MEDICAL PSYCHOLOGY

General editorship of Iryna SPIRINA

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MEDICAL PSYCHOLOGY

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General editorship of
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PREFACE

Among the sciences, developing modern approaches to the knowledge of the human person Medical Psychology stands out, specific subject of which is the study of pathological mental states and processes, including their physical forms, the one hand, as well as psychological manifestations and consequences of pathological somatic processes and phenomena-on the other. To current time it has developed into a relatively independent field of knowledge, based on a large amount of experimental data and obtained patterns on the basis of their generalization.

Modern Medical Psychology has a solid methodological and methodical apparatus that allows to obtain reliable practical guidance that needed for effective diagnostics and treatment of various diseases, as well as ethical and socially justifiable impact on the thinking and behavior of people in order to adapt to the changing conditions of life, normalization of psychological climate in labor and other collectives, rational organization of different activities and, finally, for the training and education of children, youth and adults. Theoretical and experimental researches in the field of Medical Psychology with their results contribute to the development of psychological science, medicine and pedagogics, and the use of its applied findings helps in professional activity of psychologists, doctors, social workers, educators, teachers and professors, and many other categories of professionals dealing with people.

The growing importance of Medical Psychology led to the spread of teaching in higher education. In the system of medical education, it is one of the disciplines without which one the training of modern physician of wide profile would be impossible, who should be capable of both research and practical work in the medical field, in management, in social service. Help of the doctor who seized Medical Psychology often is very necessary for diagnostics and developing of rational guidelines at the treatment of wide range of diseases that are rooted in pathological changes in the inner world of the personality. Medical Psychology is always useful to determine differential that take into account the individual

characteristics of patients, treatment methodics, increasing the effectiveness of health care in general.

Interest of doctors to Psychology, at mostly «biological» orientation of their training, is due to increasingly convincing diagnostic, therapeutic and rehabilitative experience of recent years, scientific discussions of leading experts of the world, who consider Psychology as a complement to the two other basic medical sciences pathological anatomy and pathophysiology which development is largely determined the formation of medicine and its successes.

Assuming that only 10-15 % of health care activity realizes the health improving potential of human health, it can be true only if the efforts of doctors and other medical staff are focused on «biological» treatment. In a broader approach to the disease and treatment are additional resources that provided by Medical Psychology.

Improving of psychological training of medical staff had a positive impact on the development of health care. In many hospitals, especially in psychiatric and neurological clinics branches and offices of Medical Psychology set up and successfully operate. Aviation, space and extreme medicine are developing in a particularly close collaboration with Medical Psychology that requires more attention to the inner world of the personality.

Today a medical psychologist - is a specialist whose duties include as taking part in the psychodiagnostic and psychocorrection events, and as in treatment process in general. In some clinics a «brigade» model of medical care is created, which firstly emerged in psychotherapeutic and psychiatric services. Gradually, these principles are recognized also in other areas of health care, because behind them the future - a higher level of professional and humanistic oriented medicine. There is a doctor in charge of the case in the center of the brigade as a functional unit who is working with psychotherapist, clinical psychologist and expert in social work. According to the biopsychosocial paradigm of medicine, each of them performs own diagnostic, therapeutic and rehabilitation plan under the supervision and in a close cooperation with the doctor in charge of the case.

The changes were also made the concept of «Medical Psychology» itself. The tendency to change of the title of «Medical Psychology» to «Clinical Psychology» reflects a process that began in the last decade - its integration into the world of Psychology. In post - soviet countries the title «Medical Psychology» was generally adopted. As a psychological and medical science its task was mutual enrichment of theory and medical practice and Psychology. Both terms, with all their proximity, have essential differences. The first one («Clinical Psychology») claims to be a scientific and practical psychological discipline, and the second one («Medical Psychology») acts as a collective image of the region and the place of usage of psychological speciality.

The great importance of the role of Medical Psychology for practical health care identified the urgent need to study it by future doctors. To justifying the need for psychological training of medical staff, I.P. Pavlov particularly said: «Thanks to look in, enter into Psychology I can imagine all complexity of this state subjective status of another person, feel with them the same feelings and thoughts... «The disease is always individual, it affects on specific person, and to find a cure for her healing, the physician should imagine not only external, but also internal picture of the disease, see possible psychological conditions and consequences of pathological processes, understand the changed identity of the patient's personality with disease. Analysis of complaints and collection of anamnesis, somatic and psychiatric examination of all types of expertises, the purpose and implementation of etiological and pathogenetic differentiated therapy, solving the problem of recovering patients - all these require from doctor deep penetration into the personality of a patient, for which the knowledge of Medical Psychology is needed.

Section 1.

Subject, tasks and methods of psychological examination of state of human being. The concept of mental health

Subject and tasks of Medical Psychology

Medical Psychology (from lat. Medicus - medicinal, therapeutic) - a branch of Psychology that formed at the intersection of medicine and aims to study the psychological prophylaxis, diagnostics of diseases and pathological conditions, forms of psychocorrectional influence, solving of expertise issues, as well as social and vocational rehabilitation ones for patients, the study of psychological characteristics of professional activity of health workers, the relationship between them and patients.

Field of study of Medical Psychology contains a wide range of psychological patterns which are associated with the origin and course of the disease, the influence of certain diseases on the human psyche, ensuring of optimal system of health impacts, the relationship between the sick person and his micro environment. Fields of Clinical Psychology that are connected with a psychocorrection work rapidly develop: psychotherapy, mental hygiene, psychopharmacology, psychosocial rehabilitation. Among the most important problems of Medical Psychology - the interaction of mental and somatic (physical, physiological) processes in the genesis and development of disease, regularities of formation about awareness of the disease, the formation of adequate personal settings associated with the treatment, the use of compensatory and protective mechanisms of personality in therapeutic purposes, the study of the psychological impact of treatment methods and drugs (medications, procedures, hardware and clinical research, surgery, etc.) in order to maximize their positive impact on the physical and mental condition of the patient. Significant place among questions studied by Clinical Psychology the psychological aspects of the therapeutic environment (hospital, sanatorium, clinics, etc.) occupy, study of relations with relatives of patients, medical staff and patients among themselves. The complex problems of medical measures of particular importance is

the study of patterns of psychological influence of a physician during his diagnostic, therapeutic, preventive work, rational building relationships all members of the treatment process, preventing yatroheniy.

The most important task of Medical Psychology is the study of patients psyche in different conditions. Also Clinical Psychology has and applied tasks - development of principles and methods of psychological research in the clinic, as well as the creation and study of methods of psychological impact on the human psyche as a therapeutic and prophylactic purposes. It should find coverage in various parts of the health care system - hospitals and outpatient services, spa, pharmacy, medical staff in the preparation of all levels, scientists in research related to medical problems in the organization of health care, hygiene and sanitary, medicine, and other disasters. Development of Medical Psychology is closely associated with the tasks which are different medical disciplines.

The subject of Medical Psychology is the study of patient's personality in the broadest sense of the word (various and profound mental abuse of the mentally ill are studied in detail the special science - Psychiatry), medical professional, patient relations and medical staff at the different stages of diagnostic and treatment process. Another various related problems are discussed in relation to the main task - to provide maximum patient care, protect it from adverse effects.

In foreign Psychology a Medical Psychology is often called the Clinical Psychology. Moreover, among the psychological schools still do not have a common understanding on the subject of Clinical Psychology. Some researchers believe that Clinical Psychology should study mental disorders in various diseases; others argue that clinical psychologists should engage in research of personality traits and psychological counseling, and others, based on bihevioral approach, imagine the task of Clinical Psychology is in the development ways to eliminate signs of maladaptive behavior. Clinical Psychology in the United States includes: psychotherapy, psycho - diagnostics, consulting Psychology, mental hygiene and rehabilitation, some sections of Defectology, Psychosomatics. In Poland, Medical Psychology also is widely understood, because the range covers the following tasks:

diagnosis, clinical and recovery activities, rehabilitation of the disabled, psychotherapy, correction, correction and monitoring the effectiveness of psychotherapy.

Modern views of national Psychology are based on an understanding of Clinical Psychology as a field of Medical Psychology, applied is determined by the needs of the clinic - psychiatric, neurological and somatic. This has resulted in a completely separate section of Clinical Psychology: pathopsychology, neuropsychology and somatopsyhology.

K.K. Platonov considered a Clinical Psychology as part of Medical Psychology. Clinical Psychology, in his opinion, has practical significance, answering the needs of clinics: psychiatric, neurological, somatical. Apart Clinical Psychology K.K. Platonov included psychohygiene in Medical Psychology also.

B.D. Karvasarskij believes that the name change on Clinical Psychology reflects a process that began in the last decade its integration into the world of Psychology. Clinical Psychology claims to be a scientific and practical psychological discipline and Clinical Psychology acts as a collective image of the region and the practice of psychological profession. Currently psychological discipline that integrates in health care in Russia, also received the name of Clinical Psychology.

With the focus of psychological research (to identify common patterns or features in a particular patient) distinguish general and Medical Psychology.

General Medical Psychology studies the general questions and includes the following sections: 1) the basic laws of patient's psychology (normal criteria, temporarily altered mental and painful), psychology of doctor (medical officer), psychology of communication of patient with physician, psychological atmosphere of health care settings; 2) psychosomatic and somatopsychic interplay; 3) personality (temperament, character, personality), evolution and stages of postnatal ontogeny (including childhood, adolescence, youth, adulthood and late age), affective - volitional processes; 4) medical ethics, including the issue of medical duty, medical confidentiality; 5) psychohygiene (psychology of medical advice and

counseling, family psychology, psychohygiene of personality in crisis periods of life (puberty, menopause), 6) the psychology of marriage and sexuality; 7) psychohygienic training, psychotraining of relations between doctor and patient, 8) general psychotherapy.

Private Medical Psychology studies the individual patient, such as: features of mental processes in the mentally ill; psyche of patients on stages of preparation, execution surgery and in the postoperative period; features of mental processes at patients suffering from various diseases (cardiovascular, infectious, cancer, gynecological, skin, etc.); psyche of patients with defects of organs and systems (blindness, deafness, etc.); features of mental processes at patients during labor, military and judicial review; psyche of patients with alcoholism and drug addiction; privat psychotherapy.

Ukrainian scientists divide the 4 main parts of Medical Psychology:

1) *General Psychology* studies human mental functions; biorhythms of mental activity; psychological and psychosexual development; personality and health; normal conscious and unconscious; mental health; Psychology of sex differences; developmental Psychology; interpersonal relationships (micro and makrohrupy); family and its functioning (family health); adaptation, mental hygiene;

2) *Clinical Psychology*. It has sections: general and individual psychopathology, including semiology and syndromology; pathopsychology that studies the psychological mechanisms of mental activity; neuropsychology, studying morphological correlates of mental activity; psyhoidentyficacy and psychological diagnostics (pathological changes in the psyche) using experimental psychological methodics;

3) *Psychocorrection* - correction with using sane psycho mental sphere changes;

4) *Medical ethics and deontology*.

Also, foreign scientists released a Special Psychology that studies people with disabilities from normal mental function, due to congenital or acquired defects in the formation of the nervous system.

Medical Psychology as both psychological and medical science

Any science develops in conjunction with other sciences and under their influence. These relationships can be «horizontal» and is exemplified by Medical Psychology as one of the psychological disciplines. But more important, according to opinion K.K. Platonov, are «vertical «interactions, such as Clinical Psychology and Philosophy. Philosophy is broader of methodology of particular science, which is included as a philosophical theory of knowledge and techniques to transform reality, applying the principles of philosophy to the learning process. Basic sciences for Clinical Psychology are General Psychology and Psychiatry.

Psychiatry intimately connected with Medical Psychology. The subject of the research of Clinical Psychology and Psychiatry are mental disorders. Medical Psychology, in addition, studies violations that importance is not equivalent to disease (c.g., marriage and partnership problems) and psychic aspects of somatic disorders.

According to M. Pjerrje and U. Baumann, Medical Psychology and Psychiatry are close, when you concider different emphases placed in their approach to the subject of study. Psychiatry as a private area of medicine, takes into account more somatic plane of mental disorders; and in Medical Psychology major is psychological aspects. Comprehensive understanding of mental disorders is possible only in the presence of complex biopsychosocial models. Therefore, disciplinary approaches sometimes have expressed disagreement and often implemented in joint research.

Clinical Psychology affects to the development of the theory and practice of Psychiatry, Neurology, Neurosurgery, Internal Medicine and other medical disciplines.

Patopsihological disorders are often manifesting under extreme conditions studied also by other psychological sciences, such as Aviation and Space Psychology. In this context, the term was proposed *Extreme Psychology*. According to K.K. Platonov, Pathopsychology studies abnormal personality in normal

conditions and Extreme Psychology studies normal personality in abnormal conditions.

