.A.Samardakova et al. - Kharkiv: "Region-inform", 2003. - 188 p.
2. Summary of lectures
3 Crsphoiogical structure of the topic

Theoretical questions:

1. Influence of the disease on human cognitive processes
2. Influence of the patient's intellectual features on treatment processes
3. Influence of the disease on human effector-volitional sphere
4. Influence of the disease on human emotional state. Nosogenia.
5. Importance of volitional qualities in treatment process
6. Changes of patient's will, inclinations and behaviour in disease
7. Consciousness, self-consciousness and their levels
8. Psychodynamic approach in medicine
9. Criteria of undisturbed consciousness. States of consciousness in the patient.

There are three main spheres of mental activity: cognitive, emotional and effector-volitional. Cognitive processes arc perception, memory and thinking.

Sensation and perception (sensory sphere) are the initial stage of cognitive activity, that is sensitive cognition.

When tired, excited, under the influence of noise and other outer unfavorable factors, physiological functions of the analyzers (and psychophysiological state) may change which results in inhibition and errors in perception with 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.

In clinical practice, when sensitivity in one or several analyzers disappear partially or completely, sensibilization, that is compensatory increase in sensitivity as a result of interaction and training of analyzers, is important. Thus, the loss of vision and hearing can be compensated by development of other types 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. Socio-moral orientation of the personality, conscious and organized character of the behavior influences the attitude to pain. 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, socio-moral orientation. The doctor should take these into account and try to create the conditions for the patient which will weaken the sensation of pain. It is very important to reduce the pain by suggestion.

Individual system of mental parameters of sensations is called sensory organization of the organism.

One of the necessaiy conditions of normal mental activity is a certain minimum of stimuli which enters the brain from the sense organs. If a person does not receive the necessary amount of stimuli due to abnormalities of the sense organs, he falls asleep or becomes drowsy and does not remember anything that took place during this period of time.

At sensory isolation, unusual mental states may appear. At first they are functional (reversible). When the period of the isolation increases, the changes become pathological - neuropsychic diseases develop (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).

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.

In general clinical practice we can observe the following disturbances of sensation and perception:

Hypesthesia - decreased subjective brightness and intensity of sensation and perception. Physiologically normal is hypesthesia observed as reduced sensitivity of an analyzer to definite stimulants (at its stimulation and general reduction in the tone);

Anesthesia „- complete switching off sensations and perception (blindness, deafness, absence of sensitivity to pain);

Agnosia - disturbance of .visual, auditory, kinetic perception at local lesions of the brain cortex (the patients perceive an object or its parts but cannot call it);

Hyperesthesia - increased perception of a stimulant which were neutral before;

Paresthesia - sensation of pricking, flash in different areas of the body;

Senestopathv - unusual, extremely unpleasant sensations from the inner organs and different parts of the body without any disease in this organ (sensation of softening of the bones, collapse of the lungs, hole in the stomach and other bodily illusions and hallucinations);

Visual psychosensory disorders (metamorphopsial - distortion hi perception of the objects with preserved understanding of their significance and essence as well as critical attitude of the patients to them (dysmorphopsia - distortion in the shape of the object, macropsia - enlargement of the objects, micropsia - diminished objects);

Intero- and proprioceptive psychosensory disorders (disturbances in the scheme of the body) - feeling of elongation, shortening, curving' of tire extremities, head, inner organs. They are usually a part of depersonalization, dysmorphophobia and hypochondria syndromes,

Illusions - distorted sensations and perception of real objects and phenomena in which comprehension of the images of the latter does not always correspond to the reality and can have other content. Critical attitude and ability to correction are possible.

Varieties of illusions:

a) physical - appear as a result of different physical properties of objects and substances (light refraction on the borderline of two media, mirage);
b) physiological - due to physiological peculiarities of the analyzer functioning (feeling of movement of the surrounding objects after the train has stopped);
c) psychical - develop as a result of affective changes in the consciousness which cause the changes in other mental functions; can be observed in adults who are in the state of waiting or overstrain or in patients at changed consciousness.

There are several types of psychical illusions:

- affective - develop under the influence of strong emotions (fear, emotional stress).
- verbal - false comprehension of other people's words.
- pareidolia -- perception of some real objects in queer and fantastic form.

Depending on the disturbance of a definite analyzer the following

illusions can be distinguished: auditor)' (distorted perception of the real speech, sensation of voices in the noise), visual, etc. General feeling illusions (intero- and proprioceptive) are sensation of compression, spasm, strain, pulsation in the inner organs and other parts of the body, that is different sensations which can be based on real stimulation of the respective receptors.

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.

In the general clinical practice one can often find the following disturbances of memory:

Hypermnesia is a short extreme retentiveness of involuntary reproduction; it occurs in feverish and hypnotic conditions and in maniacal patients, etc.

Hvpomnesia is an extreme detentiveness of memorizing (fixation) or reproducing past events.

Amnesia is absence of recollections about the past limited by the definite period of time or the situation.

Paramnesia is disturbance of memory as mistaken recollections (pseudoreminiscenccs and other).

Cryptomnesia is distortion of memory, which is found in decreasing or disappearing difference between the events corresponding to reality and seen while dreaming, heard or read. In some cases the heard, read or seen while dreaming is recalled as happened to the patient (associative recollections); appropriation of somebody else's ideas refers to this disturbance. In the other cases, on the contrary, real events are recalled as the heard, read or seen while

dreaming (estranged recollections).

It is necessary to remember about features of memory which can develop in the person elder 60: possible decrease of mechanical and logical memory, especially about new, recent events, and revival of memoirs about patient's childhood and youth. These features were described by T.Ribot as the law of reverse motion of 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.

Amnestic disorientation connected with disorders of memory should differ from disorientation observed against a background of impaired consciousness and it is usually accompanied by torpor and other disturbances. While studying memory about the past events besides questions concerning different periods of the patient's life, the dates which are sometimes difficult to check up it is necessary to examine memorizing well-known historic dates more or less remote in time, events in recent times (circumstances of hospitalization etc.), events preceded the disease or trauma. Flagrant disturbances in memorizing the current events, mistaken recollections (pseudoreminiscences and confabulations) are found out in questions concerning recent events (Where were you yesterday? or Where have you been today? What did you do? Whom did you meet?). Taking into account '.instability of the content of mistaken recollections one should repeat the same questions later in the conversation. With such examining the primary content of the answer usually changes.

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.

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.

Disturbances of thinking and intellect occurring in general practice

Acceleration of thought is acceleration of flowing thoughts in combination with increased distraction, surface of associations and their appearance in consonance and contiguity.

Retarded thinking is stiffness of the thoughts and their monotony.

Affective thinking is judgement and conclusions which are not critical enough and they depend on the emotional state.

Detalization is inability of picking out the most principal and important,

sticking on separate detailes in combination with stiffness of thoughts.

Obsessive thoughts occur without the person's desire and against his wish. The patient assesses them in a critical way, fights against them but can not make effort to avoid them.

Hyperquantivalent ideas are the judgements occurring as a result of real situation but have disproportionate, prevalent meaning in thinking due to the strongly pronounced emotional coloring. These thoughts would not be incorrect if the patient did not pay great attention to them. Pathology occurs because of strong exaggeration of the importance of the thought. One of the variants of these thoughts is hypochondrical state (hypemosognosia) when the patient overestimates real unhealthy sensations and considers to be ill with a very serious and dangerous disease. These patients constantly visit doctors, ask for treatment, change drugs all the time.

Infantilism is a universal or partly physical and mental retardation causing delayed maturity of judgements, infantile naivete, emotional instability and increased influence of emotions on thinking.

Oligophrenia (mental deficiency) is underdevelopment of intellect due to the causes present during the intrauterine period or in childhood under the age of 3.

Demolition is an acquired defectiveness of intellect which is characterized by inability of acquisition of new knowledge and earlier acquired knowledge, skills and hyporrmesia.

Persons with insufficient intellect demand special attention both from the doctor and nurse, and from relatives. It is necessary to try in detail and more accurately to explain essence of diagnostic procedures spent by him and the appointed treatment, achieving exact observance of all recommendations of the attending physician.

In clinical practice the most important speech disorders are:

Aphasia - disorder of speech arising at local defeat of a cerebral cortex of a prepotent hemisphere. There are some kinds of aphasia: anamnestic (difficulties when getting the name of subjects with presence of representations about them), motor (disorder of expressional speech with presence of agrammatism («telegraphic style»), disorder of structure of a word, association of syllables), semantic (disorder of understanding of sense of grammatical difficult phrases, relations between words), sensoric (disorder of ability to understand a word meaning in the absence of defeat of ears).

Ankylognossia (tongue-tie) is incorrect pronunciation of separate sounds and phrases.

Disarthria is impossibility of accurate articulation when speaking.

Agrammatism is disturbance in grammar of the sentence.

Stammering is disturbance of fluency, difficulties in operating sound combinations.

Mutism is dumbness, absence of reciprocal and spontaneous speech with preserved ability to talk and understand the speech turned to him.

Patients with speech disorders can represent certain difficulties at an estimation of their complaints, anamnesis gathering. From the doctor it is required to show patience and special attention at work with such patients.

Methods of studying thinking and intellect. When talking to the patient one should pay attention to the speed of associations and their features. It is necessary to give the patient possibility to talk freely about everything he wants including every abstract topics. While evaluating the intellect one should pay attention to the storage of knowledge, ideas and words (according to his age and education), ability to generalize ideas and make conclusions, ability to count. One should check up the volume of skill, ability to fulfil physical open»ion.

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.

The well-known methods for evaluation of level of intellect: Wechsler's test, which consists of two groups of subtests (verbal - 6 and non verbal - 5), Raven's matrices.

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 aspect of psychical processes.

Emotional reactions are the most often psychological manifestations of evety somatic disease. They can be both psychological reactions on fact of disease, and symptoms of mental disorders as the result of somatic pathology.

General practitioners and family doctors often meet in their clinical practice such changes of emotions and feelings in the patients that should attract their attention.

Euphoria: pathologically high spirits which develop without any external causes.

Depression: pathological blues, deep grief, low spirits (it may often be accompanied by suicidal thoughts).

Apathv: indifference to the surroundings and the self; it is usually accompanied by reduced requirements, desires and inducements, a weakened volitional activity; more frequently, it is of a reversible type.

Fear one of frequent symptoms of emotional dismrbances in children and is of a different clinical value.

Alarm; emotional state which appears in the conditions of uncertain danger and manifests in waiting of unfavourable development of events. Alarm is generalized, diffuse, objectless fear.

Pnobiae: annoying fears characterized by the patient's critical attitude

to them and aspiration for getting rid of them (e.g., annoying fears of height, open spaces, infections, etc.).

Dysphoria; a suddenly appearing and unmotivated melancholy-angry mood with an expressed irritability (in children - tearfulness) and tendency to affects of anger with aggression.

Lability of emotions: an easy change of emotions, a rapid transfer from one emotion to another; it is combined with a significant expressiveness of emotional responses.

Weak will (emotional weakness): it is manifested with an unsteady mood, an increased emotional excitability often accompanied by "unrestraint of emotions". It is particularly difficult for such patients to repress their tears at the moments of tender emotions, a sentimental mood. A transfer from negative to positive emotions and vice versa occurs under the effect of insignificant causes.

Emotional states have both mental and somatoneurological symptoms. They are accompanied by metabolic changes, vegetative manifestations in the form of activation of sympathoadrenal system, changes in a functional state of cardiovascular, respiratory system, gastroenteric path. At excessive for the individual or long affective stress there can be psychovegetative disorders, both diffuse and with accent on certain internal organs. Thus, it is long existing not reacted emotions can be a risk factor of development of various psychosomatic diseases.

The doctor should pay attention of the patients that not reacted emotions can lead to illness and train them methods autorelacsation. It is necessary to warn, that methods, to which some patients sometimes resort (alcohol, drugs, toxic substances), aggravate a disease state. Patients should be able to switch the attention to emotionally pleasant for them employment. It is necessary not to hide the experiences, and to try to get rid of them. Possibilities of a "healthy" relaxation depend on degree of good breeding and intelligence of the person, how its hobbies are various and how much it is moral.

At work with patients the doctor should consider the possibility of development of nosogenic states. Nosogenia is psychogenic caused depressive and hypochondriac manifestations arising as a reaction to the fact of disease and its possible consequences. Nosogenia can arise, when the patient learns about the diagnosis of the disease, especially if illness is considered severe or incurable. For the prevention of nosogenia it is necessary to consider features of the person of the patient, type of its relation to illness.

Methods for investigation of emotions

In the process of a conversation 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, colour of the skin, state of the cardiovascular and autonomic nervous systems (rate and rhythm of the pulse, blood pressure).

In order to assess the emotional state one can use both the clinical

investigation and experimental-psychological methods: the topical aperceptive test (TAT), Rorschach's method, Rosenzweig's study of frustration tolerance, Luscher's test, the level of claims.

Effectory-**volitional** sphere is 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) effectory-motor (simple and composite movements, acts and deeds) and b) volitional (ability to conscious and purposeful human regulation of acts and deeds).

Volitional qualities of the patient (the endurance, resoluteness, persistence, initiative, organization) play the important role in medical process since they define type of the patient's attitude to the disease, his tendency for recover, readiness to execute the diagnostic doctor diagnostic and medical procedures. On the other hand, volitional qualities of the doctor define his abilities to the decision of some medical and organizational questions connected with hospitalization of the patient, diagnostics of its condition, carrying out of necessary researches and consultations of other experts.

One of the basic tasks of medical workers is strengthening of patients' will weakened by illness. They should be able to distract the patient from bad thoughts, to install belief in recover, considering thus specific features of the patient and his state. The special attention is demanded by patients with disorders of volitional sphere.

Disorders of effector-volitional sphere manifest in pathological strengthening (hyperbulia'). weakening (hypobulia). absence (abulia) or perversion (parabulia) of their separate components (motive or volitional) or as inadequate, sometimes dangerous behaviour.

Patients with hyperbulia are very active, but not always productive, since do not finish the begun business. Sometimes under the influence of alarm the patients are fussy, undertake many affairs, pass or move from one place to another. It is sometimes shown unilateral hyperbulia when against the general decrease of volitional activity patients show the initiative and the activity directed on achievement of one puipose. For example, the addict against the general lack of will spends a lot of energy and forces for getting a drug.

Hypobulia is characterised by weakness of promptings and decrease of activity. Such condition can arise after overfatigue.

Abulia is a pathological symptom when patients are constantly inactive, aspire to nothing. In such cases the patients often don't feel weakness and weariness.

Parabulia is manifested by impulsiveness, pretentiousness of behaviour and negativism.

Many somatic diseases are accompanied by disorders of instincts. So, at endocrine pathology disorders of a alimentary instinct in the form of its strengthening (bulimia), decreasing or complete absence (anorexia) can arise.

Some patients, for example, women during pregnancy, have a distortion of a inclination to food in the form of eating of inedible (chalk).

The doctor sometimes observes change of self-preservation instinct in patients. At its strengthening patients or are very timid or, on the contrary, are aggressive. Decrease in this instinct leads to suicide intentions and actions, a distortion - to self-damage.

Quite often in general medical practice the doctor observes patients with various disorders of a sexual instinct in the form of its strengthening (hypersexuality), weakening (impotence, frigidity) or distortions. Some distortions of a sexual instinct do not admit in the certain circles of the population as the morbid phenomena. There are homosexuality (a sexual inclination to persons of the same sex), masturbation (irritation of the genitals for the, sexual satisfaction), sadism (reception of sexual satisfaction by humiliation of the sexual partner), masochism (sexual satisfaction when receiving painful sensations from the sexual partner), trasnvestism (desire to play a role of the person of an opposite sex without aspiration to anatomic change of genitals).

Quite often in patients, especially with chronic diseases, asthenia . develops which is manifested by weakness, undue fatigability, emotional lability, hyperesthesia, disorders of sleep.

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. Other methods (self-evaluation of activity and capacity for work, preservation of various practical skills, tremoromentry, measuring of speed and precision of sensomotory reactions, electromyography etc.) could be used as well as experimental-psychological and electrophysiological methods.

Attention is concentration of consciousness on a chosen object or phenomenon, as a result this object or phenomenon is reflected clearer.

In clinics among different kind of deviations increased distraction is more frequent. A patient has difficulty in concentrating on one object or activity. His attention is unstable, outer irritants, even of less interest, can distract the patient's attention and disturb his activity. A patient's distraction can be so high that he can not concentrate on a doctor's questions, permanently "jumping" from one thought to another.

Distraction accompanies increased tiredness, general weakness caused by exhaustion of nervous system, durable and intensive emotional strain, too difficult mental activity. It can be a result of infection, intoxication's, injuries, tumors, vascular sclerosis of a brain. A patient with increased distraction can not bear in mind more than one object at a time, even if it is familiar to him.

When frontal lobes of cortex are affected ability of switching attention decreases. Switching can be inhibited to such extent that a patient repeats some action many times not even noticing it. In clinic opposite phenomena are also observed, when ability to switching attention increases. This deviation characterizes maniac patients. Frequently somatic, infections and other pathologies result in increased exhaustion of attention, i.e. decrease of stability and volume of attention. Decrease of attraction is some difficulty or impossibility of attraction to some irritants.

Methods for investigating of attention. Change of a patient's attention can be noticed by observation and experiment (Schulte's tables, Munstenberg's test, counting by Kraepelin, proof test, etc.).

Consciousness is an integrative sphere of mental activity, the highest form of the objective reality reflection, the product of the continuous historical development. Development of consciousness gives a person ability to mark himself out of the nature, to cognize and seize it. Consciousness is carried out by a language, words forming the second signal system, personality consciousness is formed in the process of the person's mastering of the ideas, concepts, norms worked out by the society.