Subject of Neuropsychology is the study of the localization of mental functions, the ratio of psychological functional structures of brain with morphological macro- and microstructure in normal, but which are understood through pathology.

In the last decades as an independent scientific branch Behavioral Neurology was dedicated as neuroscience that studies the effects of diseases of the brain on human behavior, especially on higher cortical or cognitive function. Diagnostics includes methods of Clinical Psychology and Neuropsychology which combining the data subjects.

Psychopharmacology is also associated with Medical Psychology as both studying psychopathological disorders and methods of their treatment. In addition, medication treatment always has a positive or negative psychological impact on the patient (e.g., placebo - effect).

In the system of general clinical diagnostics, the *psychological diagnostics* is included (especially in Psychiatry). The last is close to Forensic Medical Psychology and Forensic Psychiatry.

The scope of Medical Psychology is the *labor psychological expertise* which divided into the professional orientation, professional consultation, professional selection and employment of disabled persons. Psychological labor expertise as a whole is an independent branch of Psychology - is the Psychology of labor. Medical psychological professional orientation and professional consultation of teens are related with pediatrics and school hygiene, and against to the elderly - with geriatrics and psychohygiene. Psychohygiene can be considered as an independent discipline, marginating with hygiene, and as a part of Medical Psychology.

The Medical Pedagogics develops successfully - adjacent to Medicine, Psychology and Pedagogics area. Its subject is the training, education and treatment of sick children - defektopedagogics with branches oligofreno-, surdo and tyflopedagogics.

Currently in independent medical specialty the *psychotherapy* is allocated. Theoretical and practical problems of psychotherapy cannot be developed without Medical Psychology. According to the views of western Clinical Psychology the psychotherapy is its private area. Psychotherapy is a special case of the clinical and psychological interventions. Psychotherapy is characterized, above all, by the specificity of own methods, their starting point is in the mental plane, ie in the experience and behavior that is exactly the subject of Psychology as a science. Clinical and psychological intervention is not characterized by the etiology of the disorder or goal - setting, but its methods. Thus, it can be implemented in somatic disorders.

There are some new directions in foreign medicine, connecting Medical Psychology with other disciplines.

Behavioral medicine is an interdisciplinary scientifical researching and applied area. In its approach to the problems of health and illness it focuses on the biopsychosocial model. Carried out in the framework of its synthesis of science of behavior and biomedical sciences is designed to enable successful problem solving «health - disease» and use these achievements in the prevention, treatment and rehabilitation.

Health Psychology is the scientific, psychological and pedagogical contribution into the prophylaxis and health care, prevention and treatment of diseases, identifying of forms of behavior that increase the risk of disease, making diagnose and identifying the causes of health problems, rehabilitation and improvement of the health care system.

Public health or *Population Medicine* - interdisciplinary field of research and practical activities involved in promoting overall health (disease prevention, life extension, improved health, quality of life) through social events or impact on the health care system as a whole.

Considering the healthy and the sick person in biopsychosocial unity, we can see the relationship of Medical Psychology with other disciplines such as Sociology,

Anthropology, Ethnography, cultural studies, History, Philology and Linguistics (Neurolinguistics, Psycholinguistics), Mathematics and Statistics and others.

Theoretical and methodological foundations of Medical Psychology. The role of Medical Psychology in the formation of modern ideas about the unity of somatical and mental

Clinical Psychology refers to the interdisciplinary field of scientific knowledge and practice, where interests of doctors and psychologists crossed. Based on the problems that this discipline is exploring (mental and physical interplay in the origin, course and treatment of diseases) and practical problems which are solved (diagnosis of mental disorders, the distinction between individual psychological characteristics and mental disorders, analysis of conditions and factors of disorders and diseases, psychoprophylaxis, psychotherapy, psychosocial rehabilitation for patients, health care and supporting), it is a branch of medical science. But judging from the theoretical background and research methods it is a psychological science.

Interdisciplinary status of Medical Psychology makes this discipline particularly sensitive to decision of the basic theoretical and methodological problems of modern science - the problem of «human nature» as biosocial beings in their external manifestations. Psychology deals with especial reality - subjective, which content is not always matches to the reality that exists independently of person. It is considered that Psychology - the science of the mind. However psyche is rather a complex phenomenon that embraces several related but different in nature areas: perceived subjective reality, unconscious mental processes, the structure of individual psychic characteristics, behavior that observed from the outside. Accordingly, the psyche can be viewed from different perspectives: from the mathematical, physical, biochemical, physiological processes or as a sociocultural, linguistic phenomenon.

Underlining the importance of theoretical and methodological problems in Medical Psychology, V.N. Mjasishhev wrote: «The more important and responsible health problems and diseases are, than more serious justification of methodological

aspects and basics of Medical Psychology is required, complexity and difficulties of which increase due to a combination of Medicine and Psychology.»

According to K.K. Platonov, following principles for Medical Psychology are the most important: determinism, unity of consciousness and activity, reflective, historicism, development, structuring, personal approach. Additional explanation is likely to require only some of them, including the last three principles.

The principle of development. In Medical Psychology this principle can be specificated as the etiology and pathogenesis of psychopathological disorders in their direct (disease progression) and reverse (remission, recovery) development. The pathological development of personality is a special specific category.

The principle of structuring. Philosophy understands unity as a structure of elements, their relationships and integrity. General Psychology studies the structure of consciousness, activity, person, etc. I.P. Pavlov gave the following definition of the method of structural analysis: «The method of studying the human system is the same as any other system: decomposition into parts, studing the value of each part, researching units, studing the correlation with the environment and understanding on this basis of its general work and its overall management». The task of Medical Psychology is to bring into one system of individual structures of different psychopathological phenomena and coordination it with general structure of healthy and sick personality.

The principle of personal approach. In Medical Psychology, personal approach means related to the patient or the study of man as a whole person, taking into account all its complexity and all individual features. It is necessary to distinguish between the personal and individual approaches. Last - is taking into account the specific characteristics peculiar to this man in these conditions. It can be realized as a personal approach, whether individually selected as the study of individual psychological or physical qualities.

The role of the medical psychologist in diagnostic, treatment and rehabilitation processes

The overal role of a medical psychologist in medical health care institutions are involved in the conduct of pathogenetic and differential diagnosis of various diseases, treatment and social and labor adaptation of patients. Specific tasks can be defined as follows: participation in solving problems of differential diagnosis; analysis of the structure and establish the degree of mental disorders; diagnosis of mental development and selection of routes of general education and labor training (retraining); characteristics of the personality and the system of relations; the evaluation of neuropsychic disorders dynamic and taking into account the effectiveness of therapy effects, solving expert tasks, participation in psychological correction, psychotherapy and rehabilitation of patients.

Depending on the specific conditions of activity of medical psychologist, apart from the mentioned above, other tasks may also occur before them. Thus, he/she can participate in psychotherapy and psychological correction work with the close environment of the patient (e.g., conducting family counseling and family therapy), in dealing with a wide range psychohygienic and psychopriventive tasks in promoting the psychological knowledge among health workers.

It should also be emphasized the conditional character of tasks facing the medical psychologist. Obviously, the solution of differential diagnosis, expert analysis tasks requires as a structure and establishment of the degree of neuropsychiatric disorders, as characteristics of personality and the system of its meaningful relationships, etc.

Professional activity of medical psychologist is integrated in all main areas of medical science and practice. Sources of Medical Psychology and its development as a specialty inseparably connected with Medicine, especially Psychiatry and Psychotherapy.

Development of Medical Psychology in the world and Ukraine. Contribution of works by O.R. Lurija, L.S. Vygotskij, M.O. Bernshtejn, P.K. Anohin, K.K. Platonov, B.V. Zejgarnik, L.F. Burlachuk, V.M. Blejher in the global and national Medical Psychology

Medical Psychology as one of major application areas of Psychology related with the development of Psychology and Medicine, Physiology, Biology, Anthropology. Its history begins in ancient times when psychological knowledge originated in the depths of Philosophy and Natiral Science.

The emergence of the first scientific understanding of the psyche, separation the science of soul, the formation of empirical knowledge about mental processes and their violations associated with the development of ancient Philosophy and achievements of ancient physicians in Anatomy and Medicine. Thus, Alkmeon Krotonskij (VI - V century B.C.) advanced firstly in the history the position that thoughts had localization in the brain. Following him Gippokrat considered a brain as the organ of psyche. Among the great heritage he left developed theory of human temperament with classification of types on the somatic basis (humoral concept). By Alexandria's doctors Gerofil and Jerazistrat who conducted the autopsies of human bodies nerves were differentiated, the differences between their sensory and motor fibers were determinated. At detailed description of the brain they noticed that the bark had convolutions that distinguished man in mental abilities from animals.

The Roman physician Galen (second century B.C.) firstly paid attention to the mental factor as a possible source of movement. Galen's works were handbook for physicians until the seventeenth century. The views of the ancient physicians based on different ways of idealistic Philosophy of that time (gnosticism, jewish alexandrian Philosophy, neo - platonism, etc), where the soul was identified with the start of life all processes which are ensure the smooth body operation were included into the sphere of mental phenomena.

In the middle ages, a link to the ancient world was initially quite strong. Study was based on ancient Philosophy and Natural Science achievements of Gippokrat, Galen, Aristotle. Psychology in the middle of the century received ethical and

theological nature, based on the Philosophy of Homa Akvinskij. Development of concepts of psyche during this period slowed sharply. However, in the East knowledge about the anatomical and physiological characteristics of the human body was accumulating on the basis of mental life. After the fall of Alexandria, in libraries of which manuscripts of Greek and Roman medicine were stored, scientists and doctors had found refuge in Persia, soon conquered by the Arabs. In this way remains of the manuscripts were removed to Arab scientists and from the middle of VII century the ideas of risen Hellenism began to spread in science. In works of Avicenna (Ibn - Sina), Al'gazen, Averroes the emphasis was on conditioning of mental qualities and their disorders by natural causes, a mental dependence on living conditions and education was emphasized.

From the fourteenth century the Renaissance starts in Italy, it is characterized by activity of great humanists Dante, Petrarka, Bokachcho. Their creativity leads to «discovery» of person. Medicine, Anatomy and Physiology developed rapidly in different European countries. Paracel's introduced a new view of the nature of the human body and treatment of diseases. The Anatomical School of Vezalij, which replaced the Galen Anatomy, in search of material substrate of mental processes, described solid brain in details that allowed to researchers of that time to return to the ideas about psychic indivisibility. German scholastics Goklenius and Kassman firstly introduced the term «Psychology» in the scientific life (1590). The growing interest to psychological phenomena ensured the factual basis for future successes of psychological analysis of Bekon and Dekart.

B. Spinoza, developing monistic doctrine about substance, overcame dualism of Dekart and approached ot the problem of knowledge and passions on the basis of own ideas. He distinguished three types of knowledge - the abstract concepts of certain things, general ideas about the essential properties of things and intuitive knowledge. Thus, Spinoza charted the movement of knowledge from the abstract to the concrete. He also identified three basic emotions - desire, pleasure and displeasure. Psychology of Spinoza is a new important step since Dekart in the development of consciousness as an object of psychological study. There is a final

allocation of consciousness as a subject of study. Preconditions for the emergence of empirical introspective and asocionistic Psychology emerge.

The aim of the founder of empirical Psychology Lokk was to study the origin, validity and scope of human cognition. He insisted that only experience as individual history of life is a source of knowledge. Formation of ideas he linked with the concept of association and first introduced this term in science. Lokk saw consciousness as the essential characteristics of mental phenomena, combining also experience and forms from this unity the personality. Lokk's doctrine of the origin of psychic life experienced gained popularity in the scientific community of the time and influenced the development of ideas of Berkli, Jum, Gartli.

Evolution theory, developed by Charl'z Darvin (1809-1882), influenced on the formation and development of Psychology (the term was commonly used in the second half of the eighteenth century after Hristijan Vol'f works). Animal psyche, «primitive peoples», the child's mind, psyche at mental retardation studied in details. The greatest achievement of that period was in that ignoring of environment that surrounded people was ceased.

Denying to researchers who were unable to break with dualism definitively, Gerbert Spenser (1820-1903) stated that «relational mental activity is relentless body adaptation of its internal relations to external». In his view mental phenomena can not be studied in isolation from the outside world. Tomas Geksli (1825-1895), another follower of Darvin, said: «Today no one who stands at a height of modern search science has no doubt in the fact that the basis of Psychology shou physiology of the nervous system».

The search for causes that underly in base of mental activity, continued, tendencies to localize precisely some mental processes in a certain area of the brain (psyhomorfolohizm) appeared. Other studies had position of leading role and importance of will.

A detailed study of functions of endocrine glands, autonomic nervous system had been started, electrophysiological searches. Austrian physician Franc Gall ' (1738-1828) conducted a parallel between the cranial building and features of human

psyche, his abilities and personal qualities. Attention of psychologists, psychiatrists was attracted by works of Z. Frejd (1856-1939), who was the creator of one of the leading areas of Psychology - psychoanalysis, the theory of human mental activity which is caused by the influence of the unconscious, especially sexual desire.