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

1. 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 : a) general state, which reflects the degree of requirements satisfaction, inner somatic and mental well-being, the well-being of the surrounding situation; b) mental ego unity consciousness (belonging to "ego" of all mental processes - perceptions, memories, thinking, emotional reactions ,will, actions, etc.); c) somatic ego unity consciousness (body scheme, etc.); d) ego unity consciousness and surrounding nature and social reality (stipulation of motivation, requirements, social demands, moral prohibitions, etc.) In case of disease the changes of the general state and self-perception take place. Depending the personality peculiarities and the disease the so-called in the inner picture of the disease is formed in the patient. It can influence the picture and the course of the disease .

2. 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).

Unconscious is a set of the mental phenomena, conditions and the actions which have been not presented in consciousness of the person, laying out of sphere of his reason, unaccountable and are not under control.

Unconscious - not mysticism, and a reality of a spiritual life. From the physiological point of view it carries out guarding function. The doctrine about the unconscious was created by Z.Freud who asserted, that unconscious is the leader in human behaviour. Unconscious is not realised experience of emotional, effector-volitional and is abstract-logic attempts of the adaptation collecting in the course of human life and its interaction with environment, influencing motivation of his behaviour. As examples of the unconscious instinctive reactions of self-defence, slip of the tongue or pen, involuntary fixing, intuition, vital emotion, the automated actions. The more level of morally-ethical and intellectual properties of the personality, his social consciousness, the less his behaviour depends on instinctive promptings, unconscious.

One of the major properties of consciousness which is defined by any doctor contacting to patients, is clearness of consciousness - presence of accurate and consecutive perception of surrounding and correct orientation in it (consciousness of world around, time, place etc.), consciousness with safety of memory on the past and the present, any attention and the thinking, adequate emotions and will, safety of ability to give the report in the actions and to supervise over them.

Signs of disorders of consciousness: estrangement from world around, disorientation, amnesia for the broken consciousness. Estrangement from world around should be understood as disorders of the analysis and synthesis of events which occur. The disorientation is found out in misunderstanding of where the patient is at present, who surrounds him, he cannot name the date, his surname, name, age, profession.

The disturbances of consciousness that can be caused by different therapeutic, surgical, gynaecological diseases are revealed by various degrees of its disconnection: indolization, hypersomnia, torpor, sopor, coma, syncope.

Indolization (vail on consciousness) is the slightest degree of consciousness dullness. Consciousness seems to become dull for several seconds or minute. Indolization is characterized by the change of slight dullness of consciousness into the moments of lucidity. Orientation in time and space remains. Amnesia does not occur after indolization .

Hypersomnia (somnolence) is a pathological drowsiness that can last for hours or even days. Only very strong stimuli reach consciousness . Like in indolization orientation in surroundings is not affected and amnesia does not occur hypersomnia is observed at alcohol or soporific poisoning , when glucose descreases in blood (for example at long starvation) , midbrain lesions.

Torpor (syndrome of torpor consciousness) is the dullness of consciousness characterized by the increase of perception threshold of all external stimuli, the course of mental processes becomes slower and harder.

Various degrees of torpor are possible. At slight torpor drowsiness is observed. When torpor drows the patient perceives speech but cannot speak, he lays in bed with his eyes closed. Motionlcssness, the poverty mimic signs are typical. The patient answers the question after a long interval and after the question is repeated many times.

At deep torpor it is almost impossible to wake up the patient and if he wakes up only for a short period of time he is plunged in sleep again soon. Being awaken, the patient just briefly answers simple questions pronounced in aloud voice. Amnesia is partial after torpor. The syndrome of consciousness torpor occurs in neuroinfections, typhus, anemia, etc.

Sopor is a deep stage of torpor at which there are no reactions to verbal address. At sopor arterial pressure decreases, respiratory rate is disordered , the pulse is weak only reactions to pain stimuli and pupil reflex are kept. Sopor is observed in serious infections.

Coma is the state of deep depression of the central nervous system which is characterized by the complete loss of consciousness and the reactions to the external stimuli, the disturbance of the virtual functions of the body. Coma occurs in diabetes mellitus, severe brain injury , complications of toipor and sopor due to neuroinfections , etc.

Syncope is sudden loss of consciousness of short duration accompanied by paleness , sufficient decrease of respiration and blood circulation, loss of muscle tone. The duration of syncope can differ: during slight syncope loss of consciousness Itisto for severs! seconds Vvhile at deep syncope it 1 ssts for several minutes. The causes of syncope are different .One of the main causes is acute cerebral hypoxia.

The doctor should be able to determine the physiological changes of his patients' consciousness, first of all consciousness state at fatigue and affective-clouded consciousness.

Fatigue is a state of tiredness occurring due to physical or mental exertion and accompanied by the increase of the perception threshold . Outwardly such person looks braked, his reactions to the external stimuli are retarded, his speech is poor, his answers are abrupt and given after a pause. Memorizing is reduced, attention is attracted with difficulty , thinking rate is retarded, mimicry is inexpressive, apathy is noted. Fatigue does not requite drug therapy. It is recovered after sleep and rest. The recollections, usually about the strongest stimuli, are fragmentary

Dream is images occurred at sleep and taken by a person for reality. The contents of dreams reflects the past impressions and experience of the person and also the information that comes at sleep and taken perverted ly. I.M.Sechenov defined dreams as "imaginary combinations of the impressions that happen". For example, perfumes aroma can cause dreams that the sleeping person is in the garden with blooming roses. The contents of dream can be affected by light, smell, temperature as well as a proper directive before sleep. An American psychologist P.Penfield proved that therefore it is possible "to order dream."

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.

Sometimes a dream precedes a disease on the preclinical stage, but the impulses from the affected part of the body are so weak that they are not fixed in consciousness. At sleep these impulses come to the cerebral cortex which is in the hypnotic phase state, when the mild outer and inner stimuli turn out to be more significant that the strong ones. In such cases a dream seems to be the first sign of the disease.

Besides the activation of the unconscious forms of mental activity also occurs. This can explain some well-known facts of the scientific discoveries made at sleep (D.Mendeleyev's discovery of the periodic table, Kekule-benzol's formula). This can be preceded by continuous, hard work of the scientist who collects a lot of facts, but the final stage of his discovery is carried to the sphere of unconsciousness.

According to the theory of psychoanalysis by Z.Freud who called dreams "the royal path to unconsciousness", they are caused by the insuperable instinctive activity of the unconscious sphere of human psychics. Physiologically dreams are resulted from the same material processes which pre-determine mental activity in the state of vigilance.

Affective-clouded consciousness or physiologic affect is an emotional state that does not overstep the limits of the norm. This is a brief, impetuous and stormy emotional reaction accompanied by the sharp changes of mental activity including consciousness expressed by vegetative and motor signs . These are strong and brief emotional experiences in the fonn of anger, fury, horror, delight , despair without loss of censorship. Physiologic affect is an extraordinary reaction to the exceptional circumstances for a person. In the second phase of the affective reaction the change of mental activity in the fonn of fragmentarity of perception, narrowing and concentration of consciousness on the psychoinjuring object. The marked outer signs of emotional disturbance (the change of appearance, mimicry, pantomimicry, voice) reveal the physiologic, biochemical changes in the body. The affective actions are notable for the signs of stereotypedness, impulsiveness. Intellectual and will control of behavior with the disturbance of the ability to make prognosis of possible consequences of one's actions dramatically reduces. One of the important signs of physiologic affect is the forms of behavior that were not characteristic of the subject before .In this case the behavior is at conflict with the main vital directives and valuables of the person acquiring involuntary, situational features. In forensic psychiatry the people committed a crime in the state of physiologic affect are considered to be liable and responsible for their actions .

In everyday life the state of affective-clouded consciousness is quite often found. Especially it can reveal itself in the situation of panic if people throw themselves out of the window of a high-rise burning building at fire trying to escape but at the same time they are doomed to unavoidable death.

At shipwreck some people which cannot swim jump into water having the opportunity to go down to a lifeboat. Such situations can be found in any doctor's practice, when relatives are informed about a grave disease or death of someone dear to them , especially a child the relatives can shout, accuse the doctor undeserved by the demand his punishment.

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 nearly.

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 .

Estimating the degree of consciousness clarity, easiness and speed of perception of the doctor's questions, understanding the contents of the simplest (and more difficult) questions. Rapidity, strength and expressiveness of the corresponding speech, emotional and behavioral reactions, the general state, the presence of conditioned reflexes are taken into consideration.

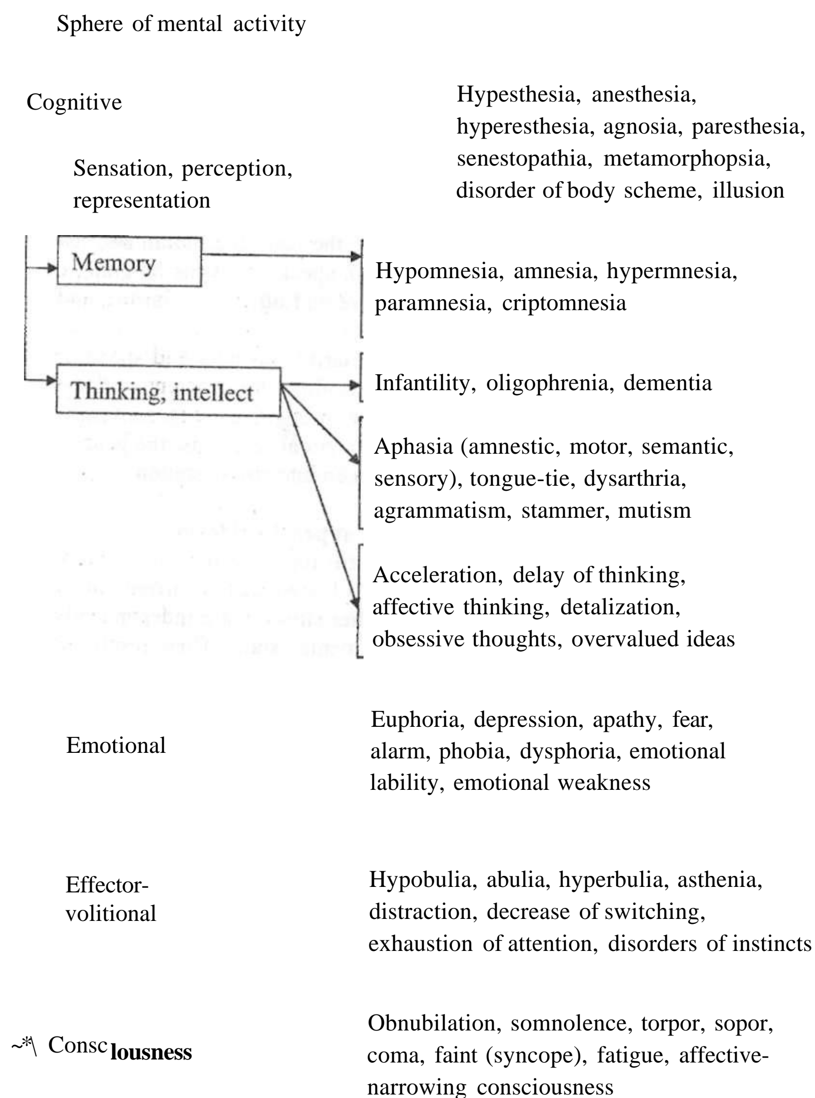
Methodical guidelines for the student's work at practical lesson.

There is 1 practical lesson (2 hours) for this topic. At the beginning of lesson the estimation of initial level of student's knowledge is carried out by oral questioning and solving of test tasks. Further students are independently speaks with patients for estimation of their mental state. Then results of examination are discussed.

Planning sheet of practical lesson

No.	Stage	Time (min)
1	Initial control (oral questioning with correction of student's knowledge)	25
2	Test control	15
3	Examination of patients by students	45
4	Conclusion	5

Graphological structure of the topic
"State of mental function and a disease"



PSYCHOLOGY OF MEDICAL WORKER

Urgency: professional success of any medical specialist extensively depends on his psychological features, professional qualities, ability to estimate the phenomenon of professional deformity and find the ways to prevent them.
General objective: to show skills of communication with colleagues, patients and their relatives taking into account their psychological features; to promote making the healthy psychological climate in medical environment.
Concrete objective:
1. To know the professional qualities of medical specialists
2. To analyze the psychological basis of interrelation in medical collective
3. To know the conditions of making the healthy psychological climate in medical environment
4. To understand the methods of prevention and settlement of conflicts.

Use the literature:
1. Essential of medical psychology: manual for medical students, interns, general practitioners /V.L.Gavenko, I.S.Vitenko, G.A.Samardakova el al. - Kharkiv: "Region-inform", 2003. - 188 p.
2. Summary of lectures
3. Graphological structure of the topic

Theoretical questions:
1. The main demands to personality of medical worker
2. Concepts "medical duty", "medical secrecy"
3. Psychological types of doctors and nurses
4. Medical errors and their reasons
5. Professional deformation, its reasons
6. Emotional burning-out, its reasons, prophylaxis and removal
7. The main professional and psychological aspects of family doctor
8. Functional duty of general practitioner
9. Knowledge and skills necessary for family doctor

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 looses 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 behaviour 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 behaviour (by the talk, assessment of the facial expression and gestures of the patient) and, secondly, in an indirect way, when his behaviour is assessed by his colleagues. It requires some effort, a certain critical attitude towards himself 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 looses 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 behaviour 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, 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 cosiness 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 Iris 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 rum 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 behaviour 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 behaviour 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 timidness, shame or exaggerated modesty.

Confidence is the main component in the patient's attitude to his doctor. Nevertheless, gaming 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 unfavourable 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.

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" behaviour of some muses 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 behaviour; 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 behaviour as "military". In a favourable case, she becomes a good organizer and successfully trains young nurses. In an unfavourable 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.

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, insufficient constmctiveness of his thinking, inability to correctly and rapidly orientate himself 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.

Professiogramm of a general practitioner. At present much attention is paid to training general practitioners, i.e. family doctors. The general practitioner (family doctor) works following the principle of the district doctor, hereby attending to adults, teenagers and children and performing the following functional duties:

1. organization and carrying out of a complex of measures for general prophylactic medical examination of the population in his district, elaboration of individual complexes of prophylactic, medical and health-improving measures for each resident of the district, prophylactic inoculations and dehelminimzation of the population, popularizes principles of the healthy mode of life;
2. rendering of the opportune medical aid to the adults and children of the district in charge.

The general practitioner (family doctor) must know:

1. fundamentals of medical psychology, social hygiene, organization of public health and economics in compliance with the tasks of health control for the population of the district in charge;
2. fundamentals of general theoretical subjects within the scope required for solving professional tasks;
3. anatomical-physiological and psychological peculiarities of the adults, children and aged people, peculiarities in the development of healthy children and teenagers, contemporary classifications of internal diseases in children and adults; health groups and risk factors in the development of diseases;
4. causes of appearance of pathological processes in the organism, mechanisms of their development, the course of diseases depending upon the sex and age, their clinical manifestations and main syndromes;
5. clinical picture, diagnosis and prevention of mental diseases and narcomanias (disturbances of perception, memory, thinking, mentality, the sphere of emotions, attention, drives, unrestricted activity and consciousness, the above aspects of psychoses related to somatic diseases, as well as those of schizophrenia and the manic-depressive syndrome, epilepsy, psychoses of the involutional period, neurasthenia, obsessive-compulsive neuroses, hysteria, psychopathies, mental retardation, alcoholism and alcoholic psychoses, narcomaniac and toxomaniae);
6. fundamentals of examination in mental diseases;
7. fundamentals of resuscitation, clinical picture, diagnosis and principles of treating main emergencies;
8. pharmacotherapy of the most common diseases, the mechanism of effect and doses of the main drug preparations.

The general practitioner must know the aspects of Psychohygiene and psychology of the family, attitude of the members of the family to their health, responses of the family to stresses, psychological problems of the family, attitude of the members of the family to sick persons (alcoholism, narcomanias, psychosexual disturbances).

The family doctor must be able:

1. to take case history of sick and healthy persons using psychodeontological regularities of communication, to determine the mental state of the patient (stress, anger, fear, joy, etc.), streaks of his character, temperament, the level of mental development, anxiety and alarm;
2. to observe the mental activity of people, to use the method of rational psychotherapy;
3. to diagnose nervous system disturbances (craniocerebral symptoms, autonomic dystoniae, polyneuritititides, plexititides, radiculopathies,

autonomic-endocrine disturbance of the hypothalamic localization, brain concussion and contusion);

4. to determine the state of the processes of perception, memory, thinking, attention and purposeful activity, consciousness and mentality, to diagnose affective disturbances, neuroses, psychopathies, alcoholism and narcomanias.

Successful performance of his professional functions by the family doctor is possible if only he has such most important personal streaks and skills as:

1. humanism and justice, mercy and sincerity, tactfulness and affability in relations with other people; modesty and delicacy;
2. high culture, a regular execution of instructive and educational work among the population, the work for strengthening the healthy mode of life;
3. initiative, discipline, careful fulfillment of his obligations, loyalty to Hippocratic oath, honesty and self-discipline in his work, a principled and exacting attitude to himself and other members of the staff; a systematic increase of his professional knowledge and skills;
4. an ability to be an attentive interlocutor and communicable in contacts with the patients and their relatives, an ability to memorize and effectively use the general and specific information (obtained in the process of intercourse with them) for prophylaxis and treatment;
5. an aspiration to a collegiate solution of professional problems in the staff of the polyclinic (out-patient department); efficient performance of his functions as an organizer of the work and an educator of the junior medical and paramedical personnel; preparedness for business contacts with trade unions and administration (management) of enterprises in the populated area or settlement where the patients attended to by the general practitioner live or work;
6. neatness, tidiness, an immaculate appearance which attracts the patient to communication with his family 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 snd cyrncisrn.

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 accents on creation of at least minimal intimate atmosphere for a patient.

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 70* 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 dav.

In International classification of diseases of the 10* 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 are

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 overfatigue 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. Overfatigue 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 calmant 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-destaiction, 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 analyze 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.