The consequences of pandemic of encephalitis (1915-1920), which is having damaged subcortical structures, significantly changed personality, including temperament, stimulated more thorough studing of the function of subcortical structures of the brain.

As a result of activities in some areas extremely valuable data have been received. Science has been enriched by new discoveries in physiology and morphology of the analyzers and nervous system. But the desire to find out real cause of mental activity was in vain.

The experimental method enriched opportunities of Psychology significantly, initiated in Psychology by V.Vundt (1832-1920). He published the book «Principles of physiological Psychology» in 1874 and founded the first laboratory of experimental Psychology in Leipzig in 1879. Following the positions to the restructuring of psychological science on experimental base, Vundt argued that such restructuring is fruitful only exclusioning the concept of the soul because the soul he understood from the standpoint of psychophysical parallelism, a staunch supporter of which was himself.

Experimental searches have allowed to study memory, attention, perception, emotional and volitional sphere in details.

Idealistic doctrines dominated in Psychology in Russia, Psychology mainly developed in line with Theology. M.V. Lomonosov, A.M. Radishhev, A.I. Gercen, V.G. Belinskij, M.O. Dobroljubov, M.G. Chernyshevskij made a great contribution to the development of the philosophical foundations to understanding the mental. In A.M. Radishhev's work «About man, his mortality and immortality «over considering the metaphysical problems from the standpoint of naturalistic humanism, the inextricable link between natural and spiritual principle in person, the unity of body and soul were recognized.

I.M. Sechenov, raised on the works of philosophers and humanists, created his theory of reflex activity of the brain and published work «Reflexes of the Brain» in 1863.

I.P. Pavlov, having developed position of I.M. Sechenov, created the original methodics using of which allowed to penetrate into the essence of reflex brain function and expose «scrutiny analyzis of basic laws that govern the whole vast complex work of higher part of central nervous system». It has been proven that mental phenomena are the result of conditioned reflex activity of the brain, and the conditioned reflex is both tangible (physical) and ideal (mental). The foundation of natural scientific Psychology was laid by works of the two giants of Russian physiological science that made it possible to move from study of external manifestations of mind to the knowledge of its essence.

The first experimental psychological laboratory in Russia was opened by V. M. Behterev in 1885 at the Medical Faculty of the University of Kazan. There, and later in a similar laboratory created by him at the Military Medical Academy in St. Petersburg, under his leadership over 20 clinical psychological doctoral theses were performed.

In 1896 such laboratory was organized by S.S. Korsakov in Moscow in a psychiatric hospital. Almost simultaneously, similar laboratories were opened in Odessa, Kiev and Derpt, where V.F. Chizh performed experimental work for studing of the mentally ill. Psychological cabinets were organized in all cases on private donations.

In 1904 at the meeting of Russian Union of neurologists and psychiatrists a special commission for review and systematization of the latest clinical and psychological methods was elected. In 1908 O.M. Bernshtejn published the managementation «Clinical methods of psychological examination of the mentally ill» firstly in Russia, and in 1911 «Atlas of psychological examination of personality» was published by F.G. Rybakov.

However, the development of Psychology, using its methods for studing mental scope of patients, largely constrained by lack of means and certain ideological and

socio - psychological problems that prevailed in Russia in the early XX century. In addition, experimental psychological researches were conducted from the standpoint of metaphysical functional Psychology that is not allowed to penetrate into the essence of consciousness or the essence of personality.

Meanwhile much has been done by domestic practicing doctors and researchers of clinics and institutions for development of medical ethics, the studing of processes of interaction between doctor and patient. The vast majority of Russian doctors believed that serving to the patient was their duty of own conscience. The humane attitude to patient in their work combined with a sincere desire to ease his/her suffering in any way. Leading national doctors studied not only the patient, but also its surroundings. S.P. Botkin is one of the first clinicians who examined the relationship of morphology and function, the unity of body and environment, the role of the nervous system in course of physiological and pathological processes.

The great influence on medical community of that time works of founders of the national clinical medicine I.E. Djad'kovskij, M.Ja. Mudrov, G.A. Zahar'in, M.1. Pirogov, V.P. Obrazcov, V.M. Behterev, S.S. Korsakov and other eminent scientists and humanist - physicians made.

In the Soviet period development of Psychology was continued, but on purely materialistic ground. Already in 1918 a special institute for the study of children with underdevelopment of mental sphere was organized and named then the Medical Pedological Institute. A new profession the clinical psychologist was appeared. Before 1923 there were 13 scientific institutes in the country that studied the problems of labor, a large number of pedological laboratories. Since 1928 publishing the magazine «Psychology, Pedology and Psychotechnics» started where the results of researches conducted in the USSR were published. The psychological diagnostics was actively developed. Thus, the psychology of mental retardation was studied at pathopsychological laboratory under the direction of L.S. Vygotskij and B.V. Zejgarnik. Pathopsychological researches developed at Psychoneurological institute under the supervision of V.M. Behterev and V.M. Mjasishhev.

First neuropsychological research in the Soviet Union was held in the 20's of XX century by L.S. Vygotskij. He formulated the basic provisions of the development of higher mental functions and system structure of consciousness on basis of studying various forms of mental activity. L.S. Vygotskij analyzed the changes occurring in higher mental functions in local brain lesions, especiality of these systemic disorders in child and adult based on the developed theoretical positions. The principles of the localization features that distinguish the human brain from the brain of animals were found and described as a result of these searches. Experimental and theoretical works of M.O. Bernshtejn (from the 20's years) had significant impact for understanding of the relationship between the brain and mental functions, from biomechanics and physiology of movements that include one of the first clear formulations of feedback principle.

Soviet Medical Psychology developed mainly in direction of clinical-descriptive and experimental psychological research. Noticeably a struggle with ideological directions in Psychology and subjectivistic methods of introspection unfolded. Along with significant positive developments in the form of greater objectification of the studied phenomena, it had negative consequences, which resulted in the 30's years before the official state ban of certain areas of Clinical Psychology, which significantly slowed its development further.

In 30-40 years of XX c. as a result of methodological, theoretical, experimental and applied researches, in the hard conditions of the strictest political control, first initial and very different versions of the theory developed by S.Ja. Rubinshtejn, O.M. Leont'ev, B.G. Anan'ev appeared. V.M. Mjasishhev began to develop the psychology of relationships as one of the priorities in the national Psychology concepts. He developed a theoretical understanding of relationship of the personality and the environment and the concept of psychology of personality as a system of individual relationship to reality, unlike the conventional approach that considers the personality as a system of functions. V.M. Mjasishhev formulated the clinical and pathogenetic concept of neurosis based on the psychology of relationships in 1939.

In the prewar period organizational strengthening of psychological science lasted. Over the 30's years the departments of Psychology were created in Leningrad pedagogical colleges under the direction of S.Ja. Rubinshtejn. B.G. Leont'ev had worked in Kharkov. In 1941 D. Uznadze and his colleagues created Institute of Psychology in Tbilisi, where the theory of settings was developed. In the 1942-1944 departments were organized at the main branches of the educational institutions of the country - Moscow State University (S.Ja. Rubinshtejn) and LSU (B.G. Anan'ev). However, in the following years Psychology got irreparable loss that was caused by Joint Session of the Academy of Sciences of USSR and the Academy of Medical Sciences of USSR in 1950, and followed by scientific discussion at a joint meeting of the Academy of Medical sciences and the plenum of the Board All - Union Society of neurologists and psychiatrists in 1951. Having opened the «distortion» and «mistakes», this ideological campaign was resulting in diminishing of the role of Psychology and its application branches, substitution of them with physiological study of higher nervous activity of Academician Pavlov, who died in 1936. At the highest level «meetings» of adjustment of Psychology and translation of it on unproductive physiological ground were held. Only in the 60's the situation began to change and appeared the preconditions for the revival of psychological science and its application areas.

In the 60 - ies in connection with studies about brain interest to the problem of consciousness and its role in behavior revived. In Neurophysiology the Nobel laureate Sperry considered consciousness as an active force. In the USSR Neuropsychology is being developed in the works of O.R. Lurija. He gained and systemized huge facts about the role of frontal parts and other brain structures in the organization of mental processes summarized numerous previous studies and the study about violations of certain mental functions - memory, speech, intellectual processes, voluntary movements and actions with local brain lesions was continued, the characteristics of their recovery were analyzed. Assimilation of experience of national and foreign authors in area of the development of neuropsychological research methods allowed to O.R. Lurija to create a complex of methods for clinical

examination of people with brain lesions. As one of the results of theoretical generalization of clinical experience that was formulated by him was the concept of three block structure of the functional organization of the brain. A large part in the work of O.R. Lurija had to issues of neurolinguistics that were developed in close conjunction with the problems of afaziology. These numerous studies in Neuropsychology created conditions for the aparte of this science in an independent discipline.

In 70-80 years in some cities of the USSR large research centers and schools of Medical Psychology which successfully developed various areas of medical and psychological research formed firmly. Moscow scientists (B.V. Zejgarnik, K.K. Platonov, K.M. Gurevich, S.Ja. Rubinshtejn, Ju.F. Poljakov, E.D. Homs'ka, F.B. Berezin, V.V. Nikolaeva etc.) have focused their efforts on basic research in the field of psychodiagnostics. They created national version of foreign psychodiagnostic methodics (MMPI, methodics of diagnosis of interpersonal relationships of T. Leary and others), a number of research works about the pathogenesis and neuropsychological aspects of various psychiatric and neurological diseases, mental changes in chronic somatic diseases were made, extensive investigations in psycho-(neuro) physiology were held, etc.

The important direction of the Leningrad school of Medical Psychology (M.M. Kabanov, A.E. Lichko, L.I. Vasserman, B.D. Karvasars'kij, V.K. Mjager, R.O. Serebrjakova etc.) is development of theoretical basis and practical implementation of models of the rehabilitation process in different fields of medicine. The range of specific scientific researches of Leningrad scientists is extremely large and includes as the problem of psychodiagnostics (creation national and adaptation of foreign methodics of diagnosis an intellect in adult by D. Veksler, diagnostics of interpersonal relationships in children by R. Zhil'etc; creation a number of original national psychodiagnostic methodics patocharacterological diagnostic questionnaire for adolescents (PDQ), methodics for diagnostics the types of attitude to disease in somatic and border neuropsychiatric diseases - TOBOL and so on), as problems of

organization of medical and psychological service and psychosocial provision of treatment and rehabilitation process.

Representatives of Kyiv Scientific School (V.M. Blejher, L.F. Burlachuk and others) decided questions of theory and practice of patopsychological diagnostics from general pathological positions.

Current trends to use the ideas and methods of Medical Psychology to improve the quality and intensificate the diagnostic and treatment process in various fields of medicine, with all the inevitable nowadays difficulties primarily due to the uneven level of development one or another section of it are preserved. Next sections of Medical Psychology are the most developed in this time as pathopsychology that occurred at the intersection of Psychology, Psychiatry and psychopathology (B.V. Zejgarnik and so on), and neuropsychology, formed on the boundary of Psychology, Neurology and Neurosurgery (O.R. Lurija and others).

Pathopsychology, according to B.V. Zejgarnik, studys patterns of disorders of mental activity and personality traits in relation to the laws of the formation and flow of normal mental processes.

Question of differentiation of subject of pathopsychology and psychopathology as a branch of Psychiatry remains controversial till nowdays. The difficulties of this distinction are inevitable because both sciences deal with one subject - disorders of mental activity. On this occasion, V.M. Blejher noted that psychopathology was not limited by pathological changes of psyche. It is a science that not only describes the clinical manifestations of mental disorders, but also studies their mechanisms, including psychological. It is hard to imagine in any branch of medicine, including Psychiatry, that studing of pathological disorders is without recourse to normal. Summing up comments by a number of leader psychiatrists and pathopsychologists, the differences between psychopathology and pathopsychology can be seen in that the first one as clinical discipline operates by medical categories (etiology, pathogenesis, symptom, syndrome) and general psychopathological criterias (origin, result, prediction of disease) based mainly on clinical method, but, in the same time,

pathopsychology studies patterns of disturbances of mental activity, using mainly own psychological methods and concepts.

The development of Medical Psychology was influenced by researches of the theory and practice of rehabilitation. M.M. Kabanov understood the process of rehabilitation as a system activity aimed to restore the personal and social status of patient (complete or partial) with special method, the main content of which consists of mediation impact through the personality treatment and recovery actions and events. He led the development of the third urgent (along with pathopsychology and neuropsychology), an extremely important chapter of Medical Psychology - psychological foundations of psychotherapy and rehabilitation. Effective using of psychotherapy in treatment and also in psychohygienic and psychopreventive purposes led to further development of psychological and sociopsychological foundations of psychohygiene and psychoprophylaxis.

On the selection in a separate section of Medical Psychology range of issues related to the nature of the study, treatment and prevention of the so - called psychosomatic disorders, whose importance in the structure of morbidity is growing, claimed.

Studies of psychosomatic relations that use the methodology of psychophysiological approach were also prospective. The works of V.M. Behterev and V.M. Mjasishhev were as a significant contribution to the development of this methodology. Representatives of this area for a long period before the emergence of the concept of stress actually studied its psychophysiological and psychosomatic features, although they described the results in other notions. Of course, with the emergence and development of the concept of emotional stress and its importance for the realization of psychosomatic problems interest in this methodology grew, and it received more and more spread in our country. The using of psychophysiological experiment in combination with psychological methods allowed to understand better the mechanisms of reaction of certain somatic systems on the social and environmental impact.

Today the Medical Psychology is the most popular areas of applied Psychology. Thus, in the American Psychological Association, the most numerous and influential psychological organization in the world, seven out of eight departments solve theoretical and applied problems of mental health. In our country the development of Clinical Psychology is just beginning. Associations of psychologists that contribute to the consolidation of specialists for solving organizational, methodical and practical problems are forming.

Psychological research methods: observation, introspection, psychological purposeful conversation Modern

Medical Psychology has a significant arsenal of methods. Most of these methods borrowed from General Psychology, some of them established in Clinical Psychology as own clinical and psychological techniques. Conventionally all methods of Psychology can be divided into *non-standardized and standardized. Non-standardized* methods presented firstly by set of so - called pathopsychological methodics which differ by «exactness», focusing on certain types of mental pathology. Their selection is carried out individually for a particular subject off investigation. These techniques are creating for study of specific types of mental activity. In conditions of psychological experiment, they used to determine the characteristics of mental processes according to the task, including differential diagnosis.

Psychological conclusion is based not so much on account of the final result of a patient activity, but on qualitative, meaningful analyzing the ways of activity, characteristic features of the process of work as a whole, rather than apart tasks. An important is a consideration of patient attitude to examination, the dependence the presentation of a task forms the state of patient and its level of development. Only with such a construction of the experiment can be fully realized the requirement for psychological research - identifying and matching a structure of modified and saved forms of mental activity. It is obviously that conducting of psychological

experiment, based on the principles outlined above, requires the hight qualification of medical psychologist.

In practice of medical psychologist *standardized* methodics are used also. In this case the group appropriately selected and structured tasks presented in the same form to each subject to compare the method and level of implementation by subject and others. Scilicet, standardized methodics are always applied in the same way from baseline to interpretation of the data. Standardized methods can be defined as tests, in the broad sense, having assigned to them tests for studing mental processes, mental states and personality.

In case of using the standardized methods way of analysis the results of each methodic is based primarily on quantitative evaluation that compared with estimates which were obtained earlier in the appropriate sample of patients and healthy subjects. Standardized methods except unification tasks themselves have to be normalized; ones that have scale assessments (standards), based on previous empirical research; should have calculated degree of stability results (reliability) and accurately assess the condition of specified characteristics of mental activity.

Standardized methods by their diagnostic value inferior to non-standardized ones, that is why their using in clinic is usually have secondary importance, often in addition to non-standardized methods. Adequate is their using in mass screening, if necessary of collective assessment of subjects for oriented rapid diagnosis with shortage of time. Over assessing the results of studies conducted with using only test methodics some caution is required because the data can be used only as a supplement to a complete clinical examination.

One of the largest national medical psychologists V.M. Mjasishhev noted that in the difficult task of psychological research at the present level, each psychological method has advantages and weak sides. Laboratory method is inferior to a clinical one in closeness to life, but can surpass it with analytical and methodological point of view. The task of the psychologist-researcher and psychologist-practice is in cleverly combining these methods according to study

The most common methods in medical practice of psychologist include observation and introspection (observational methods), psychodiagnostic methods (tests - standardized and projective), interview, conversations; analysis of processes and products of activity, biographical methods (analysis of facts, dates and events of life, documents, testimony). The using of certain methods or their combination depends on the tasks and a research object.

Among the methods of Medical Psychology, that allow to objectivate, differentiate and classificate different variants of norm and pathology, observation and introspection, physiological methods (EEG, REG, ECG etc.), anamnestical method, experimental - psychological method are distinguished.

Observation is the descriptive psychological research method that is in purposeful and organized perception and recording of the behavior of investigated object. purposes.

The observation with the introspection is considered the oldest psychological method. Scientific observations have been widely used since the late XIX century, in areas where particular importance is the fixing of the behavior of people in different conditions - in Clinical, Social, Educational Psychology, Developmental Psychology, and from the beginning of the XX century - Psychology of work.

In accordance with the goals and objectives, observation can be continuous (all manifestations of mind are being fixed) or selective (only some displays, for example, only emotional are being fixed). In observation is important to fix the results. It is carried out by means of special notices-protocols, transcripts, of using special equipment-teleaudiorecording etc. Observation requires significant time, the researcher is in passive position, he/she has to expect the onset of the phenomenon that interests him. On the results of observation installation, state and interests of the researcher may affect.

Given these shortcomings, observation is used primarily in cases when minimal intervention in natural behavior is required, necessary to obtain a complete picture. Often it is used in the initial stages of the study, and then supplemented with other research methods.

Different characteristics of behavior can be the subjects of observations.

The objects of study can be:

- Verbal behavior:
- Content of speech;
- Duration of speech;
- Intensity of speech, etc.
- Non - verbal behavior:
- Expression of the face, eyes, body,
- Expressiveness of movements, etc.;
- Movement of people;
- The distance among people;
- Physical influences:
- Touching;
- Pushes;
- Punches, etc.

Thus, the researcher does not observe mental properties, but registers only that displays of object which are available for fixation. And only proceeding from the assumption that the psyche is manifested in behavior, a psychologist can build hypotheses about mental properties, based on data which were obtained over observation.

Introspection as a real process always presents in psychological research and can act as a self-report of investigated person about own thoughts, a process of solving the problem, experiences, etc. Introspection has a particular importance in study of the dynamics of consciousness, the description of feeling in different states of activity, the dynamics of representations and experiences, motives of behavior. Techniques and data of indirect introspection presented in the form of diaries, autobiographical materials, rewriting have the great importance. The material of subjective history that is compared with the data of objective medical history, clinical and laboratory research are always used in medical practice. It should be

noted that the possibility of introspection and its adequacy depends on the level of self-analysis, which is an indicator of mental development of the person.

Clinical-psychological interview (conversation) is a method of obtaining information about the individual psychological characteristics of personality and psychological states. Interview differs from the usual questioning that it has dialogical character and is aimed not only to identify some obvious signs of disease, but to recognize the hidden signs, and also to understand the sense of problem more accurately.

During the clinical - psychological interview one should follow certain principles.

The principle of the uniqueness and accuracy implies an unambiguous formulation of questions that is not to allow diversity in understanding of what the doctor asks the patient (for example, the question «Are you feeling the mental influence?» is ambiguous, because the patient can mean under the influence different things: aliens, other people, strong experience, etc.).

The principle of intelligibility suggests that the diagnostician refers to the patient in the language that corresponds to the patient's social status, level of knowledge, vocabulary, cultural differences.

The principle of adequacy requires clarification the content of identical words which are used by patient and psychologist to exclude misinterpretation of answers.

The principle of impartiality implies the control by diagnostician if he/she does not impose to their patients own perceptions about availability pathological manifestations at the patient.

The interview (conversation) consists of two parts. The first part is establishing a psychological contact. This is the most important and difficult stage that is able to affect on quality of the results. Typically, medical psychologist faces during work with children and adolescents with the fact that children are leaded at consultation by adults: parents and teachers. The reason for seeking medical psychologist becomes a problematic child's behavior in notion of adults. That is why children often do not understand why they need to talk to a psychologist and participate in

any examinations. In this regard, the primary clinical psychological interview never should be directed to receiving the information: it is better to start with a situational support, clarification of health state and ability to participate in the examination, explain the goals and objectives of the meeting of psychologist with a child, informing of the presence of right to give up the diagnostic procedure. However, these tasks are often solved by medical psychologist who also works with adults (e.g. with patients of psychiatric clinics).

The second part of the interview is a conversation during experiment that is typical for nosological paradigm of Medical Psychology. The content of this conversation always depends on the task.

The clinical psychological interview is the main method of examination of the personality in descriptional-phenomenological paradigm, but observation and experimental - psychological researches play a supporting role.

Clinical-psychological interview can be semi-structured or free.

Semi - structured interview includes a mandatory list of specific issues relating to a particular problem. It allows to psychologist in a short period to collect all the information that needed to establish a psychological diagnosis, to clear the all necessary aspects of the problem. Semi - structured interviews are based on taxonomic (syndromic) signs of mental or behavioral disorders and facilitate classification of problems in universal definitions of disease. The questions of interview are aimed to identify symptoms of the disorder, typical situation of their manifestation, intensity and depth of disorders, family and interpersonal context. The effectiveness of a structured interview is determined by two factors: 1) the quality of interpersonal contact of psychologist and patient; 2) the flexibility of interview leading (taking into account individual state of investigated, the situation of investigation and characteristics of patient's life). The advantage of using semi structured interview is that most people do not tend to immediately share with the psychologist an important personal information. Generally, ones surveyed in this way do not tend to talk more to psychologist than answers to questions raised.

Free clinical and psychological interviews help to generate fuller information about actual problems of investigated and the situation in which he/she is located. Free interview allows subjects to express spontaneously their most urgent, not imposed by psychologist thoughts and feelings, as happens with them in everyday communication. Most of psychologists develop an individual style to attract their customers in free diagnostic interview using a variety of means. In working with children it is advisable at first to draw into a game or work together with other relatives of the child, which he/she trusts (e.g. start to work from a common painting or drawing pictures). During the free interview it is necessary to gather information about the child's perception of himself/herself and others, to know its normal behavioral responses in different situations of communication and interaction. Any information concerning the child's views on the situation in reference to a psychologist, examination and interpretation of what happened, other major life events may be important in such interview.

It is important to conduct a survey of mental status during the primary clinical and psychological interview conducted by any method. Information about mental status is a psychological impression from communication with the client. This survey reveals the aspects of behavior that require more careful analysis, to compare the complaints and formed impressions. Mental status includes five parameters:

- appearance of the subject;
- communication and behavior during the interview and testing;
- mood and emotions;
- intellect;
- features of perception of self, time and surrounding reality.

It is necessary in assessment of appearance to pay attention to appearance, matching to age, manner of dress, (cleanliness, adequacy), postures and gestures, facial expression.

Communication skills and behavior during the interview and testing provide information about direction of social skills of communication and interaction, motor status, relation to the fact of conversation with a psychologist (irritation, aggression,

desire to evoke sympathy, defensive position, apathy, sarcasm) and adequacy of behavior to situation. Communication skills also allow to evaluate the process of thinking: integrity or dissociation, mobility, relevance, thoroughness.

Mood and emotion characterize the psychological state of the subject (gloom, tension, hopelessness, confidence, sadness, euphoria, fear, etc.).

Intelligence is characterized by vocabulary, level of experience, available supply of knowledge, ability to understand the relationship of things and events, to make conclusions.

Features of perception ownself, time and the surrounding reality characterize the ability to navigate in own personality, time, location that determine the level of consciousness (clear, unclear, shuted down), adequacy of self-esteem, presence of disorders of perception, thinking.

Experimental psychological research methods of patients

Experimental psychological research is an artificial creation of conditions which show the human mental activity in disease states. It is based on the principle of functional tests. The role of specific stress in experimental psychological research belongs to tasks which require actualization of mental functions. Experimental psychological research carried out by using non - standardized and standardized methods.

There are two major principles of selection techniques for experimental psychological research: 1) a combination of methodics that allow more fully and comprehensively study the manifestations of mental activity; 2) a combination of close-focus methodic, which increase the reliability of the results. Typically, 8-9 methodics are used in one research.

The next circumstances play an important role in choosing methodics of experimental psychological research.

1. The purpose of research - differential diagnosis, determination the depth of a defect, the study of the effectiveness of therapy.

2. Education and patient's life experience.

3. Features of contact with patients (e.g., patients with impaired hearing or vision).

Methodics are offered in order of increasing complexity over process of research (except the expectation of simulation).

Principles of complex psychological research according to age and cultural characteristics of patients

The construction of clinical and psychological research involves the following steps.

The first phase of the clinical and psychological research — before meeting with patient — is the stage of formulation of clinical task. This includes a conversation with people around the investigated: teachers, parents, friends, co-workers or classmates, doctors - about the characteristics of his/her behavior and personality problems that arise; studing the characteristics of interpersonal relationships (social conditions of patient's life), evaluation of the material and cultural conditions of life; acquainting with the general state of physical health: concomitant systemic diseases, experience of using psychoactive substances. Survey after sleepless night, physical fatigue or immediately after a meal is unwanted. It is better to repeat research at the same time as the primary one. At this stage a preliminary plan of study should be consisted: selection of methodics and their sequence.