Methodical guidelines for the student's work at practical lesson.

There is 1 practical lesson (2 hours) for this topic. At the beginning of lesson the estimation of initial level of student's knowledge is carried out by oral questioning and solving of test tasks. Further students are independently speaks with patients for estimation of their mental state. Then results of examination are discussed.

Planning sheet of practical lesson

No.	Stage	Time (min)
1	Initial control (oral questioning with correction of student's knowledge)	25
2	Test control	15
3	Examination of patients by students	45
4	Conclusion	5

Graphological structure of the topic
"Psychology medical worker"

Medical worker

Psychological features of medical worker

Psychological types of doctors

Psychological types of nurses

Professional qualities of medical worker

Medical duty

Medical secrecy

Professional deformity

Medical errors

Emotional burn-out

PSYCHOLOGY OF TREATMENT AND DIAGNOSTIC PROCESS

Urgency: it's necessary to study psychological aspects of treatment process and factors which lead to conflicts in medical environment.

General objective: to show principles of medical deontology, to know how to avoid iatrogenia and correct its consequences.

Concrete objective:

1. To learn to analyze the psychological basis of communication in medical process
2. To learn to determine the reasons of conflicts on medical environment and find ways to their prevention
3. To know concepts of medical ethics and deontology
4. To analyze the reasons of iatrogenias and make conclusion for their prophylaxis.

Use the literature:

1. Essential of medical psychology: manual for medical students, interns, general practitioners /V.L.Gavenko, I.S.Vitenko, G.A.Samardakova et al. -Kharkiv: "Region-inform", 2003. - 188 p.
2. Summary of lectures
3. Graphological structure of the topic

Theoretical questions:

1. The main characteristic of communication as an activity
2. The main functions of communication
3. Influence of mimicry, gestures and clothes on effectiveness of communication
4. The main mechanisms of interpersonal perception
5. The role of culture of communication in medical profession
6. Types of conflicts
7. Styles of conflict resolution
8. Protective regiment in medical institutions
9. Medical ethics and deontology, their importance in the treatment process
10. Reasons of iatrogenias, their prophylaxis

Process of treatment of any disease is accompanied by a number of the psychological phenomena connected with the personalities of patient, doctor and applied therapeutic methods having as positive, and sometimes negative influence. The account of psychological factors of medical process allows to estimate efficiency of therapy and the forecast more deeply. The most adequate should consider an estimation of therapeutic dynamics in somatic, psychological and social aspects.

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 spécifie 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, 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 is 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 himself.

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, neighbour), 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, 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 fist 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) are 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 modem 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 is the rales about the outer side of the behavior and the principles, violation of which causes punishment and blame. Numerous rales 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 allow 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.

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.

Development of conflict:

Cause

Reaction of the parties

Key cause of the conflict: "What do you propose?

Proposition

Agreement - conflict doesn't develop

Disagreement conflict develops

Management of conflict

Consequences of conflict

Conflict resolution

Psychotraumatic conditions, pathogenetic importance for neuroses

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 than 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 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.

Medical deontology

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 are the whole complex of principles of regulation and standards of behaviour 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 behaviour 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 iatrogenics.

Iatrogenics

Iatropathogeny, contracted to iatrogeny (iatros = doctor, gennao = 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 (sorror = 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 iatrogeny 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 iatrogeny 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 iatrogeny is a type of psychogeny. 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 iatrogeny 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 iatrogenics.

An incorrect provision of medical education and popularization of data of the medical science may become a collective source of psychic iatrogeny. 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 gynaecological 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 arc 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 examinee 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 iatrogeny are distinguished:

S etiological iatrogeny, e.g. iatrogeny 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;

S organolocalistic iatrogeny 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 iatrogeny, 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, tumour, cancer, schizophrenia". Therefore it is better to avoid these expressions. Sometimes iatrogenics 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.

S Therapeutic iatrogeny 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 iatrogeny is facilitated by a so-called therapeutic nihilism, i.e. a pessimistic viewpoint of the doctor on the supposed results of the treatment.

S 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".

S Prognostic iatrogeny 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 iatrogeny 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 behaviour 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 behaviour.

The patient's personality may be another source of iatrogeny. 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 iatrogeny 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.

Methodical guidelines for the student's work at practical lesson.

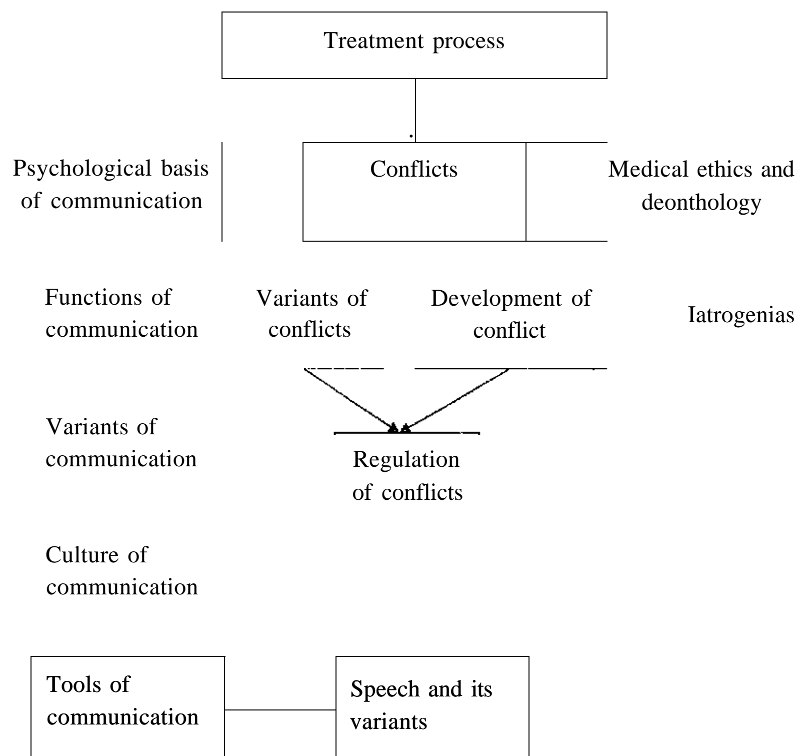
There is 1 practical lesson (2 hours) for this topic. At the beginning of

lesson the estimation of initial level of student's knowledge is carried out by oral questioning and solving of test tasks. Further students are independently speaks with patients for estimation of their mental state. Then results of examination are discussed.

Planning sheet of practical lesson

No.	Stage	Time (min)
1	Initial control (oral questioning with correction of student's knowledge)	25
2	Test control	15
3	Examination of patients by students	45
4	Conclusion	5

Graphological structure of the topic
"Psychology of treatment and diagnostic process"



PSYCHOSOMATIC DISORDERS IN GENERAL CLiNICAL PRACTICE

Urgency: The ideas about close relation between the body and the soul, somatic health and mental state have always been the leading issue of medicine. Hipocrates considered that it was necessary to treat the patient,, not the illness, i.e. a holistic approach to diagnosis and treatment was necessaiy. It's important to take onto account not only somatic state of the patient, but also his psychological features, psychosomatic mechanisms of development and course of the disease.

General objective: to estimate the psychosomatic interrelations in diagnostics, treatment and prophylaxis of somatic diseases.

Concrete objective:

1. To know the concepts "psychosomatics", "psychosomatic disorders"
2. To understand the influence of acute emotional stress on human mental state
3. To understand the features of non-pathological psychosomatic reactions and psychosomatic disorders.

Use the literature:

1. Essential of medical psychology: manual for medical students, interns, general practitioners /V.L.Gavenko, I.S.Vitenko, G.A.Samardakova et **al.** -Kharkiv: "Region-inform", 2003. - 188 p.

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3. Graphological structure of the topic

Theoretical questions:

1. Psychosomatic approach as the principle of medical activity
2. Emotional stress as the etiopathogenesis factor of psychosomatic disorders
3. Influence of psychological factors on course of somatic disorders
4. Theories of psychosomatic interrelations
5. Mechanisms of psychological defence of personality
6. Concept of adaptation, desadaptation, distress
7. Classification of psychosomatic disorders
8. Non-pathological psychosomatic reactions
9. Principles of prophylaxis of psychosomatic disorders

Psychosomatics - is the batnch of medical psychology studying psychical factors in the development of functional and organic somatic diseases.

Psychosomatic medicine began to develop quickly at the beginning of the 20th century. Millions of cases of so-called "functional patients" were registered at that time. Their somatic complaints were not confirmed with objective studies, treatment with traditional drugs was ineffective. At first correction of the affective states and disorders in the interpersonal relations of the patients, that is psychotherapy, mental consultations were necessaiy. Changes of somatic well-being because emotional influences are: non-pathological psychosomatic reactions, psychosomatic diseases, influence of

emotional state on onset and course of somatic diseases, somatoform disorders.

When studying the relation between somatic and mental states it is reasonable to distinguish the following types:

1. Psychological factors as a cause of somatic disease (proper psychosomatic diseases).
2. Mental disorders which manifest with somatic symptoms and signs (somatization disorders).
3. Mental consequences of somatic diseases (including psychic reactions to the fact of somatic disease).
4. Incidentally simultaneous mental disorders and somatic diseases.
5. Somatic complications of mental disorders.

The representatives of psychoanalysis explain psychosomatic pathology emphasizing the prevail of forcing out emotional experience (protective mental mechanism which manifests with subconscious exclusion of the undesirable thought or emotion from the conscience) which later manifest with somatic symptoms and signs in the patients with psychosomatic signs. But they neglect the organic pathology, though in practice the physician should remember that the patients may develop organic diseases, psychotherapy is not sufficient right from the beginning of the disease, the treatment of the respective disease with the use of modern pharmaceuticals, sometimes surgery are necessary.

Scientific validation of psychosomatic relations can be found in I.P.Pavlov's theory of conditional reflexes. P.K.Anokhin, a Russian neurophysiologist, worked out a biological theory of functional systems. It is the concept about organization of the processes in the whole organism which interacts with the environment. This theory views the functions as achievement of an adaptation state by the organism at its interactions with the environment. According to this theory, any emotional reaction is viewed as a holistic functional system which combines the brain cortex, subcortical structures and the respective regions of the body.

From the point of view of neurophysiology, emotional processes involve both central (hypothalamus, limbic system, structures of activation and rewarding) and peripheral structures (catecholamines, adrenal hormones, vegetative nervous system). Extreme in its force and duration irritants change the functional state of the central and peripheral nervous system. With this functional disturbances locus minoris resistentiae (sites of minor resistance) may develop. There is a system of constant feedback which determines the possibility of therapeutic action on the emotional factor.

In response to psychoemotional stimuli various non-pathological psychosomatic reactions (visceral, sensor) may develop. Psychosomatic reactions may appear not only in response to psychic, emotional influences but also to direct action of the irritants (e.g., a view of a lemon). Representations may influence the somatic health of the person. Psychoemotional factors may cause the following physiological disturbances

in various organs and systems of the organism:

a) in the cardiovascular system - increased heartbeat, changes in the blood pressure, vascular spasms;
b) in the respiratory system - delay, increased or decreased respirator}' rate;
c) in the digestive system - vomiting, diarrhea, constipation, increased salivation, dryness in the mouth;
d) in the sexual sphere - increased erection, weak erection, clitoris swelling, lubrication of the sex organs, anorgasmia;
e) in the muscles - involuntary reactions: muscular strain, tremor;
f) in the vegetative system - perspiration, hyperemia.

Psychosomatic disorders are those the origin and course of which are chiefly determined by psychological factors. The cause of psychosomatic diseases is affective (emotional) overstrain (conflicts, rage, fear) when definite personality feaUires are present. Psychological factors play a role in other diseases: migraines, endocrine disorders, malignant tumors. Nevertheless it is important to distinguish true psychosomatic diseases, their development is determined by psychic factors and prevention should be aimed at elimination and correction of emotional overstrain (psychotherapy and psychopharmacology) and the diseases, the development of which is also influenced by mental and behavioral factors because they change nonspecific organism resistance but they are not the primary cause of their occurrence. For example, it is known that influence of psychoemotional stress can decrease the immune reactivity which increases the probability of diseases (including infectious).

Psychogenic component plays an active role in various organic disorders, e.g. hypertesion, gastric and duodenal ulcer, myocardial infarction, migraine, bronchial asthma, ulcerative colitis, neurodermitis. These diseases are frequently termed "major" psychosomatic diseases, emphasizing the severity of the disease and a leading role of the psychogenic factor in their development.

True psychosomatic disorders are characterized by the following:

1. Psychic stress play a key role in the origin.
2. After its manifestation the disease becomes chronic or relapsing.
3. The first manifestations can be noted at any age, but chiefly in teen-agers.

Classical clinical pictures of seven diseases, namely essential hypertension, ulcer, bronchial asthma, neurodermitis, thyrotoxicosis, ulcerative colitis, rheumatoid arthritis, are psychosomatic disorders.

Psychosomatic disorders are the consequence of stress caused by prolonged mental traumas, inner conflicts between similar in the intensity but different in direction motives. Some types of motivation conflicts are believed to be specific for definite diseases. Thus, hypertension is associated with the conflict between strict social control of the behavior and an unrealized need of power. The unrealized need causes aggression, which cannot be manifested

because of social restrictions. In contrast to neuroses based on intrapsychic conflicts, psychosomatic disorders are characterized by dual forcing out of an unacceptable motive and neurotic anxiety and neurotic behavior.

As it is important to understand the essence of protective psychological mechanisms, therefore it is necessary to characterize them. The protective mechanisms are divided into primitive, or immature (splitting, projection, idealization, identification), and more mature (sublimation,' rationalization). But neither the number of variants of protection (several dozens have been described) nor their taxonomy are generally accepted.

One group combines the types of protection which decrease the level of anxiety but do not change the character of inducements. They are *inhibition or forcing oat* from the conscience of unacceptable inducements or feelings, denial of the source or feeling of anxiety; *projection* of transfer of the desires and feelings to the other; *identification* - mimicking the other person with ascribing his qualities; *inhibition* - blocking in the behavior and conscience of all manifestations associated with the anxiety. The other group unites the forms of protection in which the mechanisms reducing the anxiety and changing the direction of the motives work: *autoaggression* - direction of the hostility to himself; *reversion* - polar changes in the motives and feelings to opposite; *regression* - decrease, or turning to earlier childish forms of reaction; *sublimation* - transformation of the unacceptable forms of satisfaction of the needs to other forms, e.g. creative work in art or science.

The main nine forms of mental protection are the following.

1. Forcing out. This is inhibition or exclusion of unpleasant or unacceptable events or phenomena from the conscience, that is removal of the moments, information which cause anxiety. For example, in neurosis main causative event is frequently forced out. Interesting are the following psychological experiments. The subjects were given the photos of specific conflict situations close to their experience. The subjects were expected to describe them, but they seemed to forget the photos and put them aside. When the photos were given in the state of hypnosis, the protection was taken away and the photos caused the effect adequate to their content. Similar mechanism of protection is in the basis of a well known phenomena when the person notices somebody's errors and faults and forces out his own. In other experiments the subjects were given tests on achieving success at doing some task. They recollected only those tasks which they had done correctly and "forgot" those which they had failed.

2. Substitution is switching from an unpleasant, causing anxiety experience (subject) to another. This variety of psychological defense can be illustrated by the following examples. After a conflict with the chief or a quarrel with a date the person directs his anger to the members of the family (rationalization can frequently take place). The person during an exiting talk crumples a shiet of paper. A girl when hearing a phrase "your boyfriend is always letting you down" throws away the cat sitting on her knees.

3. Rationalization. This is an attempt to substantiate the desires and acts if recognition of their course could threaten with loss of self-respect. The examples are numerous. If a greedy person is asked to lend some money, he can always find a reason why he cannot do it (to teach a lesson, etc). If a person is unpleasant to you, you can always find a lot of shortcomings, though your dislike may not be associated with them. The patient can explain his interest to medical literature with the necessity to broaden his outlook.
4. Projection. Protection in the form of projection is unconscious transfer of unacceptable feelings to another person, ascribing somebody's own socially inappropriate desires, motives, acts and qualities to the surrounding persons. An example of it can be the behavior of a young well-to-do man who placed his mother to the house for aged persons and is indignant with the bad attitude of the personnel to her. To a certain degree, projection simplifies the behavior, excluding the necessity to evaluate the acts constantly. We frequently transfer our behavior to other people, projecting out emotions to them. If a person is quiet, sure of himself, well-disposed, he thinks that the rest are also well-disposed. A strained frustrated persons, unsatisfied in his wishes is hostile and projects this hostility to the other.
5. Somatization. This form of protection is expressed in exit from a difficult situation with fixation on the state of health (illness before tests is the simplest example). In this case significant is benefit of the illness - increased attention and decreased demands of the relatives. In more severe cases this form of protection becomes chronic, as a rule, exaggerated attention to the health and overestimation of the severity of the disease including creating the own concepts of the disease are present. Hypochondriacal syndrome may develop.
6. Reactive formation. In this case unacceptable tendencies are changed to the opposite ones. Thus, turned down love is often expressed in hatred to the former object of love, boys try to hurt the girls they love, the people who are secretly envious frequently sincerely believe that they are true admirers of the person they are envious of.
7. Sublimation. This form of psychological protection is characterized by transformation of unacceptable impulses to socially acceptable forms of instinctive requirements which cannot be realized in an acceptable way out and the means of expression (e.g., people who do not have children frequently have pets). For some people, hobbies are a way of realizing the most unbelievable motives. Egoistic and even "forbidden" puiposes can be sublimated with an activity in arts, literature, religion, science. Aggressive impulses, for example, can be sublimated in sports or policy. But proper psychological protection is meant when the person does not realize that his activity is determined by hidden impulses with biological and egoistic basis.
8. **Regression.** This is turning back to primitive forms of reaction and

behavior. Especially frequently this form of psychological protection is observed in children. For example, children without parents demonstrate the behavior characteristic to development retardation: the child who began to walk suddenly stops to walk, enuresis, which was present in infancy, recurs. We can mention a habit to suck the finger in difficult situations (this feature can be seen not only in children but also in adults). Elements of psychological protection in the form of regression can be observed in some mental diseases.