The second phase of the clinical and psychological study - a conversation with the patient. The conversation should begin with passport data, on what the first impression of the state of memory is based. Then the memory status is investigated more detailed (short - term and long - term data of his/her own life, historical events, recent events), attention is measured, the state of consciousness, orientation in time, place and own personality is characterized. The questions should be asked in a relaxed, natural manner, as in usual conversation. Also relation of the patient to own disease, problems is turned out, the goal of experimental psychological research is explained. In further conversation personality traits (to the disease and at the

moment) are investigated, the ability to assess changes that taking place, self - being, cultural and educational level is determined, workability.

The third phase of clinical psychological research is an experimental psychological. Each of these tasks must be preceded by instruction that defines the situation of research and provides psychologist and patient cooperation. It should be as maximal concise, match to the mental level of patient, exclude controversial meaning. It is possible to use the previous example. Carelessly provided instructions can lead to inadequate results. Instruction must be tried before the experimental psychological research. If the patient is unable to cope with the task it is necessary to jointly discuss the reasons of this. It is also important to assess if the patient use a help from a psychologist or reject it (negativism, deliberateness or resistance). It is necessary to full and accurately account the circumstances of experiment and the patient voiced opinions.

The fourth stage of clinical psychological research - analysis of the results and making conclusions. The conclusion should be the answer to the question that was put before a psychologist. There is no the only one form of conclusion. But it should never be a simple duplication of the study protocol. It is needed to create a description of the mental state, note the features of behavior, relation to research (including the presence of constituent behavior), identify the pathopsychological key features (syndromes), describe the particularity of mental processes flowing (for example, the rate of reactions, exhaustivness, stability), describe saved sides of mental activity based on these data. It is allowed to bring bright characteristic examples. The resume, at the end, reflects the most important data (e.g. the structure of pathopsychological syndrome). The conclusion should not be categorical assertions in style.

The definition of mental health and psychological levels of human adaptation. WHO Health Criteria

Categories of norm and pathology, health and disease are the main vectors that specify the perception and evaluation criteria of the human state in Medical Psychology. Category of norm is used as a benchmark of comparison of the current (actual) and permanent (common) state of people. The state of health is closely linked with the notion of norm in our mind. Deviations from the norm are considered as pathology and disease. The word «disease» in everyday language is used to describe states that do not seem «normal», «such as it usually is», and therefore is required special explanation. However, meaningful, but not intuitive definition of clinical norm as a theoretical construct is a great problem.

Norm is a term that can include two main senses. The first is a statistical content of standards: a level or range of levels of the body or personality functioning that inherent to most people and is typical, that is most common. In this aspect, the norm seems as some objectively existing phenomenon. The statistical norm is determined by calculating the arithmetic values of some empirical (found in life experience) data.

The second is an estimated content of norm: the norm is an ideal example of the human state. In this example there is always a philosophical and ideological justification as a state of «perfection», which has to achieve all people in varying degrees. In this aspect the norm manifistates as an ideal norm- subjective, arbitrary installable regulation, that taken as an ideal example with the consent of the persons who have the right to establish such samples and having power to over others: for example, specialists, leaders of the group or society and etc. As standard an ideal norm is the tool for simplification and unification of the diversity of life forms and the individual displays, therefore some of them are recognized as satisfactory, while others are out of acceptable level of functioning. Thus, into the concept of norms evaluative component can be turned: a person must be such and not another. All that does not meet the ideal is abnormal.

The problem of norm - standard is associated with problem of the choice of regulatory group - people whose livelihood serves as the standard by which the effectiveness of functioning of the body and personality is measured. Depending on whom empowered professionals include in regulatory group different limits of normal are established.

To some of the norm - standards not only ideal standards are included, but also functional norms, social norms and individual norms.

Functional norms assess the human condition from the standpoint of their effects (harmful or not harmful) or ability to achieve the goal (if this state promotes or does not promote the implementation of related with the purpose problems).

Social norms control human behavior, forcing him/her to conform to some desirable (that is ordered by surroundings) or the prescribed by authority sample.

Individual norms involves a comparison of the human state not with other people but the state in which it certainly was earlier and which corresponds to his/her personal (but not that society offers) targeted instruction, life values, abilities and circumstances. In other words, individual norm is ideal from the individual standpoint, but not from a dominant social group or the immediate environment status, taking into account the capabilities and the individual self-performance.

The psychologist or psychiatrist may apply any of these standards depending on the purpose for assessment of normality (compliance to norm) of the individual psychological state. Therefore, the assessment of psychological state (status) of the individ often gets hidden political and ideological character, because the system of values which dominant in society or in the mind of a particular group of people is detected at the ultimate criterion for evaluating.

Characteristics of general well - being appears as the central differentiation element of health and disease. A healthy person is the one that feels good and therefore can perform everyday social functions. Sick person is the one that has poor health and therefore can not perform everyday own social functions. Thus, the actual or absence of various irregularities on a biological level of existence is not often significant for association of self to healthy or sick person. For example, people who

have used alcohol at the party, with deviations from «normal «parameters of mental functioning (they locate in the so - called «altered state of consciousness»), but they are not sick as long as they have not disturbed performing of social functions. It turns out that the concept of health is broader than the concept of norms and concept of illness differs from the concept of pathology by content. These circumstances have led researchers to search for positive health concepts.

According to constitution of WHO «Health is a state of complete physical, mental and social well - being but not merely the absence of any disease or actual disability». This general definition provides such human condition at which:

1) structural and functional properties of the organism are retained;

2) high ability to adaptate to changes in the conventional natural and social environment is characterized;

3) emotional and social well - being is stored.

The WHO describes mental health as a state of well - being which allows a person to achieve its own potential, overcome usual life stress, work productively and fruitfully and make a contribute to the life of their community. In this positive sense the mental health is the foundation of well - being and effective functioning for the individual and for society. This basic concept of mental health corresponds to its wide and varied interpretations in different cultures.

The criteria of mental health according to WHO:

1) awareness and sense of continuity, permanence and identity of own physical and mental «I».

2) sense of identity and constancy of experiences in similar situations;

3) critical to own mental productivity (activity) and its results;

4) compliance of mental reactions (adequatety) to strength and frequency of environmental impacts, social circumstances and situations;

5) ability to control of own behavior according to social norms, rules and laws;

6) ability to plan own life and realize these plans;

7) ability to change the own behavior depending on changes of life situations.

Thus, the health generally and mental health particularly is a dynamic combination of various indicators, unlike the disease opposite can be defined as narrowing, extinction or breach of health criteria, as a special case of health.

The leading role in assessing of the health status within the biopsychosocial model psychological factors play. Subjective health is manifested in the sense of optimism, physical and psychological well - being, joy of life. This subjective condition is caused by the following psychological mechanisms that provide health:

1) taking responsibility of own life;

2) a self - knowledge as analysis of own individual physical and psychological characteristics;

3) self-understanding and self-acceptance as a synthesis - the process of internal integration;

4) ability to live in the present;

5) awareness of an individual being and as a result is awarenessly built hierarchy of values;

6) capacity for understanding and acceptance of others;

7) trust to the process of life. It is necessary to have the mental quality that J Jerikson called basic trust along with rational installations, orientation on a success and conscious planning of own life. In other words, it is the ability to follow the natural flow of the life process, wherever and whatever it is detected.

The concept of adaptation, which is contained in the WHO health criteria, should be considered in terms of K.K. Platonov, who defined the adaptation as «flexible accommodation of internal changes to external changes». The mechanism of adaptation has a certain structure that contains the following interrelated levels (components):

- Psychophysiological adaptation is an ability of organism to advisably rebuild the physiological functions in accordance with the requirements of the environment;

- Proper psychological (mental) adaptation - the ability to preserving the integrity and adequate response to different environmental situations, its violations are often linked with a tension, psychological stress;
- Psychosocial adaptation or adaptation of the individual to communication with new collective.

All levels of adaptation at the same time, but in different degrees are involved in the process of regulation of vital functions.

Thematic plan for self-control

1. Component parts of Medical Psychology
2. Basic stages of Medical Psychology
3. The contribution of representatives of Kyiv scientific school in the development of Medical Psychology
4. Clinical and psychological interview and its varieties
5. Principles of clinical psychological interview
6. Basic settings of research of mental status
7. Leading principles of selection of methodics for experimental psychological research
8. The main stages of clinical psychological research
9. Criteria of Mental Health according to WHO 10. Levels (components) of adaptation by K.K. Platonov

Section II. Personality and disease. The internal picture of disease.

Psychic structure of personality: temperament, character, intellect, abilities

Personality is a collection of various aspects of the human psyche reflecting the conscioused unity of the «I «that is stored with all the variability of temporal and spatial relationships. Personality can be defined as separately taken, particular person - the product of social development of a certain historical era with inherent individual biological and socially defined properties and qualities of psyche.

To understand the nature of personality means to resolve complex issues of correlation with mental and physiological, social and biological.

The concept of *«human»* and *«personality»* is distinguished at the social analysis of personality. The term *«person»* is the natural concept, and the notion of *«personality»* is social one, that it is not associated with a physical human being. but with some social properties. Each person has a specific functional structure of individual properties. Some properties of personality, that are usually called traits, are unstable and able to change under the influence of living conditions, education, disease, and others. Generally, it is said not just about the structure of the personality, but the dynamic structure of personality.

The individual is a biosocial definition of human being as a representative of Homo sapiens. Individuality is original, unique combination of psychological peculiarities of character, temperament, mental processes.

«Ones are born individuals, become personality, acquire individuality».

The combination of stable motives that determine a selectivity of relations and human activity relatively to situations is called the orientation of personality. Mechanisms of activity and behavior orientation are closely related to the concept of *motivation*. It includes such components as needs, motivations, intentions. objectives, interests and aspirations. The most important of all motivational concepts is the concept of «*need*», «*motive*» and *«objective*».

Requirements are the mental condition that is experienced by a person when he/she feels the urgent need of anything. Requirements express dependence of individual on specific conditions of existence. Requirements are always associated with the presence of frustration, with the objective deficiency of what the body needs to eliminate it.

Motives are the forces that encourage people to activity, it is an subject that acts as a mean of satisfaction of needs. It organizes and directs a behavior in some way.

Goal is an expected result, which is directed the current behavior. The goal, as opposed to the motives, is always understood.

Temperament

As temperament one should understand the natural behavior features that are typical for the person that found in the dynamic, tone and balance of reactions to life's influences. All mental manifestations of the individual are caused by temperament, it is displayed on the nature of the percolation of emotions and thoughts, affects to the rate and rhythm of speech, volitional actions. At the same time it should be remembered that the interests, hobbies, social attitudes and moral education of the individual are not depend upon the temperament.

The doctrine of temperament dates back to antiquity. Doctors Gippokrat and then Galen tried to explain the individual characteristics of behavior. Gippokrat (V c. B.C.) believed that there were four liquids in the human body: blood, phlegm, yellow and black bile. Preference of one of them determines the temperament of the person. The names of temperaments have survived until present time. Gippokrat described the types of temperament correctly, but could not scientifically explain them. I. P. Pavlov did the most successful attempt to link the temperament with the features of the human body. He suggested that temperament depends on the characteristics of higher nervous activity. These features are: firstly, the strength of the nervous system, which refers to the nerve cell and efficiency, and the ability of the nervous system to withstand heavy loads, and to produce conventional bonds; secondly, the balance of excitation and inhibition processes; thirdly, the mobility as

the ability to quickly change the neural processes of each other. It provides the adaptation to unexpected and sudden changes of circumstances. I.P. Pavlov concluded that particular ratio of the specified features was in the basis of each of four types of temperament that has been called the type of higher nervous activity.

Classification of types of temperaments

Features of external behavior	Features of nervous processes			Type of HNA	Type of temperament
	by strength	by mobility	by balance		
hyperactive	strong	fast	unbalanced	effuse	choleric
active	strong	fast	balanced	strong	sanguine
faintness	strong	slow	balanced	inert	phlegmatic
stiffness	weak	slow	unbalanced	weak	melancholic

Temperament is a mental property which features depend on the conditions of life and work of the individual. Therefore, its characteristic does not confine by a simple indicating for the type of HNA that inherent to the temperament.

Basic properties of temperament

The properties of temperament determine firstly the dynamics of person's mental life. One can judge of it by some of its basic properties.

- *Sensitivity* - it is judged about it by the fact which the smallest external impact force is needed to originate one or another mental reaction, with what speed this reaction occurs.

- *Reactivity* - this feature founds in the power and energy of a person to respond to a particular effect.

- *Activity* - it means the energy which person affects to the surrounding world with, his/her perseverance, concentration, etc.

- *Plasticity and opposite quality* - rigidity. They display an ability of person to adapt to external influences easily and quickly.

Plastic person can instantly rebuild own behavior when circumstances change. Rigid one hardly changes the habits and opinions.

The temperament characteristics also include the rate of mental reactions, emotional irritability, reactivity and activity and others. The swiss psychologist K. Jung noticed that for some people external objects and phenomena are the most important, if ones turned, so to speak, from the outside, but others are the more deped in their inner life. They are not so interested in their external events as their own experiences and the self. The first he called *extroverts*, and the second - *introverts*. Researches of other psychologists have shown that intro- and extroversion brightly showed, especially, in the communication process.

Six varieties of temperaments have the practical interest among the most frequently encountered types of temperaments depending on the combination of properties of the nervous system, such as strength, mobility and balance:

Strong *sanguine* (balance, strength, mobility); Movable choleric (*strength*, mobility, imbalance); Unbalanced choleric (mobility, imbalance, weakness); Weak *melancholic* (imbalance, weakness, inertia); Inert *melancholic* (weakness, inertia, balance); Balanced phlegmatic (inertia, balance, strength).

Considered characteristics are indicating that the advantages of one type (e.g., phlegmatic) are the shortcomings of other types (e.g., unbalanced melancholic). But pure temperaments are extremely rare. Typically, each person has the qualities that can not be attributed to a particular type of temperament. However, researches have shown that people with a strong, mobiled and balanced nervous system achieve better results, than people with weak, inert and unbalanced nervous system.

Character

Character is the especiality of mental activity which manifested in the peculiarities of social behavior of the person and especially in relations to people, matter and ownself.

Character is formed in the process of cognition of the surrounding world and practical activity. The fullness and strength of character depend on the range of

impressions and diversity of experience. Basic and main character rod consists gradually, strengthens during life and becomes typical for the person, and the specific manifestations of character can evolve depending on the situation in which the person is under the influence of people with whom he/she communicates. Being oneself one can detect openness or closure, determination or indecision, hardness or softness. Some changes in the character are observed with aging, prolonged illness, or other changes in the psyche.

Structure of character

To determine the structure of human character means to select the basic components in character and install the specific features in their complex relation and interaction. In the character as in integrated system of properties that reflect the history of the interaction between the individual and conditions of life, one can always identify the main parts of a system, or dynamic stereotypes that are fixed by external influences that characterize human behavior in the circumstances of life. In meaningful plan character is a system of human relations to the surrounding world, activity, other people, himself/herself.

The relation to the surrounding world is expressed in orientation of the personality, manifested in actions, behavior and determined by person's outlook, his/her needs.

In relation to the people to the surrounding world one can talk about the *principle* and *unprinciple* characters. The principle character is inherent to person that has defined sustainable views and behaves according to them. On the contrary, the person with unprinciple character or does not have strong views and beliefs, or acts contrary to them, obeying feeling, circumstances or outside influence.

Active and inactive characters are distinguished *regarding to labor*. A person with an active character is inherent the commitment, which makes organized labor, gives it a social significance and moral value. Active but disorganized people are fussy outside, characterized by a lack of purpose, inability to conquer his/her own actions to their thoughts.

Attitude to people is displayed in the relationship with friends, in cooperative activity in a collective. There are people with *sociable* and *self - contained* characters according to this principle.

In life there are people with a friendly superficial character. They are easy tie datings which are not based on awareness of any community. Such people are usually called frivolous. They are able to all sorts of surprises, and therefore they are needed in constant monitoring. Human sociability can be selective, based on the interest to people who think the same way with them. This sociability is positive, it describes the person as a fundamental and consistent.

The closed character may be as the result of negative or indifferent attitude towards people, deep, inner concentration (and then it does not indicate indifference), or distrust to them, caution that happens when a person lives in unfamiliar environment.

Attitude to themselves. Everyone somehow refers to itself. This ratio includes the awareness of his/her position in the team, community and responsibilities before them. Reassessment of its importance, opportunities and needs is inherent to persons with selfish character. Egoist puts himself/herself, their personal interests above the interests of the team, so this person is unreliable People with such traits are experiencing great difficulties in relationships with friends. Person with altruistic traits puts the interests of team and other people above all others ones. *Altruism* is an important character trait, without which existence of a real collective is impossible.

Character gets the important role not only for the individual, but for society. Life and work of staff, special mood of everyone are determined by character qualities of individuals. It happens that one person with a difficult character hinders to live around the team. Due to such person there are often conflicting relationships that affect to the work of all people in the team. A long-term observation in different situations is required in order to examine the character.

Accentuations of personality. Typology and classification of personality accentuations by K. Leongard, A.E. Lichko

The concept of «accentuation «was introduced firstly by the German psychiatrist and psychologist, professor of neurological clinic of University of Berlin, Karl Leongard. He also developed and described the classification of accentuations of personality.

In the works of Karl Leongard a combination of two concepts is used: «accentuated personality «and» accentuated character traits».

Accentuation of character by Leongard, it is something intermediate between psychopathy and the norm. According to him accentuated personality is not sick, they are healthy individuals with their individual characteristics. K. Leongard does not give a clear answer on the question about the boundary that separates accentuated persons from psychopaths.

Accentuated characters do not depend on natural biological properties, but on environmental factors that leave their imprint on the life of the person.

Accentuation always involves a certain strengthening degree of amplificated feature. Thus, this personality trait becomes accentuated. Accentuated features are not so numerous as variations of the individual features of the character. Essentially accentuation is the same individual traits, but which tend to move in a pathological state. At more expressivity they leave their imprint on the individual, and finally can acquire the pathological character, destroying the structure of personality.

German scientist K. Leongard identified 12 types of character accentuations. His classification is based on an assessment of communication style with others. K. Leongard divided the types of character accentuations into two groups on the principle of accentuation of character traits or temperament.

Classification of character accentuations by Karl Leongard

Demonstrative type. For persons of this type of accentuation tendency to «crowding out» of consciousness of those estimates that are unpleasant for the image

of “I»; desire for any price always to be in the spotlight; high self - esteem, attempts to make «wishful thinking «are characteristic.

Pedantic type. For this type of accentuation inertia of mental processes, susceptibility «wallow» in the details, difficulties with making decision are inherent. People of this type attract by equal mood in communication, reliability in business, integrity and cleanliness.

Getting stuck type. The main feature of this type of accentuation - a significant affect stability, «rancor», desire in the main and in the details defend own point of view, without taking into account the position of the group.

Excitable type. For such people tendency to «explosion» of emotions is characteristic as a means of periodic discharge of the nervous system.

Accentuations of temperament traits include *hyperthimic*, *dysthimic*, *anxious*, cycloid, exalted, extraverted and intraverted types.

Hyperthymic type. People of this type have high level of optimism and also greed of activities at possible susceptibility to superficial conclusions.

Dysthymic type. For this type of accentuation pessimistic orientation of the individual and fixation on the dark sides of life are characteristic.

Anxious type. The main feature - a high level of anxiety, highly developed «inferiority complex» - as a confirmation of low self - esteem.

Cycloid type. The leading feature - the tendency to arbitrary sudden mood changes within a short time interval: from increased - optimistic to pessimistic reduced, and vice versa.

Exalted type. For this type of accentuation, a large range of emotional states is characteristic, they admire something joyful and just easy fall into despair.

Emotive type. They are sensitive and vulnerable people, that determined the depth of experience in the field of subtle emotions.

Extroverted type. People of this type are open to all media, willing to listen and help anyone who calls them, are able to conform. They are characterized by a high level of sociability, talkativeness, compliance, diligence.

Intraverted type. For such individual's low contact, isolation, isolation from reality, a tendency to philosophizing are characterized. They focused on his/her inner world, their assessment on the subject or event, not the subject itself.

These types of accentuations not always manifest. As the structure of character is dynamic and changes throughout life, character accentuation can be reduced in the process of education, or self-correction. A person should know his/her characterological features and improve them if necessary.

In our country a different classification of accentuation has spread, that was proposed by renowned child psychiatrist professor A.E. Lichko. He believed that the accentuations of character had similarity to psychopathy. Their main difference from psychopathy is the absence of signs of social malajustment. They are not the main factors of pathological personality formation, but may be a factor in the development of borderline states.

According to A.E. Lichko accentuation can be defined as dysharmony of character, hypertrophied severity of its individual features that causes the increased vulnerability of the individual in relation to certain kinds of influences and makes it difficult to adapt to some specific situations.

It is important to note that selective vulnerability to certain kind of impact that occurs at one or another accentuation can be combined with a good or even increased resistance to other influences. Similarly, the difficulty with adaptation of the individual in some specific situations (communicated with this accentuation) can be combined with good or even increased ability to adapt to social situations. However, these «other» situations themselves can be objectively and more complex, but not paired with this accentuation.

All accentuations of Lichko are considered as temporary changes of character that smooth when mature. At the same time many of them pass into mental illness or save for a lifetime.

So accentuations are extreme, but variants of norm. Therefore «accentuation of character» can not be a psychiatric diagnosis.

According to studies of A.E. Lichko pathocharacterological reactions that act on the background of accentuations, usually, about at 80 % cases, smooth with age, are made soft and then satisfactory social adaptation can be watched. Would the prognosis be good or bad, it depends on the degree and type of accentuations - hidden or explicit, as well as social conditions.

Explicit accentuation - this degree refers to the extreme variants of norm. However, the severity of a particular type usually does not preclude of social adaptation. As a rule, employed position corresponds with abilities and capabilities. With age, particular qualities of character or remain fairly expressed, but are compensated and do not hinder to adaptation, or so smooth that clear accentuation becomes latent in.

Hidden accentuation - this degree refers not to the extreme, but to the ordinary variants of norm. In everyday, familiar conditions that features or type character or weakly expressed or are not detected at all. Even at prolonged observation, with diverse contacts and detailed acquaintance it may be difficult to of suddenly and get an idea about defined type. However, the features of this type can vividly manifest under the influence of those situations and mental injuries that are addressed to the place of the least resistance.

The most favorable prognosis is observed at hyperthymic accentuation, the worst one - at clear unstable accentuation.

There are several species for sustainable change:

- the transition of explicit accentuation into hidden when with age accentuated features are compensated. Only under the influence of some factors that addressed to vulnerabile place, the features of this hidden, disguised type suddenly show up, unexpectedly and in full force;

- formation of psychopathic developments on the grounds of accentuations, when environment plays role and as a result of it premorbid state may be there, and sometimes even disease;

- transformation of types of character accentuations, adherence to the basic type of close, compatible with this type other accentuations.

In some cases, the features of newly acquired accentuations can even dominate the main one, sometimes the features of one accentuation can «squeeze», «shade» the features of other accentuations.

As one of the common mistakes practical interpretation of accentuation as established pathology is. However, it is not so. In the works of K. Leongard it was intentionally emphasized that accentuated people are not abnormal. Otherwise, the norm should be considered only as average mediocrity and any deviation from it would be viewed as pathology. K. Leongard even thought that a person without a hint of accentuation certainly was not inclined to develop in an unfavorable direction, but also unlikely that he/she somehow differed in a positive way. On the contrary, for accentuated personalities willingness to special (as socially positive, as socially negative) development is inherent. In sum, perhaps, it can be assumed that accentuation is not a pathology, but an extreme version of normal.

The combination of different types of accentuations and psychopathic and neurotic tendencies may lead to different final states. For example, when a combination of accentuated and psychopathic personality traits at one or another person does not reinforce of accentuation or psychopathy, but, on the contrary, leads to equalization of character, that is to norm.

Classification of character accentuations by A.E. Lichko

Hyperthymic type. Teens related to hyperthymic type from childhood differ obstreperousness, sociability, excessive autonomy, even courage, tendency to naughtiness. They have no shame or shyness in front of strangers, sense of distance in relation to adult. In games they like to control peers. Educators complain about their restlessness. At school, despite the good abilities, lively mind, ability to grasp everything on the fly, they learn unevenly through restlessness, distractibility, lack of discipline. In adolescence, the main feature - almost always good, even slightly elevated mood. It is combined with a good feeling, often blooming appearance, high vitality, activity and energy, always excellent appetite and strong refreshing sleep. Only occasionally sunny mood is clouded with flashes of irritation and anger that

are caused by opposition to others, their desire to suppress too turbulent energy, to subdue their will. Reaction of emancipation strongly affects the behavior: such teens early exhibit autonomy and independence. With adults - parents and teachers they often arise conflicts. Very rapidly they respond to routine care, instruction and morality; do not tolerate rigid discipline and strictly regulated regime. But in unusual situations they do not lost, show dexterity, know how to cheat. To the rules and regulations representatives of this type relate frivolous, they can unwittingly overlook the distinction between what is permitted and prohibited.