9. Negation. This is a protective mechanism, which does not recognize but rejects impracticable desires, intentions, facts and actions by unconscious negation of their existence, that is real phenomena are believed to be not existing. It is necessary to emphasize that negation is not a conscious attempt to renounce, like in mimicking or lie.

In the majority of real situations several forms of psychological protection are usually used together. This should be taken into account by the doctors working both with healthy and sick persons.

An unresolvable conflict of motives (as well as uncontrolled stress) causes capitulation, refusal from the search, which creates the background for development of psychosomatic disorders in the form of masked depression. The lesion to the organs and systems is due to genetic factors or peculiarities of ontogenetic development.

Characteristics of "sychQsoniatic disorders

Revealing psychological features which are responsible for development of psychosomatic diseases resulted in description of the features which aire 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 rushes (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.

We examined the mental state in patients with arterial hypertension and performed daily monitoring of the arterial pressure. Our study demonstrated that at the early stage of arterial hypertension after increase of the arterial pressure the patients reduce the level of anxiety. Thus, compensatory role of pressure elevation due to prolonged psychoemotional strain was confirmed.

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.

In some patients the diagnosis of the disease does not produce any reaction, they neglect the disease, refuse from treatment. This attitude to the disease is observed chiefly in alcohol abuse.

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, 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 form 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 injuriing 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 "posess-give". 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.

It is known that emotions (anger, fear, excitement) can produce and increase the attacks in asthma. It was reported that in children who had died of severe form of asthma, chronic mental and family problems had been noted more often than in the other asthma patients.

Mental disorders are not more frequent in children with asthma than in the whole children population but when these children have mental problems they are more difficult to treat.

There were several attempts to treat asthma using psychotherapy and behavioral therapy but there are no convincing data suggesting the efficacy of these methods when compared with ordinary advice and support. Individual and family psychotherapy can benefit in treatment children with asthma in case when psychological factors are important.

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.

Strong prolonged affects, negative emotions such as constant fear, grief, fright at strained cortical activity can cause prolonged spasm of the blood vessels in the stomach walls, if the resistance of the mucous membrane to the action of hyperacid gastric juice is low, it can result in ulcer appearance. Further development of ulcer depends on both the above factors and appearance of pain impulses from interoreceptors of the involved organ. Psychotherapy influences the course of the disease and the efficacy of treatment.

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.

Prophylaxis of psychosomatic diseases

The leading role in treatment psychosomatic disorders is played by general physician. But psychotherapy is also important for prevention of these diseases and at all stages of treatment and rehabilitation. Important is revealing personal predisposition and prolonged personality-oriented psychotherapy. General physicians should train the patients the skills of psychic self-regulation, autogenic training for mobilizing and relaxation in stress situations.

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.

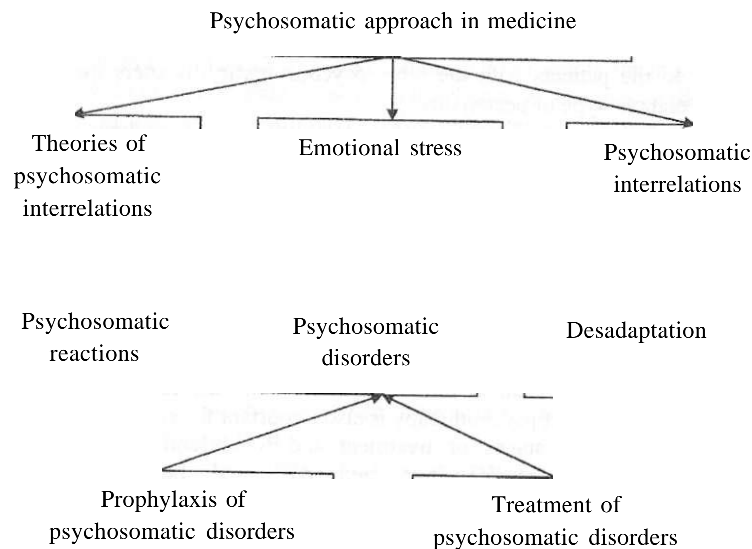
Methodical guidelines for the student's work at practical lesson.

There is 1 practical lesson (2 hours) for this topic. At the beginning of lesson the estimation of initial level of student's knowledge is earned out by oral questioning and solving of test tasks. Further students are independently speaks with patients for estimation of their mental state. Then results of examination are discussed.

Planning sheet of practical lesson

No.	Stage	Time (min)
1	Initial control (oral questioning with correction of student's knowledge)	25
2	Test control	15
˃	Examination of patients by students	45
4	Conclusion	5

Graphological structure of the topic
"Psychosomatic approach of treatment and diagnostic process



PSYCHOLOGICAL PECULIARITIES OF PATIENTS WITH VARIOUS DISEASES

Urgency: Each disease, besides its typical clinical manifestations, always is accompanied by larger or smaller changes in patient's mentality. Any disease, even if it is not accompanied by organic disturbances in the brain, influences the patient's mentality. On the one hand the clinical picture of mental changes is determined by of disease and on the other hand by peculiarities psychological characteristics of the patient. ,

General objective: to determine the psychological features of the patients with various diseases and take into account their influence on treatment process features.

Concrete objective:

1. To analyze the psychological features of the patients with various diseases
2. To interpret the influence of psychological features on the course and treatment of the disease and psychological changes in patients.

Use **the literature:**

1. Essential of medical psychology: manual for medical students, interns, general practitioners /V.L.Gavenko, I.S.Vitenko, G.A.Samardakova et al. - Kharkiv: "Region-inform", 2003. - 188 p.
2. Summary of lectures
3. Graphological structure of the topic

Theoretical questions:

1. Psychological changes in cardiovascular diseases <
2. Psychological changes in diseases of respiratory system
3. Psychological changes in diseases of digestive tract
4. Psychological changes in infection diseases
5. Psychological changes in endocrine, neurological and mental diseases
6. Psychological changes in patients of gynecological units v/
7. Psychological features of women during pregnancy and delivery
8. Psychological features of ill children and people of declining years t/
9. Psychological features of patients in surgical units before and after surgical operations, in traumatological unit, v

10.Psychological features of patients in stomatology, ophthalmology, ENT
] 1 .Psychological features of patients with oncological pathology */
12.1nfluence of inherent and acquired physical defects on human mentality

Psychological peculiarities of patients with internal diseases. At acute onset of the disease a sense of confusion, fear of death appears in patients. At lingering the illness the mood is reduced, irritability and excitability appear.

There is fear, anxiety, confusion in acute period of disease in patients with **rheumatism.** In future the mood is reduced and in severe cases

flaccidity and apathy are changed by the appearance of locomotive and speech activities with underestimation of severity of disease and its consequences. The patients with progressive polyarthritis are suppressed and depressive, such patients get on with each other badly. As opposed to this the patients with Bechterew's disease are amicable, as rule, optimistic, they accept their fate with a smile even at immovable spinal column.

During the initial period of forming valvular heart diseases there are unpleasant sensations, the patients fix their attention on the heart work, fear of death from cardiac arrest appears.

In hypertension during the first stage the majority of patients estimate their health condition adequately, they fulfill all doctor's prescriptions. People with anxious hypochondriac character perceive increased arterial pressure as a catastrophe. They fix their attention on unhealthy sensations, range of their interests is limited by the disease. In hypertension some patients ignore the possibility of sever consequences and refuse from treatment and they do not give up harmful habits.

At cerebral atherosclerosis the patients become groundlessly susceptible, hesitation of mood, lacrimation, diminution of efficiency and irritability are noticed.

During the period, preceding to development of myocardial infarction, a sensation of vagueness in the head, difficulties in concentration of attention, presentiment of approaching danger, anxiety, melancholy, in some cases - euphoria appears. In acute period of myocardial infarction the painful syndrome is accompanied by fear of death; during the recovery the attention of patients is fixed on their sensations, they are hypochondrical.

At bronchial asthma the emotional tension promotes the origin of asphyxia attacks, moreover, the reaction at this to a considerable extent depends on peculiarities of the person. Such patients often feel fear connected with waiting for another attack. In chronic course of bronchial asthma the change of patient's character occurs. In pneumonia when the temperature is rising consciousness of patients can be disturbed.

In acute pneumonia in some patients reduction of activity, hypodynamia, unsociability unhealthy attitude to investigation and treatment are observed. When the temperature is rising the consciousness of the patients can be disturbed.

In chronic lung diseases many patients feel reduction of mood, irritability, their attention is fixed on unpleasant sensations and thought of incurability appear.

In pathology of digestive organs psychological peculiarities of patients are formed under the influence of such symptoms as meteorism, frequent urges to defecate, which cause a sense of shyness, discomfort. The patients with chronic gastritis complain of weakness, reveal the activity in investigation and treatment, some of them are afraid of carcinoma of stomach.

In peptic and duodenum ulcer patients often "go into disease", fixing their attention on unpleasant sensations, they feel fear of pains. The loss of

weight, gastric hemorrhage, diminution of efficiency cause anxiety for life, sensation of irreparability.

Nonspecific ulcerative colitis is often accompanied by sense of melancholy dissatisfaction with the fear of death.

In chronic liver diseases in patient's nature such characteristics as dissatisfaction, grumbling "irritable" appear.

It is necessary to pay special attention to the patients with **malignant neoplasms** because various mental reactions can develop according to the stage of disease. Thus, at first stage the mood usually comes down in waiting of "verdict"; attention is riveted to own sensation, results of investigations, doctor's words; overestimation of vital values occurs, features of character often become keen. When the diagnosis is known there are affective reactions, the patients begin to fight with the approaching danger, fatigability appears, the mood is come down, the sensation of pain becomes keen. These is no fear of death at premortal stage in many patients. A special caution and tact should be kept at contacts with incurable patients. All trivialities must be taken into account, personnel and relatives have not to bustle, an important question of telling the diagnosis to the patients in case of incurable disease. It is necessary to have an individual approach with taking into consideration characterologic peculiarities of the patient.

The patients with groundless persistent fear of malignant neoplasm, which they have supposed by found, require a great psychotherapeutic work. The doctor must, patiently and persuasively prove insolvency of patient's suspicions. Such patients must not be ignored on no account, because a scornful doctor's attitude can finally persuade them in their truth and it can lead to suicide.

Psychological peculiarities of patients with infectious diseases. The fact of discovering of the infectious disease and necessity of hospitalization cause senses of shame, fear in patients, that they can become a source of contamination of their nearest.

At prodromal stage of the infectious disease the patient's estimation of his condition depends on psychological traumatic situation and is defined **by** ethic emotions of general toxic character are predominated, sometimes there is disorder of consciousness at recovery stage various asthenic manifestations prevail. In patients with special dangerous infections, the degree of disease, a high contagion, a doubtful prognosis often cause acute psychological reactions, reminding the conduct of people in situations of mass natural calamity.

Psychological peculiarities of patients, infected by AIDS. The reaction on the diagnosis of AIDS (the most terrible disease, "the plague of the XX cenmry") is manifestation of psychological stress with reduction of mood, ideas of self-accusation, suicide thoughts or tendentious. The obsessive fear of death, ideas about the process of death appear in patients, some people are afraid of a thought about a possibility of infection of the relatives. In future the symptom of intellect reduction appears. In patients from the risk

group, including the infected persons and the most exposed to contamination people, alarm, irritability, anxiety are observed, capacity to work is reduced. They are fixed on their health, read a lot of literature about this disease, look for the symptoms of this disease. Many people break their sexual contacts. Some of them reveal the frank antisocial tendencies, trying to pass the virus of AIDS to other people.

Psychological peculiarities of patients with tuberculosis. Diagnosis of tuberculosis, necessity of prolonged hospital treatment are taken by some patients as a tragedy, as a catastrophe. The anxiety, fear of avoiding the contacts with the nearest people and colleagues develop. However, the majority of people receives the fact of disease and necessity of treatment correctly.

Psychological condition of the patients with tuberculosis is characterized by special sensitivity, sentimentality, emotional lability, exhaustion. The patients are asthenic and on this background there are situational conditioned affective manifestations and hysteric reactions. The doctor must take into account these peculiarities and estimate adequately appearing conflict situations with surrounding People and personnel as a manifestation of the disease. In these cases it is necessary to prescribe sedatives and not to reprimand the patients.

In asthenia there is an increased mood with garrulity, motor activity, which rapidly change into irascibility, tension or indifference.

A number of psychological problems are also caused by the treatment. The cooperation of patients and their responsibility have great significance. The condition of undisciplined and irresponsible patients is often worsened because they do not keep prescribed regimen and method of treatment. This circumstance increases the demands to the organization of the regimen and to individual psychotherapeutic approach to the patients.

Psychological peculiarities of patients with dermal and venereal diseases. Skin is the organ which the person shows to the surrounding people, as well as his figure. It has a significant psychological meaning. Mental reactions in skin disorders include more wide circle of disorders, conditioned by negative aesthetic ideas, squeamishness on the hand of surrounding people and by shame, a sense of own inferiority complex and uncertainty if future on the hand of a patient. The appearance of a patient is distorted the most by psoriasis, eczema, acne, scars after chronical granuloma and bums, colloids, hypertrichosis. Especially in the pubertal period the patients fall into depression, often not corresponding to the character of the disease on the objective point of view, for example, at imperceptible acne or at moderate loss of hair. At some skin disorders a special problem is pruritus, which may lead to irritability, insomnia and depression. The patient is often thankful for elimination the signs of the disease.

Venereology, Some patients dissimulate their sexual life in order to avoid investigation of circumstances when the disease appeared. They look for prohibited methods of treatment; uncertainly in effectiveness of treatment

may inspire with misgivings and tension, whether they have cured or complications have not appeared. The result of dissimulation may be infection of other people. According to the patient's conduct, opinions, partly to the appearance and hygiene, skilled venereologist decides whether he can rely upon the patient's information and his cooperation in the process of treatment. In contradistinction to socially doubtful persons, who are vulgar, toady, sly and insincere, some accidentally infected patients are shy or they suffer from shame and; feel pangs of conscience, sense of own inferiority complex and they need an approval and definite reduction of the disease significance. Gonorrhea and trichomoniasis are the examples of that somatically "banal" and easily cured disease may be veiy heavy on psychological point of view.

At recovery some patients underestimate the role of the doctor's observation for the consolidation of treatment successes. Other patients reveal suspiciousness, overestimate the significance of a separate coming symptoms.

Psychological peculiarities of patients with organic cerebral disorders. A neurologist meets fear of brain tumor and severe encephalopathy in minor diseases, for example, in headaches of other ethiology. Psychological examination may help in determining the level of disorders of higher nervous activity and mentality at organic cerebral affections.

Psychogenic factors sometimes provoke extrapiramyd symptoms of organic disorders, for instance, in Parkinson's disease, in some patients they also provoke a big spastic fit and attack of migraine. Diseases are connected with limitation of mobility cause depression and suppression. More attention should be paid to development of consequences of cerebral hemorrhages. The question is about individual school for adults, who need renovation of disturbed knowledge and abilities, such as speech, reading, writing and calculation.

Peculiarities of contact with mentally ill patients. The attitude to mentally ill people must be the same as to other patients: correct, polite, benevolent, merciful, affable.

Spearing to such patients it is necessary to listen attentively to patient's complaints even if they seem absurd as to manifestations of the disease. It is impossible to show rudeness, contempt, mockery to the patients. The doctor should get out existed in society prejudices with regards to mentally ill. It is necessary remember that in some patients there is absence of understanding of disease and to carry out the urgent hospitalization to the psychiatric department and to treat them without agreement or, sometimes, in spite of their demands. It requires tact and patience from the doctor and personnel of psychiatric clinic. It is necessary talk calmly, softly with the relatives, io convince them in necessity of treatment in out-patient or in-patient departments. In psychiatric clinic it is necessary to keep vigilance, to see to it that the patients do not make any actions, threatening to health and life of the patient and surrounding people. In contacts with mentally ill it is necessary to

convince, but not to deceive them.

Psychological peculiarities of patients in gynecological clinics. In young the appearance of first menstruation sometimes causes fear and neurotic reactions, that is why they should be psychologically prepared. But, even in that case, when girl is informed, she can feel painful menstruation. The girl, who little by little becomes a woman, feels her feet and looks for the corresponding examples. Most often her mother becomes such an example. If the mother's marriage is unhappy the daughter takes the part of the woman dually or even with misgiving and aversion. But even in healthy women, during the menstruation there are pains in sacral region and abdomen, pressure in genital organs, mental irritability and inclination to depression. At negative mental feeling of menses these symptoms may be strengthened and dysmenorrhea appears. In dysmenorrhea it is difficult to establish the role of hormonal and mental factors and all the peculiarities should be born in mind. At premenstrual period in many women the similar manifestations are present: irritability, fatigue and headaches. Premenstrual complaints may be relieved by means of placebo in 60 per cent, that shoes the considerable influence of mental factors in their origin. Expectation of menstruation is often tense, connected with fear of pregnancy. Amenorrhea (e.g. the full absence of menstruation) may be caused by suggestion and hypnosis. It also develops in depression and fear of unwanted pregnancy. In that case there is a positive reverse connection, "vicious circle": misgivings lead to amenorrhea, which strengthens the fear. The influence of these disturbances was described: at earthquakes, air raids, in concentration camps, at death of the closest people or relatives and even at removals. Sometimes it is said about amenorrhea as "tendentious" purposeful symptom; living in a hostel the girls are ashamed, try to avoid the attention and takes, that is why they press psychogenically the menstruation. In the contrary menstruation as a tendentious symptom can appear prematurely, for instance, before the operation which causes fear in women so that the menstruation "saves" the patient from unpleasantness for some time.