They stretch for to the company, burden and poorly tolerate loneliness, among peer they are seeking to lead, not to formal, but actual role of leader. At sociability while choosing of acquaintances they are illegible and can easily occur in questionable company. They like risk and adventures.

Good feeling of new is characteristic. New people, places, objects attract. Easy inspiring such teenagers often do not show started to the end, constantly changing «hobby»; they badly cope with work that requires great perseverance, diligence, hard work; do not differ with accuracy in performance of promises, money matters, they easily climb into debt, like luxury, boast; they tend to see their future in bright colors. Failures can cause a violent reaction, but incapable of long unsettle. Temper quickly subsides, they quickly putting up with friends and even those whom previously quarreled with.

Sexual feelings frequent wake early and are strong. That is why early sexual life can be. However, teenage sexual deviance is fleeting, inclination to fixation is not found.

They usually overestimate own abilities and capabilities. Hyperthymic teenagers well know and do not hide although most of the features of his/her character, but usually try to put themselves as more conformal than they actually are.

Hyperthymic type occurs usually in the form of explicit accentuation. On its background acute affective reactions and situational violations caused by abnormal behavior (early alcoholism, toxicomanic behavior, emancipatory escape, etc.) may

occur. Hyperthymic accentuation can also be ground for psychopathic development of hyperthymic - unbalanced and hyperthymic-hysteroid types. Under the influence of repeated head injuries hyperthymic-explosive type of psychopathy can form. Hyperthymic type of accentuation occurs as frequent premorbid background at manic-depressive and schizoaffective psychosis.

Cycloid type. In childhood such persons are no different from their peers or make an impression of hyperthymic people. With the onset of puberty first subdepressive phase may occur. Subsequently, these phases alternate with phases of recovery and periods of equal mood. The duration of the phase change - at first days, then 1-2 weeks, with age they can lengthen, or vice versa, flatten.

In subdepressive phase lethargy, fatigue, feelings that «everything falls out of hand» are marked. What previously was easy and simple, now requires great efforts, learning becomes more difficult. Society of people around begins to bunden, adventures and risk lose appeal. Teens become sluggish homebody these days. Small troubles and failures that are frequent in this period due to falling performance, are experienced difficult. Although on the comments and accusations they often respond with irritation and rudeness, but at heart they fall into even greater gloom. There is more complains about boredom. However, if serious reproach or big failures fall in these days, especially when they humiliated pride, thoughts of their own inferiority, weak will, insignificance can easily arise. Acute affective reactions with suicidal attempts may be triggered by this.

Appetite is reduced. Even favorite dishes do not deliver former satisfaction. Insomnia does not happen in adolescents usually. Sometimes they complain that it became difficult to fall asleep and almost always about lethargy and weakness in the morning.

During the recovery cycloid teenagers look like the hyperthymics. Uncommon to them risky jokes under the olders and desire to wit anywhere and everywhere fall in the eye.

Self - esteem is formed gradually over accumulation of experience «good» and «bad» periods. If they lack such experience, it can be very inaccurate.

Labile cycloid is a form of accentuation, intermediate between typical cycloid and labile teenagers. The phases are very short - 1-2 days. In the «bad» days silly mood certainly not combined with loss of strength or unsatisfactory feeling. Within one period short mood changes are possible that caused by events or relevant news. But unlike described below labile type of accentuation, there is no excessive emotional reactivity, constant readiness of mood to change abruptly from minor reasons.

Cycloid psychopathy does not exist. At stark expressed cycloidity cyclothymia appears that rightly regarded as a mild form of manic - depressive psychosis. Cycloid accentuation itself can be the background for the development of both this and schizoaffective psychosis.

Labile type. In childhood, such persons differ from their peers, but tendency to neurotic reactions is exhibited. The main feature of adolescence - the extreme lability of mood that changes too often and too abruptly from minor and even invisible to others reasons. The spoken disrespectful word, surly look of accidental interlocutor are capable to immerse suddenly in gloomy mood with no serious trouble and failures. Conversely, interesting conversation, fleeting compliment, attractive, but few real prospects heard from someone, are able to inspire gaiety and cheerfulness and even distract from the real trouble until they remind of themselves. During a frank and disturbing discussions or tears that are ready to convert in the eyes, or joyful smile can be seen.

Everything is depended to the mood at such moment: health, sleep, appetite, efficiency and sociability. According to mood and future looks - that is painted with rosy colors, it seems sad and hopeless, and the past appear or as a chain of pleasant memories, or it consisted entirely of failures and injustices. Casual environment seems or nice and interesting, or ugly and boring.

These teenagers set deep feelings, sincere commitment to those from whom they see the love, care and attention. Affections are stored despite the ease and frequency of transient quarrels. Losses are transferred hard. Committed friendship is equally peculiar to them. They prefer to be friends with those who in moments of

sadness and discontent are able to console, distract, if attacked to protect, and in minutes of recovery to share the joy and fun, to satisfy the need for empathy. They like company, change of scenery, but unlike to the hyperthymic teenagers they looks for in it not field of activity, but only new impressions. Responsiveness to all kinds of favors, gratitude, praise and encouragement, delivering true joy, is not combined with arrogance.

The desire for clustering with peers depends entirely on the mood. In good minutes - they look company, in bad ones - they avoid contact. In peer group they do not claim on the role of leader, readily satisfying the provisions of the ward and pet defending by others. Hobbies are limited by informative - communicative type, sometimes amateur, pets hobby (own dog is especially tempting, which serves lightning rod for emotions with mood swings).

Peculiar selective intuition allows to such teenagers immediately understand the relation to them of people aroud, at the first contact determining who is friendly to them and who is indifferent, and who lurks a drop of ill or hostility. The corresponding ratio appears immediately and without attempts to hide.

Self-esteem is characterized by sincerity and ability to note features of their character correctly.

“Weak link» of this type is dependence from emotionally significant persons, separation from them.

Accentuation on labile type is often combined with harmonic psychophysical infantilism, as well as vegetative lability and tendency to allergic diseases. This type of accentuation is ground for acute affective reactions, neurosis, especially neurasthenia, reactive depression and for psychopathic personality development.

Asthenic neurotic type. Since childhood signs of neuropathy, poor sleep and appetite, moodiness, fearfulness, tearfulness, sometimes night terrors, nocturnal enuresis, stuttering, etc are often. In other cases, childhood goes well, the first signs of asthenic neurotic accentuation occur only in adolescence.

The main features are fatigue, irritability, suspiciousness and moodiness. Fatigue is especially manifested in the classroom or in the mental, physical and

emotional stress, for example, in an atmosphere of competition. Irritability leads to sudden mood outbreaks that occur frequently with little regard. Irritation is often poured on those who accidentally hit «arm», easily changing remorse and tears. These teenagers listen carefully to the smallest bodily sensations, are readily treated, conclude in bed, are subjected to medical examination.

Teenage behavior problems in abuse of alcohol is not peculiar to this type. They are drawn to their peers, looking for company, but quickly are tired of it and prefer the solitude or communication with a close friend. Self - esteem primarily reflects concern for health.

This type of accentuation is ground for the development of neurasthenia, acute affective reactions, reactive depression, developments of. Breakdowns often occur when a teenager is aware of unrealistic hopes and desires. Severe illnesses in relatives and friends increase hypochondria.

Sensitive type. From childhood they are little shy and timid. They often astonish darkness, shun animals, are afraid to stay alone, to be closed at home. They shun brisk and noisy peers. Thy do not like mobile games and mischief. They are timid and shy among strangers and in a strange environment. They are averse to easy communication with strangers. All this may leave a false impression of isolation and being fenced off from the outside. In fact, these children are quite friendly with those who are accustomed to. Often they like to play with kids, feeling with them more confident and calmer. They are tied to the family and friends, even at cold and severe handling with them. They differ with obedience. They have a reputation of «home children». School frightens them with noise, fuss and fights over breakes. They learn diligently. They astonished every kind of control, audits, examinations. They are often embarrassed to respond in front of blackboard. Getting used to the new class and even suffering from harassment by some classmates they are reluctant to move to another one.

The beginning of puberty usually passes without much difficulty. Difficulties begin in late adolescence, after the entry into independent life. Then two main features of this type serve: the excessive vulnerability and feelings of inferiority.

They see many shortcomings in themselves, especially in the ethical and volitional qualities. Children's attachment to their relatives remains. They obey to ward of relatives willingly. Reproaches and punishment from them cause tears and despair. A sense of duty, responsibility, excessive moral demands on themselves and others formed early.

Reaction of hypercompensation is expressed. They search for approval of themselves not where they can open up their capacity, but namely in the area where they feel their weakness. They are timid and shy, they put on the mask of fun, solvability, even arrogance, but in an unexpected situation they quickly pass. At trustful contact behind the mask of «no difference» life opens with a lot of self-flagellations, subtle sensitivity and excessively high requirements for themselves. Unexpected compassion can change bravado to stormy tears.

They are not fenced from peers, tend to them, but are picky in choosing friends. A close friend is higher value then noisy company. Interests of sensitive adolescents are of two kinds. Some are intellectual and aesthetic character (art, music, painting, pets, flowers, songbirds, etc.), and the process of these studies itself delivers satisfaction; they does not seek a particularly good results, estimate even their real success as very modest. Another type of hobbies is due to reaction of hypercompensation. Achieved result and recognition from others are important there. Boys try to overcome the «weakness» with occupations of power sports (wrestling, athletic gymnastics, etc.), and the timidity and shyness they are trying to overcome, being allocated to public office, where they usually carefully carry out a formal part of the assigned functions, leaving the actual leadership to others.

Due to hypercompensation declaration in love can be so decisive and unexpected, that is frightening and repulsive. Discarded love approves thoughts about their inferiority. Suicidal intentions may be there.

Sensitive young men usually do not smoke. In alcoholic intoxication instead of euphoria it is often possible to observe depressive feelings.

Self - esteem has a high level of objectivity. They do not like and are not able to lie and. To refuse to respond is better than to lie.

Blow to the «weak link» is the situation where a teenager becomes the object of hostile attention of others, ridicule or suspicion of dishonest deeds, when a shadow falls on the reputation or when he/she is exposed to unfair prosecution.

Sensitive accentuation is ground for acute affective reactions intrapunitive type, phobic neurosis, reactive depression, endoreactive psychosis. Obviously, sensitive accentuation is combined with higher risk of disease of progressive schizophrenia.

Psychasthenic type. In childhood, along with some timidity and fearfulness, motor inconvenience turns early, tendency to prudence and not age «intelligent» interests. Sometimes in childhood phobias begin, that fear of strangers and new items, darkness, fear of being behind a locked door.

The critical period when psychasthenic features begin to unfold in its entirety, the first classes of school usually are, when carefree childhood is changing by requirements of the first sense of responsibility. The need to be responsible for themselves and especially for the other represents one of the most sensual strokes for psychasthenic nature.

Usually, in puberty sudden exacerbations of psychasthenia do not happen. Decompensation may occur at the time of filing requirements for the high sense of responsibility (e.g. during exams).

The main features of psychasthenic type are indecision, susceptibility to all kinds of reasons, anxious mistrust in the form of fears for the future - their own and their loved ones, love of introspection, soul-searching and ease of obsessive fears, misgivings, rituals, representations, thoughts. Misgivings are addressed to the possible, even to unlike in the future, if it would not happen anything terrible and irreparable with them or the close to which they exhibit an extremely strong commitment. Troubles that have already happened, scare them much less. Boys are particularly anxious for the mother, as if she would not be sick and not die, not get under transport, etc. If the mother is late and she stayed somewhere without warning, a teenager does not find a place to him/herself.

Invented omens and rituals become the protection from the constant anxiety for the future. For example, leaving home it is need to cross the threshold only with left

foot, to wear the same «lucky» shirt on the control examinations and etc. Another protection is a specially developed pedantry and formalism, supported the idea that if all is predicted and there is no evasion from the plan, nothing bad will happen.

Indecision is in particularly long and painful oscillations when need to make an independent choice. However, taken decision should be made immediately. Striking impatience suddenly appears. Reaction of hypercompensation against their indecision and uncertainty have to be seen in psychasthenic teens. It appears with unexpected arrogant and peremptory expression, exaggerated determination and premature actions in moments when prudence and caution are necessary. Failures that occur at this reinforce the indecision and doubt.

Physical development leaves much to be desired. All manual skills and sports are given bad. Exceptions are only those kinds of sport when doing of that load falls on the legs (running, jumping, skiing, cycling). In these forms sometimes better results are achieved.

Teenage reaction of emancipation is expressed weakly and often substituted of pathological attachment to someone from relatives. Thrust to peers is in cowardly ways. Interests are usually limited to the intellectual and aesthetic interests. Sexual development is often ahead of the general physical. Teenage behavioral problems (delinquency, escape from the house, alcoholism) are not peculiar for psychasthenic.

Self - esteem, despite the tendency to introspection, does not always differ with accuracy and completeness. Tendency to find the features of various types, including not inherent, for example, hysterical, often stands.