At gynecological examination in is necessary to remember that women are often admitted to gynecological clinic for intervention, that is why it is necessary to keep similar recommendations as in surgical departments. Obstetric divisions deserve a special departments. Obstetric divisions deserve a special attention. The physician should know about the feelings of an expectant mother, especially of primípara: anxiety for pregnancy termination, fear of labor pains, trouble for the infant's health. **The** unbalance, emotional instability, shame of parturient women demand benevolentness, affableness, cordiality from the personnel. If possible delivery room should be situated not closely to admitting unit and prenatal wards. It is very important to watch for puerperant women as various mental reactions may occur during postpartum period.

Climacterical period is one of the most important stage in woman's life, when the hormonal changes sometimes cause hot flushes to the head,

tachicardia and other symptoms. But all these disturbances, appearing in. Climatical period, are not only hormonal ones. Fore a number of woman menopause is a stimulus for summing up the life, for thoughts of whether they are glad of their life and what they can expect from future. Many women do not know that sexual life may be continued after menopause and it may be more harmonic, especially in women who were afraid of pregnancy. Doctor's assertions, that disorders in climacterical period have exceptionally hormonal origin, are sounded fatalistically and can cause iatrogenia.

Psychological peculiarities of relations: mother - child - doctor. The work with children, care for them, sick or healthy, correct estimation of their conduct, reactions require a special knowledge. In pediatrics, psychologically difficult question is a demand of corresponding and differential approach to children of various age groups. A good pediatrician possesses the entire scale of verbal and mimic expressions which help him artistically approach to the degree of reactivity and contact with sick children. A pediatrician, who has his own children, is in more profitable condition, as he can use his own experience. The age of the child is not a reliable indicator, showing to the personnel the level of communication with him. There is a certain percent of feeble-minded children, a great number of narrow-minded and retarded children, who can make up this lag in future and children with accelerated development, which is retarded afterwards and none the less caught up with other children.

A child's disease is a very difficult situation for all family. A chills reaction of the disease depends on the parents' conduct and ways of upbringing. The child of a pre-school age is afraid of the fact of hospitalization, isolation of parents. If in the family the children were spoilt "idols", they would be helpless in hospital. The parents' conduct at severe conditions often influences unfavourably their children.

In case when the urgent hospitalization is need the pathologic reaction may arise when the child weeps, cries or does not leave his mother **Such** reactions may last for some hours to some days.

The great psychological problems arise in the parents, when they learn about a severe, incurable, chionic disease of the child. At first, reactions of distrust are observed and the parents consult various specialists, they hope for a mistaken diagnosis. The results of the investigations are often discussed in the presence of the child, that influences him negatively.

In children with a lingering illness, when the parents create them special conditions, inclination to hysteric reactions, features of mental infantilism appear, which makes difficult adaptation to outer environment.

In children's medical establishments the doctors and personnel must be able to devote themselves to the children, to play with diem, as in the play a child is calmed down. During the process of plays the doctor studies the personal peculiarities of the child, his wishes and needs. The play abstracts children from unpleasant feelings.

In the same ward it is reasonable to gather children with the same level

of development. It is necessary to remember that children, even little ones, always listen to doctors and student's talks in the ward and then they speak out their misgivings to the parents.

Sometimes in teenagers the cases of simulation malingering in order to attract the attention or as the protests again any vital unpleasantnesses are observed.

The most heavy moments for the parents are when their child is ill with sarcoma or leukemia. The personnel receive the death of a child more heavily than the death of an adult.

Gerontology. In some therapeutic departments there are more than 60 per cent of people over 60. There is no doubt that the improvement of vital conditions and medical aid prolong the life. But somatic preservation of life is not always connected with its positive mental filling. Old people can not adapt to rapid changes of life and they are not able to understand much that is difficult for young people too. In spite of that they live with young people in the family, they are still relatively isolated as far as they do not always understand new conditions of work and life. But in those cases when the people live in total solitude, their condition is the most complicated. In old solitary people such paradoxical phenomenon may be occurred that their disease will become the last opportunity of establishing the contact with people: the doctor comes to the patient, the patient can be hospitalized, where in the group of patients he would feel sympathy and interest to him.

The border between the health and disease is more pronounced in old people than in young age. German people say about everyday usual malaise - "Alltagsbeschwerden". In frequently repeated malaise in old people attitude to it plays an important role: whether this malaise will be felt more intensively, cause fear and diffidence or whether a person on the border between health and disease will be able to abstract from unpleasant sensations, to live more by impressions of events, happening in the word and the contacts with surrounding people than by own body and fear of it. At deficiency of other stimuli, aged solitary people concentrate their attention on somatic processes, intensively feel their sensations, conditioned by organic and neurotic causes, and do the only, which, to their.opinion, makes sense: they go to the doctor and ask for help.

Psychological **peculiarities** of **patients in surgical clinics.** In this specialty the technique has achieved more perfection both in sense of interventions and in equipment. Surgeons' concentration of attention on surgical technique and its facilities sometimes comes to underestimation of patient's psychological state. In a number of cases there is cold, featureless atmosphere, where the patient does not feel well. When the patients change frequently and the personnel is in a hurry, which is cased by emergency it is not always possible to develop psychological relations between the medical personnel and the patient. Moreover, the patients often consider the surgeon as an ideal doctor who brings help by means of rapid energetic intervention, which is taken by the patients passively. In surgery, in surgeon's conduct, in

popularization of prominent achievements of modem surgery those are definite magic features, that is why today we can speak about one of the magic foims. In surgery the patient more than in other speciality is given to doctor's power, especially when he is under narcosis during the operation. Mental shocks, felt by the patient in such circumstances often leads to that, the patient, before the operation, informs his doctor about vital problems frequently kept from the other.

Considerable mental traumas for patients are crippling interventions such as amputation of limbs, amputation of breast in women in breast carcinoma, providing intestinal potency in intestinal carcinoma, partial gastroectomy at relapses of ulcer. Subjective feelings and patient's attitude to his own physical state often play the most important part in the future life than the size of organic lesion.

Sometimes patients refuse from operation. The causes of refusal are:

1. The patient has been frightened by other patients, who had undergone such intervention, and telling about unpleasant impressions, which they had "felt heroically" they want to be in the centre of attention and to call the astonishment.
2. Similar operation led to severe consequences, deformation or even death of the patient's relative or friend.
3. The patient underestimates or denies his disease on light - mindedness or to avoid misgivings or cares.
4. For everything the patient reacts by fear or misgiving. The question is often about psychopathic and neurotic persons.
5. Unpleasant own impressions of the previous operations, for example, fear of narcosis, when many patients feel expressed fear "of a sense of falling into a bottomless precipice".

One of the most important stage is preparation to the operation. The surgeon should reveal interest and affability, to estimate the role of the disease and operation in the patient's life and his future; it is important to listen to his misgivings and wishes. Some patients are afraid of unconsciousness and helplessness, caused by narcosis, they feel fear of not waking up, suffocating, disclosing their secrets, "telling nonsenses", becoming funny. Such mood is sometimes strengthened by other people who tell about their impressions, which they had felt. Some patients unwarrantly say that "narcosis had not taken an effect" and they were operated "in clear consciousness". Sometimes because of ignorance they take local or lumbal anestesia for general one.

At first stage of narcosis the patients are not notable for increased receptivity to personnel expressions which retained in their memory, but sometimes, these words are perceived illusory or remembered distortly after recovering from anesthesia, and mental iatrogenia can develop without the fault of personnel. That is why it is necessary to bring to minimum speech contact between the medical personnel during the operation. At recovery from anesthesia patients demonstrate increased sensitivity to sensory irritations

such as noise, strong light, smell, which can cause nausea and vomiting. It is necessaiy to take this into consideration at preparation of the room, where the patient will be kept after recovery from anesthesia.

The operation is a source of tension as it is connected with waiting of result, sometimes the patients are injured by the delay of in the terms of the operation. Although after the operation the majority of patients do not know about its consequences, they have a sense of alleviation, because of "becoming a thing of the past", "their returning to life", or "avoiding of death". It can favourably influence the action of a surgical placebo, especially in patients with inoperable rumours. However in the majority of cases a sense of alleviation is brief or it is changed by strengthening of symptoms, resulting both the disease and the postoperative weakening of the organism. If the disease becomes worst the patients unwarrantiy attribute it to the operation: "The operation is guilty", "I should not have agreed to the operation". The postoperative course becomes difficult due to such circumstances as: a bad contact of patient with the personnel, the patient's incapacity to express his condition by means of words; unfavourable vital and family situations, which can complicate the operation's results; bad adaptability; his emotional immaturity, a weak or unbalanced type of temper, neurotic features of the character.

Elderly people adapt worse to the changes, they are more afraid of death. Their wounds heal slowly, the postoperative complications develop frequently and last for a long time. (Twenty five per cent of elderly people have postoperative complications). They also have brain disorders with disturbance of blood supply and metabolism. They long for visitors who must be admitted to the patients as they get accustomed to their belonging, the nurse should arrange with patient's relatives, which things are necessary for the patient, for instance, spectacles or hearing apparatus.

In spite of strict demands of a hygienic regimen in surgical department these requirements can be satisfied.

Piastic surgery. According to this specialty two fields of psychological problems can be described, which are various to some degree, but equally labour-intensive and complicated. On the objective hand there are those conditions when the surgeon improves the results of severe traumas or bums and during the team-work with a personnel or psychologist he should prepare the patient to a sudden mental trauma, for example, the first look in a mirror after plastic operation the face looks aesthetically better when compared with what it was after the trauma or bum, the patient compares his appearance with that he had before the trauma or burn and he can be disappointed or shocked.

Another field of problems deals with cosmetic operations, with the dissatisfaction of appearance carries exclusively subjective character. For instance, the patient does not wish to have a "potato" hose or a "very snub-nosed" and he persistently demands on improvement of this defect. Satisfaction of this requirement, if it has very subjective reasons, moreover, if it is accompanied by being striked, exalt, a hysterical conduct. There is also

some danger, that such patient will not be satisfied of improving the defect and she will insist on one more operation.

In such patients their "defect" is a subjective internal justification of their vital failure, for example erotic. Then they put "guilt" for their problems on surgeons and try to punish them. In this case the question is about an expressed type of extrapunitic reaction of frustration.

Traumatology. Traumatologists should take into account that the attitude to trauma and rendering help change according to that fact whether the trauma prevents some interests and demands of the injured patient or relieves them. As a rule sportsmen do not visit a doctor with small traumas. Injured people, who want to hide their traumas, for example, children, who had come to blow and had been afraid of punishment, or adults, entered in conflict with police avoid the registration. At injury the motivation influences trophic processes and healing of wounds. "The wounds are healed better in soldiers of attacking army than in soldiers of retreating army".

The most impotent psychological task of medical personnel is attraction of the injured patient to an active rehabilitation for prognosis of favourable results.

Orthopedy. Expressed body deformations influence the development of the person. The inferiority complex, malice, sarcastic, hostile prejudice with respect to healthy people are observed. Such development is noticed in persons with scoliosis; they are unsociable, gloomy, avoid the society, they do not go to disco or to bathe, especially girls. Sometimes some very high young people insist on shortening their extremities in order to find a partner more easily. The attitude to orthopedic defects is often disharmonic: some people try to hide their defect and avoid such kinds of activity which may be useful for them, for example, swimming. On the contrary, others incline to liypercompensation, try to compare with healthy people or even to leave them behind in sport, tourism or dances. Some people try to derive benefit, for example, to get retired. Possible malingering is not diagnosed easily as in such cases the organic functional psychogenic symptomatology is interlaced indistinctly. Sometimes, according to their imagination about "the right on health", the patients insist on complicated operations which require the fulfillment of unreal demands.

Psychological peculiarities of the work of dentists. In dentistry the first place is occupied by a pain, which leads the patient to the doctor. There is the vicious circle: fear of pain leads to that the patients do not cure small carious processes and processes causing a pain as a rule demand more extensive and painful interventions. When rendering help a dentist usually takes into consideration the fact that the sensitivity to pain is various in different age categories; it is also due to refraction of the pulp with the age. It is necessary to take into account individual differences in sensitivity to pain caused by either innate or acquired reasons. Super-sensitive patients whose pains are not managed by ordinary methods of treatment should be cured gradually, dentists have to receive them repeatedly and use the all accessible

means for reduction of pain. If the doctor has to hurt the patients he must act quickly without hesitation because uncertainty slows down manipulation reduces, the quality and none the less, harms the patient. It is appropriately to show the patient, that the doctor understands and fully estimates his pain, but it is not necessary to express an excessive sympathy when the dentist rendering aid, hurts the patients. The patient's anxiety before the treatment and his fear of pain complicate the work of the dentist considerably. That is why in some cases it is necessary to carry out the joint work of a dentist, psychotherapist and psychiatrist. Both psychotherapy and some psychopharmacologic facilities can reduce the fear and pain.

Tooth extraction and preparation to it cause the most considerable tension in many persons. Skilled dentists sometimes can do extraction so dexterously that the patients prepared for a great torture can be very astonished. It is not necessary to show the patient the bloody extracted tooth pressed in pincers as negative associations are created for future. Before extraction or during it some patients reveal an abnormal reaction of a fear or fee attack of a hysteric type. It is necessary to distinguish confidently depressed hysteric attack from a collapse and an epileptic attack. At giving a help to the patient it is possible to recommend the dentist to signal the nurse his demands by means of gestures to avoid the use of unpleasant acting upon the patient technical terms, for example, "lower jaw (mandibula) pincers! "

The patients insist on making dentures on different reasons: the most frequent - it is striving for improvement of jaw functions, sometimes there is an aesthetic reason, especially in women. There are great mental problems at removable dentures which uninterruptedly remind the patient about his age, association of his condition with the age and about other circumstances. Total denture change the face that is why the patient is not always satisfied by the denture even if it functions well. The term "mental incorporation of a denture" is used for signification of patient's adaptation to the denture. The most expressed prove of a perfect incorporation is that fact when the patient looks for his teeth and finds them at last in his mouth. Persons feeling shy of his denture sometimes isolate themselves from the society, avoid acquaintances and friends. Symbolically teeth have a significance of aggressiveness, success society and erotics; thus, depression and sense of inferiority complex develop in teeth defects.

Children with teeth anomalies suffer from speech disturbances and can differ from others by appearance and face, they look "stupid". They suffer from mockeries of surrounding people and react for them differently; inferiority complex and aggressiveness appear, sometimes they take the part of "clown in class". In order to compensate this difficulties in children's group the parents sometimes praise to excess and overestimate the abilities and talents of their child so that it may lead to disappointment.

Psychological factor is also connected with caries and its complications. Caries is often observed in the countries where there is the highest consumption of sugar and sweets. Considerable role belongs to the

way of children's nutrition which mainly depends on parents and from that whether the parents allow the children to eat sweets especially before sleep. Parents, grandparents can not be principle in this question, even if they know a lot about correct nutrition of die child. There is a reason of "giving a child all that they could not afford to themselves", a striving to like to men-children, sometimes they try to suppress the pangs of conscience in that they do not pay enough attention to children. In some children and adults sweets become the compensation of calming at personal unpleasantnesses, failure and shortage of aim and sense of life.

In gingivitis depressions and apathy are always noticed at careless information of this chronic disease. In inflammation of oral mucosa and tongue, cancerophobia sometimes arises. There is an offensive bad breath, both in society and at contacts with other people.

The place where dental aid is rendered, must correspond to the demands of deontology and psychoprophylaxis. The waiting room must be very comfortable with many magazines, not such in hospitals. The sanitary educated posters are not an object of attention of die patients, who feel fear and tension in the waiting room. In dentists's surgery it is appropriately to limit as much as possible specific dental elements such as a white colour, "exhibition of instruments" with which die patient connects a number of his misgivings. A row of chairs standing next to each other, acts negatively on the patient, because it reminds them a conveyor.

Psychological peculiarities of blind people. In childhood the parents of blind children try to guard them excessively, to create sparing conditions, to protect them from difficulties to forge the initiative. It leads to development of shyness, indecision, a striving to cry, inclination to fantasy, the departure from children's group.

The beginning of school studying is often accompanied by neurotic reactions, suspiciousness, offence, helplessness.

In blind people the overvalued ideals of decline form, they feel badly among sighted people, a forced stay in such group causes authic tendencies.

With suddenly arised blindness, for example, after injury, young people up to 20-30 years of age manage better than middle-aged and elderly people. The last constant hope for any change or any scientific discovery. Difficult mental problems appear in a married couple where blindness of both spouses stipulates genetically. They doubt if they can have children, expecting that I heir children will be blind and all the consequences of this, for example, difficult upbringing of blind children, help of healthy children to blind parents and as a result there is parents' dependence on children.

Psychological peculiarities of hard on hearing and deaf people. Personal reactions for declining or loss of hearing are polymorphous. Hearing apparatus plays an important part in the life of the patients. Increasing deafness causes painful feelings as regards of inferiority complex, there are irritability, offence, difficulty in contacts, suspiciousness, mistrust.

Because of difficulty in contacts with surrounding people the ideas of

reference may develop, patients think that the surrounding people condemn or laugh at them. The treatment of such people at in-patient departments has a lot of difficulties. The patient tries to listen attentively to doctor's words and "hears something terrible about his disease." The people with hearing loss usually hide their defect from other patients in a ward and feel too shy to say that they do not hear everything.

The doctor must give a special talk to patients with hearing loss to dispel their doubts and misgivings.

Psychological peculiarities of patients with injures of face. The face of person defines that impression, which it makes on other people and helps to give an idea about himself. Mimicry defines the emotional state of a person. Aesthetic criterion with regard to the body is inherent in every man, but it plays an important role with regard to his face. People with disfigured faces notice the curious and sometimes mocking looks of surrounding people, that is why they become supersensitive, suspicious and touchy. They are often afraid to go to the street, to meet people, who knew them before. Some people leave their places and begin in a new life in those places, where they have never been before. A correct psychotherapeutic approach may relieve me sufferings of such patient and it helps to create a new vital leitmotiv.

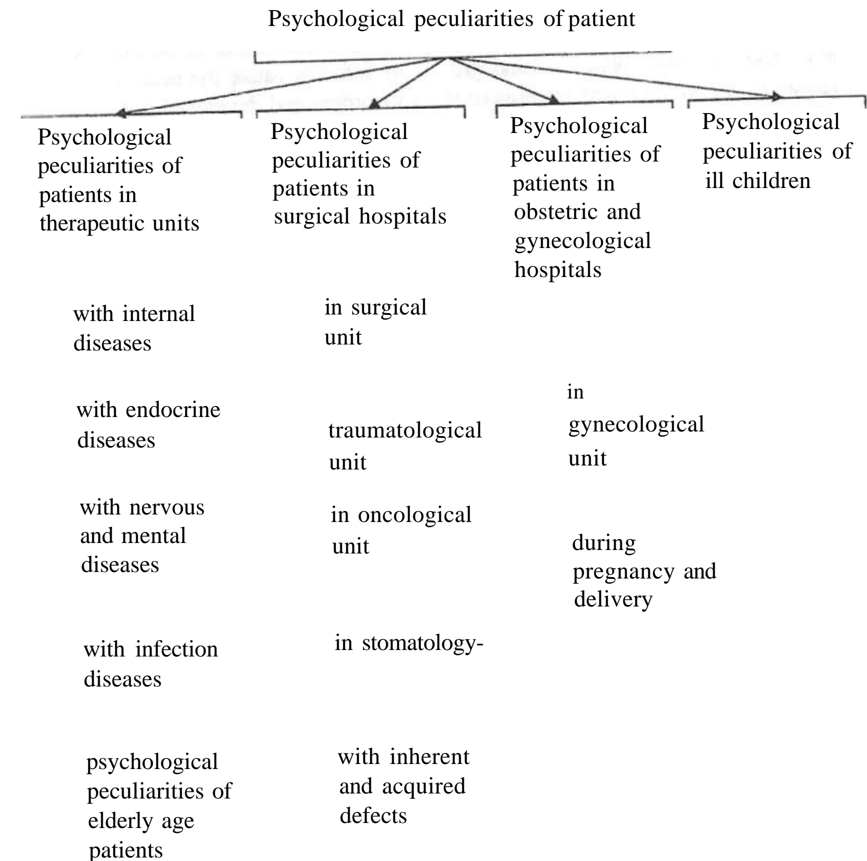
Methodical guidelines for the student's work at practical lesson.

There is 1 practical lesson (2 hours) for this topic. At the beginning of lesson the estimation of initial level of student's knowledge is earned out by oral questioning and solving of test tasks. Further students are independently speaks with patients for estimation of their mental state. Then results of examination are discussed.

Planning sheet of practical lesson

No.	Stage	Time (min)
1	Initial control (oral questioning with correction of student's knowledge)	25
2	Test control	15
3	Examination of patients by students	45
4	Conclusion	5

Graphological statcture of the topic
"Psychological peculiarities of patients with various diseases'



PSYCHOLOGY OF DEPENDENCE, SUICIDE THANATOLOGYAND EUTHANASIA

Actuality of the problem: at present different forms of dependence have taken a wide spread; annual growth of suicides cause the necessity of research of psychological features of these disorders and developed measures of their prevention. Every doctor has to know psychological mechanisms of dying and death, and be able to render adequate assistance to dying patients.

General tasks:

1. To show the ability to treat suicide patients and patients with different forms of dependence with the aim of prevention and correction of these disorders.
2. To show the ability to treat dying patients.

Specific tasks:

1. Be able to identify the features of suicide behaviour of patients with different disorders.
2. Be able to identify the features of behaviour of patients with different forms of dependence.
3. Be able to analyze the psychological features of dying patients.

Theoretical issues:

1. Psychological aspects of dependence on psychoactive substances
2. Fixed ideas
3. Dependence of food-connected behaviour
4. Co-dependence, psychological features of co-dependent persons
5. Concept definition of suicide and suicide behaviour
6. Reasons of suicides
7. Motives of suicide behaviour
8. Variants of suicide behaviour
9. Signs of hopeless situations causing a suicide
10. Internal and external forms of suicide behaviour
11. Forming stages of decision to commit suicide
12. Precautions of suicide actions
13. Concept definition of thanatology
14. Tasks of thanatology and thanatogenesis features
15. Psychological aspects of dying
16. Concept definition of euthanasia
17. Types of euthanasia
18. Concept definition of passive euthanasia
19. Concept definition of active euthanasia
20. Mental and ethical aspects of euthanasia

Dependence is characterised by pathological inclination for an action or substance , as well as by sense of psychical and physical discomfort with impossibility to realise such an inclination. An individual becomes dependant 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, (hat is psychological immaturity of the person with lack of "ego" consciousness. Behaviour of such persons is characterized by childishness, the infantilism is shown as a protest, shocking behaviour, 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 characterised by suggestibility and imitation, but can not estimate their behaviour 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 behaviour, readiness to do I lie 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, 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, jewellery.

Dependant persons arc characterised 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 the substances which one-off take causes different individual pleasant psychical states, in case of their abuse the dependence appears, personal degradation develops, social adaptation is destroyed.

Motivation of psychoactive substances use can be different. Someone lakes these substances for relief or suppression of discomfort, these states are (ear, anxiety, and depression. In case of hedonistic motivation the users of psychoactive substances strive to take pleasure, experience the joy due to lake. 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 know about the harm of smoking, but keep 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 can not 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).

Fixed ideas.

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

Signs of fixed ideas:

> deep and continuous concentration on object of ardour;

> partial, emotionally rich attitude to object of ardour;

> loss of inner sense of time spent on ardour;

> ignoring of any other type of activities.

In case of fixed ideas the "escape from reality" to any activity to the prejudice of another one and to personal harmony in whole take place.

Pathological inclination to games of luck (gambling, gamehotism). 1 Iigh 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, comes on teenage, and for women - on the second half of life.

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

1. Constant ardour 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.
!. "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).
I. Presence of signs of "dry absistention", 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 characterised 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 all the 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 alter loss. Sense of euphoria that takes place at the period of stake and the result feeds the inclination. The social dysadaptation grows, incl. financial problems, conflicts at work and in family, participation at risk activities appear, legal breakings for gaining of money are possible. At the same time I he 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.

Ill 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 absistention with expressed depressive disorders and attempted suicide, as well as with aggressive behaviour. 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.

<u>Computer dependence.</u> From 5% to 14% of Internet users suffer from computer dependence. Mostly these are teenagers and young persons. Important characteristic of dependant behaviour 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 behaviour, 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 centres and search engines);
2. addiction to on-line auctions and games of luck;
3 virtual g^nnqTiiton^M-
4. cyber-sex (ardour for pom-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 untme 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 dysadaptation.

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. Dysactualisation 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 i he computer sphere, but on the other hand a kind of infantilism, practically lull 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 actualisation the aggression, malignance, psychomotor agitation, depressive phenomena, lack of attention, involuntary "printing movements" of hand lingers dominate. The demonstrative and outrageous suicide behaviour in case is possible, if people around try to limit computer activity. At this stage I lie 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 dysadaptation is expressed.

Disorder of human eating behaviour

Eating behaviour of a person is characterised as harmonic (adequate) or deviant one, depending on variety of parameters, particularly on what place i he 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 behaviour 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 behaviour of people around for formation of some personal characteristics (for example, hospitality).

Eating behaviour 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 behaviour 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 behaviour

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 behaviour is sure to take into account the ethnic and cultural stereotype of eating behaviour of people around.

Main disorders of eating behaviour 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 characterised 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 characterised 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 "fatting" influence of food consumed.

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

Dysgeusia as a disorder of eating behaviour 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 behaviour is possible in case of brain diseases.

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

Stereotypes of deviant eating behaviour 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 ardour 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 realise the deviations of own behaviour (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 favourable ground for formation of religious fanaticism is a scctarianism.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:

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

> formation of psychological dependence on the leader and organisation (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 behaviour is the desire for leaving of monotonous, joyless reality.

Overvalued psychological ardours also include activities dedicated to worshipping of any mystical traditions, emotional involvement and following (he 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 behaviour of another person, and does not care about satisfying of own essential needs. It is the dependence on already a dependent person.

(Vdependant persons are characterised by:

> Low self-concept - there are numerous "I must", "you must", "how must 1 behave myself with my husband?" in the consciousness and lexicon of co-ilependant persons. The co-dependant persons are ashamed of the behaviour

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-dependant 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-dependant 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-dependant persons experience other feelings: anxiety, shame, fault, despair, indignation, sometimes rage.

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

The co-dependant 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.

Suicide behaviour. 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 sh'ess, 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.

The growth of the number of suicides is explained by the sharp increase of divorces, alcohol and drags consumption increase, unemployment, increase of different religious communities of destructive type.

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 behaviour includes not only committed and attempted suicides, but as well suicide reactions, thoughts, threats, imitations, demonstrations of suicide intentions.

Basic psycho-traumatic situations, resulting in development of suicide behaviour, 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, competitionconflicts 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 favourite 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 behaviour are evident, and in general can be represented by the following **motives:**

> "Protest" forms of suicide behaviour arise in conflict situation, because hostile or aggressive treatment of a person

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

> Suicide behaviour 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 •..•use is in avoidance of threat to personal or biological existence by means of •.clf-elimination.

" "Self-punishment" can be determined as "internal and external protest of pi-i son"; the conflict basically is an internal one, with specific separation of **"ego",** interiorization 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.

Actually, the suicide behaviour stands for any internal and external forms of psychical acts that are directed by ideas of committing a suicide. Internal forms of suicide behaviour include suicide thoughts, presentations, feelings, inch suicide tendencies, intentions and purposes. Passive suicide thoughts are characterised by presentations, fantasies about own death, but not about self-deprivation of life as a spontaneous activity. Suicide intentions are an active form of suicide, that is a tendency for suicide that increases proportionally to the stage of realisation plan development. Means of suicide are as well being thought over. Suicide purposes suppose their addition to intention decision and component of will that motivates direct external behaviour.

External forms of suicide behaviour include suicide attempts and suicides committed. Suicide attempt is a purposeful use of means of self-deprivation of life, which though has not led to death.

There are the following variants of suicide behaviour:

1. True suicide behaviour, which is characterised 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 ran 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 behaviour - 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 characterised 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 behaviour: 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 characterised 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 realises that his actions can not 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 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 rales 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 any more?" The display of sympathy, understanding and 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 problematics 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) Ihe only proper decision can be a continuous observation of the patient or hospitalisation 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 ihe 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. Perhaps, there is no person who would like only to live or only to die. The suicide wants his desire to be understood and taken seriously.

More deep meaning of the desire to die is more often expressed in fantasies connected with alienation. Natural death is not the purpose of the suicide. Realisation 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 centres, accounting of risk factors and suicide risk groups).

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 autoagression, 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 (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.

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 ether suddenly developed states, dangerous for life, caused heat discussions of ethic 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 lime 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 centre 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 60-70''' the bioethics appeared. On the basis of **ethic** and legal positions the specialists of this sphere solve different pioblematic 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 organizm, inevitable natural end of existence of any creature. Modem science gives this **very** concept definition. Different interpretations of the definition are evident **due** lo 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 doctors very difficult ethic, philosophic, • conomic and legal problems, connected with the statement of death, range of resuscitation actions, euthanasia and taking decision as for continuation or ••lopping of medical assistance.

Psychological aspects of thanotology 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. Tendency of "telling the truth" is supported by medical persons of cancer departments, where the patients will get to know anyway about the disease and the type of department treatment.

Modem 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 ipecific 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 "light 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:

I' 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 modem paraclinical methods of diagnostics. The patient considers the formulated diagnosi wrong there occurs nsvcholomc.a! substitution of the diagnosis to a disease that is not fatal.

Other patients, who has got to know about fatal disease, become indifferent, doomed, inactive. Then they begin to talk about soonest recovery. This original psychological protection relieves painful worries and stress. But alreadys 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. Ay this stage the patient needs the help of a qualified psychologist who knows logotherapy, help of family is as well very important.

3° 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 (hey have not realized their state in full. Considering that the dying person can be significantly exhausted physically and mentally, as a rale, 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 behaviour; 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 modem 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 (Greek "cu" - good + "OavctTOc" — death) is the satisfying of ihe 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. I (aeon 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 Netherlander 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 :i)02. In 2003 euthanasia helped 200 patients with fatal disease and 360 patients in 2004. Since April, 2005, in Belgium the pharmacies propose ipecial sets for euthanasia that help to ease the procedure of voluntary death. I he 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. (infer may be made after the address to one of 250 Belgian drug-stores that luwe the appropriate licence. Under the legislation of Belgium.the euthanasia

can be used for a person over 18, who suffers 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 CIS countries 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' behaviour.

For quarter of a century the world watched the legal process over the follower of practical euthanasia - American doctor Jack Kevorkyan, 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.

Doctors of different countries and specializations have a great interest in this problem, and a number of them tend to admit euthanasia. However, at the present in most countries the euthanasia and "assisted murder" are considered non-ethic and ever}' such case is made public and assessed by ethic committee of medical associations.

Methodical guidelines for the student's work at practical lesson.

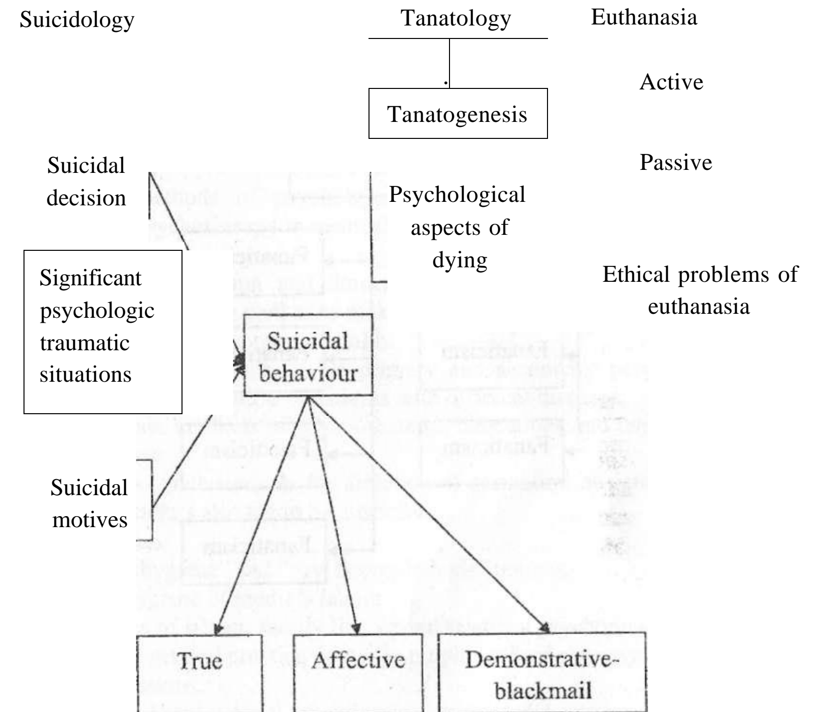
There is 1 practical lesson (2 hours) for this topic. At the beginning of lesson the estimation of initial level of student's knowledge is carried out by oral questioning and solving of test tasks. Further students are independently speaks with patients for estimation of their mental state. Then results of examination are discussed. . .,

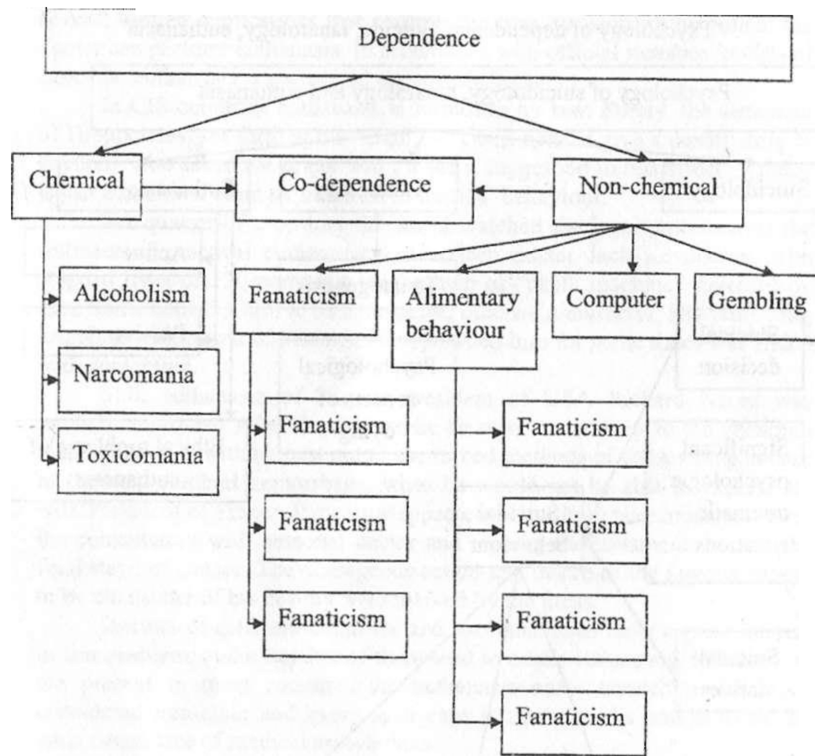
Planning sheet of practica! lesson

No.	Stage	Time (min)
1	Initial control (oral questioning with correction of student's knowledge)	25
2	Test control	15
3	Examination of patients **by** students	45
4	Conclusion	**5**

Graphologicai structure of the topic
"Psychology of dependence. Suicide, tanatology, euthanasia"

Psychology of suicidology, tanatology and euthanasia





PSYCHOHYGIENE. PSYCHOPROPHYLAXIS. PRINCIPLES OF PSYCHOTHERAPY

Actuality of the problem: Psychohygiene and psychoprophylaxis are very important parts of medical science, for they settle the problem of maintenance and strengthening of mental health of people. Psychotherapeutic influence is aimed at prevention and elimination of mental dysadaptation, which may appear against the background of any somatic disorder, stress, which requires high physical or mental activity. Hence, doctors of any sphere have to know principal methods of Psychohygiene, psychoprophylaxis and psychotherapy.

(General task:

lb apply methods of Psychohygiene, psychoprophylaxis and principal methods of psychotherapy in medical practice.

Specific tasks:

I. To analyze working and domestic conditions, peculiarities of family, sexual relations, as well as to make conclusions as for presence of negative influence factors on mental health.
To make conclusions as for primary and secondary psychoprophylaxis methods, rehabilitation of patients with different diseases.
!, To explain methods of psychotherapy, indications and contra-indications **of** their use.
4. To make conclusions as for direction of correction of pathologic process and a patient's attitude to his disorder.

Theory **issues:**

1. "Psychohygiene" and "psychoprophylaxis" notions.
2. Psychohygiene of medic's labour.
3. Principles of labour, family life, sexual relations psychoprophylaxis.
•I. Role of a genera] practice doctor in prophylaxis of nosopsychological manifestations.
5. Social and professional rehabilitation, its principal sections.
6. Basic modem methods of psychotherapy, principles of psychotherapy.
7. Indications and contra-indications of certain psychotherapy methods.
8. Psychological help during crisis periods.
'» Psychological peculiarities of medical assistance within emergency situations.

Psychohygiene is a branch of medicine that develops measures for maintenance and strengthening of mental health of population, as well as •indies conditions of optimal psychical functioning. -

Psychohygiene researches influence of external environment on mental **health** of a person, sorts out harmful factors of nature and society at work and ii **home,** defines and organizes ways and means of overcoming of harmful **Influence** on psychical sphere.

At present there is a great number of branches and directions in

medicine that are sure to use psychohygienic measures. In circumstances of constant informational and emotional stress our society needs psychological attention, especially medical one. Every day doctors of any specialization meet the manifestations of psychological dysadaptation of patients of any profile. Irrespective of age and disorder type of such a patient, the doctor should be an attentive listener, whom the patient entrusts with not only-physical, but spiritual sufferings as well. A doctor of any specialization has to be able to practise psychohygienical measures in real life.

Parts of Psychohygiene:

1. Psychohygiene of labour;
2. Psychohygiene of age;
3. Psychohygiene of upbringing and education;
4. Psychohygiene of family and sexual life;
5. Psychohygiene of recreation and family life;
6. Psychohygiene of a sick person;
7. Eradication of bad habits, alcoholism and narcomania;
8. Psychohygiene of sport, engineering, space Psychohygiene, etc.

Psychohygiene of labour. It includes the necessary provision of professional selection process for right professional orientation of a person, with account of his individual features and skills. It is necessary to take into account the influence of harmful industrial factors (noise, vibration, temperature, continuous stay in confined space, at depth, etc.), for these harmful factors can cause professional diseases, Important factor to be eliminated is the deficiency of time for solving production problems. For normal work of all team and of each member it is necessary to develop positive attitude to the work being done. Emotional fatigue is as well to be avoided (frequent cause - sensorial deprivation in case of monotonous work operations at conveying production, transport driving, etc.)

Psychohygiene of age. Every age group is characterized with its specific features of psychohygienical measures. E.g., in early childhood the following elements are important: timely mastering of new skills, being in favorable family conditions, gradual complication of game activity, communication with children, etc. In preschool age the following elements are required: positive attitude of a child to education, interest to material, regular character of education, correspondence of teaching load with the child abilities, presence of psychological comfort in the family and in school, firm day order, necessary physical exercises, sufficient sleep, exclusion of smoking, drugs and alcohol, dosed work at computer and TV watching. In teen-age the psychohygienical measures include dosed physical and psychical loads, struggle with of smoking, alcohol consumption, favorable atmosphere within the family, at work or in educational institution. The middle age has its features, which are surely to be taken into account when performing psychohygienical measures. It is necessary to follow labour, family, sexual Psychohygiene, reasonably consume alcohol, as well as to refuse from bad habits. In old age one must follow psychohygienical measures, active

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psychical and physical activities, prophylaxis and early treatment of diseases and etc. When working, the person continues active psychical and physical activity, has to keep himself in good condition, regards himself to be an individual who is useful for the society. Timely prophylaxis and treatment of diseases ensures full, healthy life of an aged person.

Psychohygiene of **family and sexual life.** These are very important for society, for full and healthy families create healthy, able-bodied society that **ran** bring up new, socially adapted generation. For provision of psychohygiene of family and sexual life the following conditions are required;

presence of mutual understanding between spouses and among all members of the family;

skills for householding and distribution of these duties, for at present time, when women work with men equally, the former have difficulties in coping **with** housekeeping, with up-bringing of children;

absence of bad habits and alcohol abuse;

satisfaction with sexual relations, which has basic meaning in marriage and inlluences not only physiologic sphere of relations between spouses, but psychological atmosphere within the family as well;

ability of correct understanding of the priority of own family compared to the family of parents, to job and hobbies;

respect and trust of spouses expressed to each other, to the opposite partner's interests.

Psychohygiene of rest having and of family life is aimed at provision Of normal conditions of family life and rest, prevention of negative consequences due to incorrect rest and life conditions.

Psychohygienical measures within the period of rest are aimed at correct planning of rest according to hobbies, physical and psychical l ondition. Provision of "healthy" rest is determined by adequate physical loads, prevention of alcohol abuse, etc. In case of rest at exotic countries the preliminary vaccination from tropical diseases that can be shown after arrival is required.

Psychohygiene of family life is provided by the following rules: Creation of favorable domestic conditions in accordance with hygienic norms and individual features; use of nontoxic materials in case of repair works; taking into account of psychological compatibility of members of the family living together at one house or apartment, etc. When taking psychohygienical measures **as** for family life, it is necessary to take into account the fact that in case of unfavorable social and family conditions the person switches his problems to professional activity.

Psychohygiene of sick person. The sick person needs appropriate ittcntion of medical workers and relatives. Well-timed diagnosis favors well-**limed** adequate and complete treatment that prevents the prolonged run of **disease,** change of it into chronical form, disability **as** well. The patient is to **be** explained the reasons and mechanisms of his disease. The patient's

realization of his own state 'leads to his maximum cooperation with the doctor, as well as leads to agreement with necessary treatment and methods of research. In case of surgical procedures, serious diseases, the psychological support should be provided (by a psychologists, psychotherapeutists) - in case is necessary.

At present the **psychohygiene of bad habits, alcoholism and narcomania** is very actual in connection with their wide spread. Smoking, alcohol and drugs affect more and more youngsters. Alcoholism and narcomania have become younger, as well as have dangerous tendency to spread over the youth. Now consumption of alcohol and "light" drugs for the latter are no more something blamed and forbidden. As a result, the number of alcohol- and drug-addicts of teenage increases.

Psychohygienical measures for prevention of bad habits, alcoholism and narcomania are based on the following:

1. access to infonnation about the harm-fulness of cigarettes, alcohol and drugs;
2. spread of information about consequences of alcohol, tobacco and drugs influence on the health of a person and children, born from him;
3. bringing up of correct priorities of healthy life-style, sport exercises;
4. reduction or lack of advertisement of cigarettes and alcohol;
5. strict observance of age qualification for sell of cigarettes, alcohol, etc.;
6. organization of spare time for the youth at sport sections, circles;
7. creation of state programs for children of problem families.

Psychohygiene of medical worker's labour. It is generally known that the doctor has to follow principles of healthy life-style not only for the strengthening of own health, but also as an example for his patients. Healthy doctor can make more good for society in case he has sound psychological and physical condition. For work of doctor of any specialization the sufficient level of functioning of all types of psychical sphere is demanded, for his work requires fast responsible decisions, and patients' lives and health depend on those decisions. Thus, the psychohygienical measures of medical worker's labour include:

1. proper organization of working time;
2. consideration of personal psychological features when choosing a medical profession;
3. skills of correct communication with patients;
4. ability to mark the patients' psychological features at the process of communication and use these skills at treatment;
5. ability to use a psychotherapeutic approach for communication and treatment of patients;
6. usage of psychotherapeutic approach for the communication with relatives of patients, because they also worry about their relative and sometimes can not understand the doctor's actions;
7. following the mles of medical ethic and deontology - doctor always has to act collectively, not to refuse to give advice to another doctors, not to be ashamed to ask for advice of colleagues, to state gross errors of other members of the collective.

Psychoprophylaxis is a branch of medical psychology that develops measures as for prevention of mental diseases and their consequences.

Primary psychoprophylaxis - measures, aimed at the prevention of **mental** diseases of mentally sane persons. Persons with high risk of mental **disease** are those with serious somatic diseases, who are engaged in heavy industry, experience high brain work, have had birth traumas, are of **late** age, **alcoholized,** have blood relatives with mental diseases, and are within Continuous psychotraumatic situations.

The measures of primary psychoprophylaxis at production sphere **Include:**

Study of working conditions and character of enteiprise;
study of neurologic-and-behavioral sickness rate of enterprise;
advisoiy examination at a psychoneurologist;
detection, calculation and dynamic examination of contingent of high risk as lor ncuropsychic diseases;
development of plan as for psychoprophylactic work on the enterprise;
preliminary talk and examination of future workers;
strict control over the observance of legislative standards and rules of safety measures and individual protection;
prophylactic treatment, aimed at certain professional hazard and etc.;
control of bad habits and alcoholization;
realization of spread psychohygienical popularization and public education.

Secondary psychoprophylaxis provides possible early detection of ••tailed mental **disease,** its well-timed, and adequate treatment with the purpose of breakup of the pathological process at initial stages, prevention of development of acute disease forms, of its serious manifestations, of change **Into** chronical run, disease recidivation.

The basis of secondary psychoprophylaxis is early aetiological diagnosing and therapy, detection of connection between disease and inherited features, production, other factors.

Tertiary psychoprophylaxis is a special work with patients that pi events disability in case of mental disease.

Role of somatic diseases in the development of psychical decompensation is not brought only to somatogenous influence. Negative emotions, fear, worry about health, reactions to unpleasant and traumatic (animations, change of life-style are **of** great importance. Against this background the neurotic reactions and conditions, reactive states are easy to appear. Iatrogenics (unhealthy states caused by incorrect behavior or IXpressions of the doctor) can as well be the source of neurotization.

Psychoprophylaxis of childhood and teen age is important not only loi the child, but for ail the family as well. The increase of attention to piychical state of the child is also necessary due to the fact that the age period Ol up to 16 years is of high risk as for mental disorders.

There are three basic crisis periods at child psychology and psychiatry, within these periods the child needs extreme attention and psychoprophylactical measures:

1) 3 years - change of forms of behaviour from reactive to active, it is expressed by appearance of consciousness, necessity to do everything by himself. Deprivation of this need disturbs development of personality, becomes the basement of conflict, and causes protest reaction of the child, favours the fixation of certain features of character, namely stubbornness.
2) 7 years - appearance of social consciousness.
3) 12-15 years - predominance of the necessity **of** self-expression and self-affirmation.

Solution of the following problems is typical for the psychoprophylaxis of childhood and teen age:

a) correspondence of school loads with intellectual and psychological loads of child;

b) reasonable day order;

c) efficient (those with emotional adequacy) relations **of** child with teachers and comrades;

d) prevention of frequent change of school collective;

e) development of proper attitude to similar sex, self-orientation.

Another psychological issue for children and teenagers is the fullness of their family, parents relations, their attitude to child.

Psvphonrntihvlavis of *nlH* **hop Orcein icstinn nf rvctr^i-inrirnnVivlovic** *nf* old age should use the knowledge of not only the weak points, but the compensatory possibilities of this period of life as well. The primary psychoprophylactical measures of old age include:

a) social activity;

b) possibility to use and share personal experience;

c) maintenance of job and professional contacts;

d) active life-style;

e) gradual preparation of person to the retirement;

f) provision of regular necessary medical assistance.

Secondary psychoprophylactical measures foresee:

a) consideration of anxiety predominance in the psychical symptomatology irrespectively of nosology;

b) prevention of disease tendency for prolonged run with resulting organic dementia.

Tertiary psychoprophylactical measures include:

a) well-timed diagnosing and treatment of diseases;

b) rational duration of hospitalisation;

c) prescription of psychotropic and other medicines with consideration of the patient's age;

d) full social adaptation.

Psychoprophylaxis of family and sexual life means:

a) sensitiveness of relations on verbal and nonverbal level;

b) necessity to take into account the sexual constitution of both partners;

c) awareness of plans and needs, expectations of partners;

d) confidence between spouses, common purposes for the future, etc.

Psychotherapy is a systematic psychical influence on the patient's nmsciousness with medical purpose or for correction of his behaviour. Prime **means** of psychotherapy is a word, i.e. information giving with the purpose to explain the reasons and mechanisms of disease, conviction in order to re-think personal opinions as for traumatic situation and own state, suggestion of new **lets** for the future. Different types of psychotherapy are different types of Introduction, treatment or influence of information. Leading methods of psychotherapy are personal-oriented psychotherapy, behavioural psychotherapy, suggestion, self-suggestion and casual psychotherapy.

Methods of personally oriented psychotherapy.

Rational psychotherapy is to help the patient to choose right strategy ol'behaviour for the future, and, if possible, to influence as deeply as possible i he features of character or deep-rooted opinions, which make him extremely ensitive and easily hurt by a number of influences. During conversations **with** patient the doctor explains him the reasons of the disease and invertiblc I haracter of his disorder, begs him to change the attitude to disturbing lituation, net to fix attention on pathological symptoms. This type of psychotherapy is used for all types of neurological reactions and states.

Of extreme importance are not only speaking skills, the ability to hold a logical and considered medical talk, but as well the ability to listen to (he **patient,** make him talk sincerely, to receive his trust by high level of geholarship, kindness and hearty attitude.

Doctors of any specialisation, especially family ones, have to know the methods of rational psychotherapy. As a rule, the patient at first appeals to **family** doctor and even after treatment at psychiatrist in hospital the patient is hack to family doctor. Many diseases can be shown in different ways; as a **result,** the patient can visit cabinets of doctors with different specialisation.

Group psychotherapy. With this method of the psychotherapist influence it is possible to influence group of patients, together with their uilluence on each other. General principle is a conscious and intended usage ui all interrelations and interactions that arise inside of the group that is group dynamics with medical purposes. During the session of group psychotherapy **me** same methods of individual psychotherapy are used. One of its forms is I **in** ing with "psychodrama", when scenes important for patients are played by **[hem.** One of the participants or whole group plays those roles, which are difficult to play in casual life. It is used for vast majority of neurological disorders treatment.

Family psychotherapy is a system of methods of purposive change of umibined and interconnected relations that develop in family and have a **i** nificant connection with the disease, treatment and social recovery of the patient. Forms and technique of observation of one family by one or two pgychotherapists, work with group of some families are possible. It is used for

neurosis, somatogenic pseudoneurotic states.

Methods of suggestive psychotherapy.

Suggestion is a presentation of information that is taken without critical assessment and makes influence on neuropsychic processes run. Suggestions in reality are performed with emotionally rich tone in the shape of sharp short phrases, usually repeated for some times. It is used for hysterical, neurasthenic, phobic states.

Besides this type of suggestion, there are other types: suggestion during natural sleep, suggestion during hypnotic sleep. Hypnotic sleep is a state of **naiTowed** consciousness, caused by actions of hypnotist and characterised by high suggestibility.

Hypnotherapy can be both individual and group.

There are three types of hypnotic sleep: sleepiness, light sleep and deep sleep or somnambulism. Exactly under somnambulism it is possible to suggest disabling **of** any analyser function and any hallucination. But even in the state of somnambulism it is not usually possible to suggest something that has deep contradiction to ethic and moral principles of hypnotized person.

Hypnosis can be successfully used not only for treatment of neurosis, but also for treatment of narcomania, alcoholism, as a symptomatic mean for elimination of pains of genesis, for relieving the pains of childbirth, in case of toxicosis of pregnancy, amenorrhea, for treatment of eczema and etc, Hypnotherapy is also used for treatment of a number of somatic diseases, bronchia! asthma, insular diabetes and etc.

Treatment with suggestion at the state of hypnotic sleep is contra-indicated for patients, inclined to delusions of attitude and influence (schizophrenia and other psychoses), because it can cause strengthening of these ideas and connection of hypnotherapist to the delusional system.

Suggestion **during narcotic sleep** can be performed only on condition that this state will not be deep. The patient is introduced with gexenal, thiopental sodium, as a result the patient is at the state of pleasant drowsiness and at this time he is medically suggested; then he should have a good sleep. It is used in case of border-line disorders with phobic, hypochondriac, depressive symptomatology.

Method of self-suggestion can be involuntary and voluntary. The most common method of self-suggestion is autogenous training under Schultz of various modem modifications. When applying this technique, at first the muscular relaxation is to be gained, and then self-suggestions, aimed at different organism functions, are performed. It is used for all types of neurological and pseudoneurotic disorders, phenomenon of vegetal imbalance, a number of somatic diseases (essential hypertension, insular diabetes and etc.). The patients with serious cardiovascular disorders need special care.

Any method of suggestion and self-suggestion is strictly contra-indicated to the patients with delirium, hallucinations and other psychotic disorders.

"Behavioral" (conditional-reflexive) psychotherapy. Treatment technique includes two elements: formation of new reaction that does not Hive anything in common with fear, and one-time conditional inhibition of i.ii For example, in case of fear of metro the patient is asked within some fliys lo come gradually closer to the entry, then to enter, go a stop, then some ItOps, Gradually the positive experience of trips is formed, it drives back the i'ii tear. Thus, new positive reflex is developed. It is used in case of i ibiessive-phobic disorders and isolated monophobias.

Casual (analytical) psychotherapy. In case of casual psychotherapy th< exchange of information between patient and doctor occurs, it leads to IWareness and reaction of patient's psychologic-traumatic worriesIn order to i UK a number of unhealthy symptoms of psychogenic genesis, it is necessary 1[1] detect them; the patient has to realise their cause. Analytical therapy was iniiiuluced by Z.Freud.

Besides the above-listed methods of psychotherapy there are such **Dnothods** that have been populated recently. They are:

a) music therapy;

ᐅ) bibliotherapy;

c) art therapy (applied methods of artistic creation are used)

Gestalt-therapy. Main purpose of gestalt-therapy is the increase of pei'Nonal potential, strength and abilities by the. way of integration and i •. lopment. Mobilization of personal resources, ability to find right ways of Interconnection with surroundings are the most important tasks of gestait-llli rapy. The basement of therapeutic process is experience of contact with illi'NcIf and surroundings, increase of acknowledgement of different sets and of behaviour, thinking, which are fixed in the past and stable at present, II as checking of what their current meaning and function are.

Techniques used for gestalt-therapy can be divided into principles and i in s The "now" principle, or concept idea of the present moment, is the mi i a important principle of psychotherapy. The patient is asked to determine Ml i in rent activities, feelings, what happens to him and around him right ROW Mc is asked to state the past events as if they are happening at the moment. Continuity (continuum of consciousness). Intended concentration of i iiieous ran of experiences content, consideration of what happens and in i way. Games are another group of procedures. They are various exercises i il patients to make under the offer of psychotherapist, they favour more liri'l I'onlrontation with personal worries and give to patient the possibility i i tporiment performance with himself and other people. It is used for the неп! of neurological diseases.

N1,1' (neuro-linguistic programming). It includes the combination of i n "built-in" commands, suggestive potentiation of ideornotonc i nlypcs and rhythmic word structures; hereby the forms of therapeutic iliou are fonned indirectly with introduction of keywords to the in ol sentences with indifferent meaning.

\lining all **NLP** techniques the basic techniques are: reframing -

"reprogramming", (applying to unconscious resources of the patient, change of imperfect stereotype of reaction or problem solution way to more adequate and adaptive ones); "anchor" technique - associative relation that is fixed; technique of visual-kinesthetic dissociation (with depriving the worries of their initial emotional richness, transferring the negative memories to associated appreciation, memories of built images); "wave" method (method principle is in inborn desire of a human to come over from something "unpleasant" to "pleasant").

The psychotherapy is widely used for hypertensic disorder, at gastro-enterological hospital, in case of bronchial asthma, for work of obstetrician-gynecologists. The psychotherapy is also used for the treatment of endogenous psychosis, especially with effaced run, at the beginning of the disease, without expressed productive symptomatology. It improves adaptation of the patient to his disease, within society, can be a means of maintenance of capacity for work. In case of organic lesion of brain the psychotherapy is important for elimination of sleep, appetite, mood disturbance, asthenic disorders. In case of epilepsy the psychotherapy is usually aimed at sedation and levelling of mood, increase of activity, optimisation of relations with surroundings, increase of social adaptation.

The largest perspectives for psychotherapy are provided by neurotic disorders, when the psychotherapy is a principal method of treatment. The psychotherapy is a necessary basis for successful therapeutic treatment of alcoholism and narcomania. Alcohol-addicts do not always realize their inclination for alcohol and excuse alcohol consumption by "life difficulties", etc.

Psychical influences of complex treatment measures in case of disorders of internal organs, mental diseases are traditional. The usage of psychotherapeutic methods is obligatory for doctors of any specialisation, the observance of principles of medical ethic and deontology is necessary for normal work of the doctor and psychological comfort of the patient..

Psychological assistance in crisis periods, peculiarities of medical assistance within emergency situations. Psychogenic disorders as a result of natural disasters and mass catastrophes are of certain importance because they can happen to many people at the same time, causing disorganization of the general process of salvage and recovery operations. This fact determines the necessity of operative assessment of victims' condition, prognosis of detected disorders, and also application of necessary and possible medical measures. Due to great number of sudden active psychological-traumatic factors at extreme situations the single-time psychical disorders of many people appear. In this case.the clinical presentation does not have strict individual character as under usual psychological-traumatic circumstances, the character is specified by quite limited number of typical manifestations. Within this situation the person can not relax and deepen into own unhealthy worries, but has to fight for own life and lives of relatives and people around.

The tasks of doctor of any specialisation are:

a) assessment of psychological and clinic-psychopathological characteristics of persons, that are at the centre of disaster;

b) prevention of panic reactions;

c) treatment of psychical diseases, appeared or aggravated under extreme conditions;

d) doctor himself has to stay calm, decided, precise, able to render assistance to suffered persons, never to show panic, to fear of situations he docs not know what to do;

c) prevention of suicide behaviour;

Sudden presence of life situations can cause great fear with changed niirid conditions of non-prepared people. Obnubilation, expressed by incomplete understanding of the present situation, complicated perception of lUrroundings, uncoordinated actions as for life-saving, appears most often. I Inder such condition the doctor has to pay attention not only to psychical, but lo somatic health of a person as well, for the patient can not have any complaints even with presence of considerable injuries and pathological conditions.

Social and professional rehabilitation, its principal parts. Rehabilitation is a socially necessary functional and social-labour restoration Of human capability for work with the help of the State-involved, medical, educational, legal and psychological measures.

The main task of rehabilitation is restoration of health of the person juffered due to disease or trauma, up to possible optimum of physical, spiritual, professional and social condition.

Principles of rehabilitation are:

I) biological - based on quality of systems and organs, to adapt to new life conditions and labour activity due to compensatory-restorative processes;

' | moral-ethic - based on humanism, sense of collectivism;

1) social-economical - based on usage of experience, length of service, deep professional knowledge, skills and abilities of a person, that has partially loss of working ability;

I) psychological - based on important features of human personality, such as fense of being useful for the society, desire for active labour activity, sense of prestige and etc.;

5) medical - based on success, achievements and possibilities of modem medicine and technology.

Final tasks of the rehabilitation are determination of loss and restoration levels, conclusion as for clinical and labour prognosis, development and realization of measures and conditions necessary for restoration of labour iielivity and social state of the patient. Maximal success of rehabilitation is possible only in case of the cooperation of doctors of all levels and ipi cialisations.

Rules of rehabilitation:

II possible early return of disabled person to labour activity;

' I creation of optimal conditions for social activity.

Types of rehabilitation:

1) medical (medical rehabilitation) - complex of treatment-and-diagnostic measures aimed at the restoration of health of the patient, functional abilities of his organism. It is performed by doctors of all specialisations of ambulatory-hospital and stationary establishments.

2) social (domestic) - complex of measures aimed at the development of skills of the suffered person to provide the possibility of self-service. It is performed by specialists of rehabilitation by means of patient training with methods of use of different devices and instruments for self-service.

3) professional (work) - preparation of the patient for specific labour activity with taking into account his skills and abilities. It is performed by specialists of labour training with active participation of the doctor.

4) psychological - studying of biogenic, sociogenic and psychogenic elements of the patient's personality, his interests and sets, attitude to disease with purpose of detection of potential and factual social "role" and rational usage of residual working ability. It can be performed by doctors, psychologists. Maximal effect is achieved with the participation of psychotherapists.

All patients that have partial loss of working ability and disabled persons mainly can bear the rehabilitation. At the same time very important is the role of doctors in rehabilitation of timely disabled, who are vast majority of the patients that have partial loss of working ability.

The rehabilitation of persons with mental diseases with different nosologies has its features. Herewith the ratio of biological and psychosocial influences at different stages can change in connection with the disease. Specific tasks of rehabilitation in connection with a number of circumstances can be different. The task can be quite simple: for example, to reduce the necessary nursing of the patients at home or even in hospital (in case of senile dementia or so called final stages of schizophrenia). In other cases the task of rehabilitation is more significant: to change profession, to adapt the patient to it, to life conditions and activities out of the hospital. At last, in case of good and stable remission that can be gained with active measures at the first stage of rehabilitation, or sufficient compensation of the current defect that is gained more often at the second stage of rehabilitation, - the task is a possible return to the job of previous specialisation, or continuation of education.

The important issue of rehabilitation is work therapy that is aimed at the restoration of lost functions, social adaptation of the patient.

Types of work therapy:

1. Toping up (is intended for support of general state of physical and psychical spheres of the patient);
2. Restorative (is intended for restoration of lost professional functions);
3. Diagnostic (is intended for detection of following labour perspectives of the patient);
4. Productive (complete restoration of all professional skills of the patient).

Principles of work therapy:

- individual dosing with graduai increase of labour volume and complexity of working operations, the effective technical support of working process and place;
- constant control by medical workers, management, the instruction by operating personnel;
- psychological preparation (work at working collective, conscious work, interest in result of work).

The rehabilitation has to be performed both at ambulatory and •iliilionary establishments of general system, independently from departmental subordination, and at the specialized establishments.

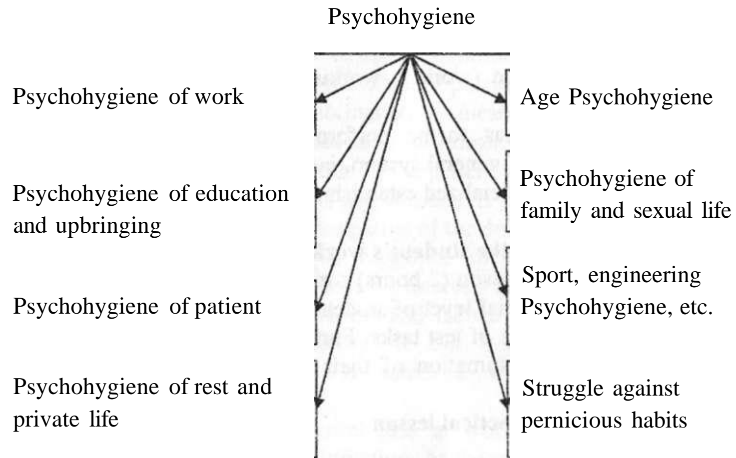
Methodical guidelines for the student's work at practical lesson.

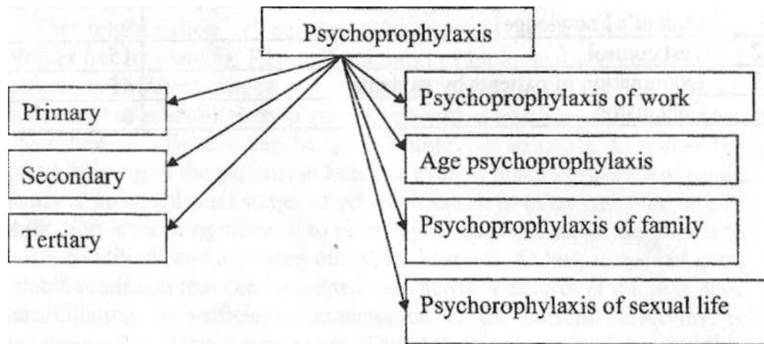
There is 1 practical lesson (2 hours) for this topic. At the beginning of lesson the estimation of initial level of student's knowledge is carried out by Oral questioning and solving of test tasks. Further students are independently .peaks with patients for estimation of their mental state. Then results of examination are discussed.

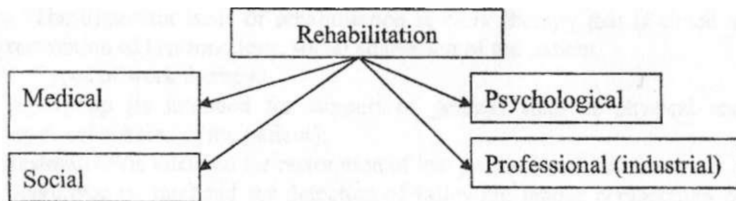
Planning sheet of practical lesson

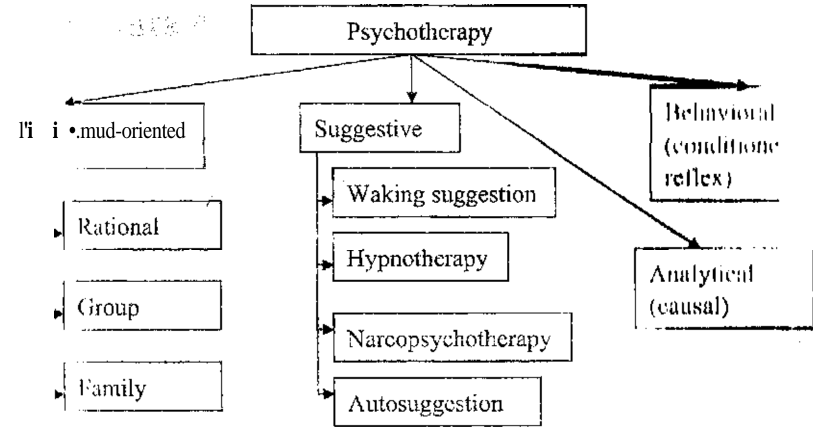
No,	Stage	Time (thin)
1	Initial control (oral questioning with correction of student's knowledge)	25
	Test control	15
1	examination of patients by students	45
•t	Conclusion	5

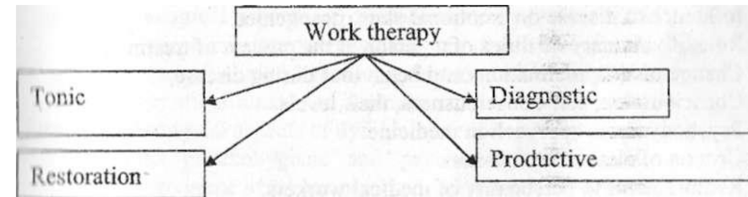
Graphological structure of the topic
"Psychohygiene, psychoprophylaxis, psychotherapy"











LIST OF QUESTIONS FOR PREPARATION OF STUDENTS FOR FINAL MODULAR CONTROL

1. Determination, subject and tasks of medical psychology. '
2. Methods of psychological research.
3. Principles of development of a directed psychological conversation.
4. Determination of psychical health and levels of psychological adaptation of a person.
5. Criteria of health under WHO.
6. Influence of age and chronical diseases features on personality.
7. Determination and psychology of personal accentuation, doctor's tactics as for patients with accentuated features of personality.
8. Determination and classification of basic types of attitude to disease, features of behaviour of the patients with such reaction types to disease.
9. Diagnosing of basic types of attitude to disease.
10. Principles of psychotherapeutic correction of attitude to disease.
11. Influence of disease on cognitive abilities of a person.
12. Influence of intellect features of the patient on treatment process.
13. Influence of disease on effect-voluntary sphere of a person.
14. Influence of disease on emotional state, nosogenies.
15. Role of voluntary qualities of a person at the process of treatment.
16. Change of will, inclinations and behaviour during disease.
17. Consciousness, self-consciousness, their levels.
18. Psychodynamic approach in medicine.
19. Criteria of clear consciousness.
20. Requirements to personality of medical workers.
21. Notion "medical duty", "medical secrecy".
22. Medical mistakes: causes and conclusions.
23. Psychological types of doctors.
24. Professional deformation, "burnout syndrome", types of prevention.
25. Rules of deontology and subordination at medical sphere.
26. Types and features of communication at medical sphere.
27. Psychological features of stages of diagnosing process.
28. Principles of communication of the doctor with patients and their relatives.
29. Conflicts at medical sphere, their varieties, types of solution and precautions.
30. Psychosomatic approach as a principle of medical activity.
31. Emotional stress as a factor of etiopathogenesis of psychosomatic disorders.
32. Influence of psychological factors on the run of somatic disorders.
33. Theories of psychosomatic interrelations.
34. Mechanisms of psychological protection of a person.
35. Notions "adaptation", "dysadaptation", "distress".

36. Classification of psychosomatic disorders.
17. Non-pathologic psychosomatic reactions.
18. Principles of precautions of psychosomatic disorders.
39. Psychological changes in case of disorders of cardiovascular system.
40, Psychological changes in case of disorders of bronchus and lungs.
II. Psychological changes in case of disorders of gastrointestinal tract.
•12. Psychological features of patients with infective diseases, tuberculosis, AIDS.
43. Psychological features of patients with endocrine, nervous and psychical disorders.
II. Psychological features of woman-patients at gynaecology stationary.
15. Psychological features of women at the period pregnancy and childbirth.
16. Features of psychology of sick children and old persons.
47. Psychological featares of patients at surgical stationary of pre- and postoperative periods.
•IS. Psychological features of patients at stomatology, ophthalmology, otolaryngology.
•I') Psychological features of patients with cancer pathology.
50. Influence of inborn and acquired physical defects on psyche of a person.
51. Psychological aspects of dependence on psychoactive substances, fixed ideas (gambling, internet-dependence), dependence of eating behaviour.
52. Varieties of suicide behaviour, features of suicide behaviour of patients with somatic diseases and dependences.
• **1.** Psychological aspects of dying and death.
'«I Notions "Psychohygiene" and "psychoprophylaxis".
55 Psychohygiene of labour of a medical worker.
56. Principles of psychoprophylaxis of labour, family life, family, sexual relations.
57. Role of doctor at the psychoprophylaxis of nosopsychological manifestations.
18 Social and professional rehabilitation, its principal parts.
59. Modern methods of psychotherapy, principles of psychotherapy.
lid. Indications and contra-indications for performance of certain types of psychotherapy,
d I. Psychological help at crisis periods.
<>:. Psychological features of medical assistance at emergency situations.

LIST OF PRACTICAL WORKS AND TASKS

1 I o hold a considered psychological talk with patients independently, to make psychological anamnesis of disease and life, to assess psychological stale of the patient.
' To analyze data, received within experimentally-psychological research, to conclude at the basis of analysis of research results.
I I o be able to detect accentuation of the character.