Psychasthenic accentuation is beneficial ground for the development of obsessive neurosis. Education in «high moral responsibility» when oversee the kids or supervision of helpless family members are moved by adults on children's shoulders, dramatically enhances the psychasthenic features. «Increased responsibility» can be associated with too great hope of the fathers upon the outstanding success of children and adolescents in school, music lessons, etc. Teenager that is tended to psychasthenia sensitively captures these high parental expectations and is afraid of not to justify them, in order not to lose the whole

fullness of parental love. Education as dominant hyperprotective type, that is combined with constant and excessive calls to a sense of responsibility, foresight, intimidation of possible problems and troubles can also lead to psychopathic development of psychasthenic type.

Schizoid type. Since the early years, these children like to play alone. They had little drawn to peers, avoid the bustle and noisy amusements, prefer adult society, staying silent longly and listening to their conversations with each other. To this unchildish restraint and even coldness can be added.

In adolescence all the features of schizoid type are extremely acute. First fall into the eye is their closure and estrangement. Sometimes spiritual loneliness weighs little for teen, that lives their own, unusual for other interests and hobbies. More frequently, the inability to establish contacts experienced difficult. Unsuccessful attempts to find friend for the soul, mimosa-like sensitivity in moments of such searches, fast exhaustion in contact («I do not know what else to say») encourage the further withdrawal.

Insularity is combined with a lack of intuition - inability to guess about the unsaid by others aloud, guess their desires, feel emotions of other people, hostile attitude toward themselves or, conversely, sympathy and predisposition, to capture the moment when one should not impose own presence. To lack of intuition, lack of empathy is adjacent - the inability to respond to the joy or sadness of another person, understand the insult, respond to another's anxiety and excitement. Weakness of intuition and empathy creates the impression of coldness and callousness. Some actions may seem cruel, but they are linked to the inability to feel the suffering of others, not from desire for sadistic pleasure.

The inner world is almost always closed to outsiders and often is filled with fantasies and hobbies. Schizoid teenagers suddenly may be disclosed and usually before unfamiliar individual and even random, but something emposed to their capricious choice. At the same time their inner feelings can remain forever hidden from friends or from those they know for many years.

Inaccessibility of inner peace and restraint in the expression of feelings do unexpected and incomprehensible to others many acts, so that the whole course of previous experiences and motives remain hidden. Oddities are unexpected but are not aimed to attract attention.

Teenage reaction of emancipation usually is very peculiar. Schizoid adolescent can tolerate petty care at home and submit to the established schedule and regimen, but is ready to respond with violent protests to the least attempt to invade without permission in world of his/her interests, passions and fantasies. However, the reaction of emancipation can easily rotate to social nonconformity - indignation about the existing rules and regulations, mockery of common ideals, interests and spiritual values. Such judgments can be hatched secretly long and unexpectedly for all be realized in decisive actions or public statements. Straightforward criticism of others in such cases accomplishes without considering the consequences for himself/herself.

Grouping reaction with peers is weak outside. Insularity complicates contacts, and intractability to general impact is not fully allowed to merge with the group. Sometimes schizoid adolescents are exposed to ridicule and persecution by peers, sometimes, due to cold restraint and unexpected ability to stand up for themselves, earn respect and make follow distance. But success among peers may be only the subject of secret schizoid adolescent fantasies.

Interests often differ uniqueness, strength and constancy. Most are intellectual and aesthetic interests. Interests often conceal from others, being afraid of misunderstanding and mock. They divide them if interest is welcome, but never flaunt. In sports, they prefer private lessons, but not collective games. Among hobbies many hours of walking can take place. Thin manual skills, playing musical instruments, handmade products are given to some schizoids well.

Alcoholism is rare. Intoxication is not usually accompanied by euphoria. Understanding and drinking atmosphere of companies they easily resist. However, some small dose of spirits can facilitate the establishment of contacts and eliminate unnatural feeling during communication. While alcohol may regularly be used as a

kind of «communicative doping». It may be unusual psychological dependence that is different from known psychic dependence in alcoholics. In these cases, intake of alcohol stimulant by teenager becomes necessary ritual before forced active conversation. For the same reason start of taking drugs can easily happen. Danger of toxicomanic behavior in schizoid is greater than alcohol abuse.

Delinquent behavior occurs infrequently. Group offenses are not peculiar. However, offenses may happen «in the name of the group» so that group «has recognized their». Single sexual offenses occurre.

Self-esteem of schizoid differs with selectivity. They are well aware of their isolation, difficulties of contacts, lack of understanding of others. They do not notice the contradictions in their behavior or they are not given the importance to them. They like to emphasize their independence and autonomy.

Usually attributed to schizoid somatic symptoms (thinness, flabby muscles, sutuluvatist) during acceleration may be distorted by endocrine changes, causing, for example, excessive fullness.

Blow to the «weak link» of schizoid accentuation is the situation in which it is necessary to engage quickly and easily in informal contacts (formal contacts, in contrast to the sensitive adolescents, at schizoid accentuation come relatively easy). Rough violent intrusion into an intimate world of fantasy and hobbies is also unbearable. Other psychological traumas are tolerated sometimes with surprising firmness. Overall schizoid accentuation after finishing adolescence certainly does not prevent good social adaptation.

Schizoid accentuation is combined with increased risk of schizophrenia with slow course. This type of accentuation in adolescence also leads to transient metaphysical intoxication.

Epileptoid type. Only in some cases features of this type clearly show through in childhood. Such child may cry and it is impossible to soothe or distract nor rein. Along with this, sadistic inclinations may occur, children love to torment animals, irritate the younger, mock the helpless. There is also an unchildish providence

regarding clothing, toys. The school appears petty neatness in the conduct of notebooks, all pupils menage.

In most cases features of this type become evident only in adolescence. The main of them is a tendency to periods of angry-sad mood with irritation that seething and search for object, which the evil can be disrupted on. Such condition lasts for hours, rarely days, starting gradually and slowly weakened. They are closely linked with affective explosiveness. Flashes of violation only seem to be sudden. Affect is seething long and gradual. The reason for the explosion may be small, can play the role of the last drop. Affects are not only strong, but long, long time calm is coming. Unbridled rage, swearing cynical, brutal beatings, indifference to the helplessness of object of attack and failure to take into account its precedence can be marked in the heat of passion. Rarely this rage turns to autoagression with causing a serious injury to themselves.

Instinctive life is distinguished by high voltage. Strong sexual attraction, predisposition to sexual excesses can be combined with sadistic and masochistic inclinations. Love is almost always colored by jealousy.

Alcohol intoxication often runs hard, with fury and fights. In a drunken state of actions which then do not remain memories can be taken. However, tendency to get drunk «disable» is often. Rudeness affects around; preference is to spirits, strong cigarettes. In intoxication as aggressive as autoagressive affective reactions arise easily.

Reaction of emancipation often runs hard. From relatives they require not only a «freedom» and independence, but also «rights», share of property, wealth. Before superiors they are prone to servility if waiting for any advantage. Reaction of grouping with their peers is combined with the desire to rule. In group they want to establish orders, that are beneficial to them. They can adapt well in conditions of strict disciplinary regimen where they are able to flatter to superiors, get a certain power over other teenagers and skillfully use it to their benefit. Power in the hands of epileptoid teenager can be a blow to his/her «weak link». Intoxicated with power, he/she loses control of themselves, so oppresses and suppresses the fallen under

his/her control ones that general revolt is maturing against him/her, that is depriving his/her former benefits and malajust long.

Among hobbies propensity for gambling should be marked. The passion for enrichment wakes very easily. Collecting involves primarily the value of the collected material. In sports that seems attractive, allowing to develop physical strength. In the field of hobbies different items may occur that are required particular diligence of implementation and can bring the financial benefit. They are willingly dealing with music and singing alone, giving with this special sensual pleasure.

Common features are also stickiness, gigidity, inertia, that lay mark on everything - on notor skills and emotion to thinking and personal values. Petty meticulousness, curious compliance with all the rules, even to the detriment of case, annoying pedantry - all this is considered by some authors as a way to compensate own inertia. Great attention to their health, careful adherence to their own interests are combined with rancour, unwillingness to forgive the insults, anger at the slightest restriction of interests.

M.S. Pevzner (1941) drew attention to the special version of epileptoidity in adolescents that differed, in her opinion, «hypersociality» - love to work, accuracy, underlined «correctness» in behavior. V.V. Kovalev (1973) these qualities of character regarded as compensative. This «hypersociality» remains lopsided: teens are able to carry «double life»: they exemplary behave in one situation and identify extreme egoism, virulence, tendency to aggression, moral and physical violence in another.

Appearance of epileptoid teenager, that described by G.E. Suhareva (1959) - dignified strong figure, massive torso with short extremities, round head that is pressed in shoulders, big jaw - are common, but certainly not always.

Self-assessment is one-sided. Tendency to gloomy mood, prudence, commitment to accuracy and order, dislike of empty dreams and the preference to live in real life, concerns about health, even tendency to jealousy are marked. In other aspects they represent themselves much more conformal than they actually are.

Hidden epileptoid accentuation appears or in the situation that has an impact on the «weak link», such as conflicts of interest with the restrictions, at possiblity, to identify despotic power, or under the influence of alcohol, which, as indicated, flows very difficult.

Epileptoid accentuation is ground for acute affective reactions, situational behavioral disorders of delinquent or even criminal type, early alcohol abuse, and also psychopathic development. Particularly detrimental is education in conditions of oppressive relationships. Hypoguardianship may contribute to instability, hyperguardianship — hysteroidity.

Hysteroid type. The main feature is the self - absorption, insatiable thirst for constant attention of surrounding people to his/her person, need to cause admiration, surprise, respect, compassion. At worst preference is to even indignation and hate against themselves, but not the prospect of leaving unnoticed. All other qualities are defined by this feature. Often suggestibility that is attributed to hysteriods differs with selectivity: nothing remains from it if the situation is not grist to the mill of egocentrism. Fantasizing is entirely directed to embellish of own personality to draw attention more. Seeming emotionality actually rotates the lack of deep sincere feelings at high expressivity, theatricality of experiences, tendency to posturing.

All these features are often outlined since childhood. This child can not stand, when other children are praised in front of him/her, attention is paid to others. Toys quickly become boring and often serve only as boasting subject to other kids. Attracting views to themselves becomes the urgent need, listening to delight and praise. To do this, children with hysteroid features willingly recite poetry, dance, sing. Progress in education is largely determined by whether they are put as an example to others.

In adolescence, with the same purpose to attract attention, first of all of comrades behavioral disorders can be used. Delinquency is reduced to absenteeism, reluctance to work and learn, because «gray life» is not satisfied them, and to take in training and labor the prestigious position, which would be stilled their pride, they do not have neither skills nor, most importantly, perseverance. But idleness and

laziness are combined with very high, in fact, latent claims in regards of future profession. They are inclined to defiant behavior in public places. More serious violations of behavior they usually escape.

Flee from home can start from childhood. Having run off, children or teenagers try to be there where they will be looked for or attract the attention of police (such demonstration flee usually the result of the reaction of the opposition). They are tend to exaggerate their alcohol abuse: to boast a huge number of drunk or shine with exquisite selection of alcoholic beverages. Sometimes these teenagers are willing to portray of themselves the addicts. Having heard about drugs, having tried one time - any other substitute that is available, they love to paint their drug excesses, unusual state due to administration of extravagant drugs, such as heroin or LSD. Detailed questioning reveals that flimsy information is quickly depleted.

If nothing fails to attract attention, the course can indulge imaginary disease, lie and fantasies. Latest ones are always intended for others. While dreaming up, they easily get used to the role, mislead of gullible people.

Hysteroid accentuation is often combined with mental infantilism (psychophysical or psychical on the background of physical acceleration). Due to infantilism in teenage period child's reaction of opposition on the loss or reduction of attention from loved ones, the loss of the role of the family idol is stored. Manifestations of this reaction may be the same as in the childhood - advantage by illness, attempts to get rid of that who shifted the attention (for example, to force the mother to disperse with a stepfather that appeared). But more often opposition reaction appears with teenage behavioral problems: alcoholism, familiarity with drugs, truancy, theft, antisocial peer company — it all is done only to signal to close people with a help of actions language: «Turn me former care and attention, otherwise I will go astray».

The reaction of emancipation can get violent external manifestations - loud demands, conflicts, etc. In fact, they are not looking for true freedom and independence, are not eager to get rid of attention and care from relatives.

Reaction of grouping with peers is connected with claims to leadership or the extreme state in the group. Lacking sufficient sthenicity and readiness to subordinate the others to themselves, such teenagers try to achieve a leading position in other ways. Having a good intuitive felling of mood in the group, still simmering desires, aspirations, events in it, hysteroid teenagers become their first spokesmen, pioneers. On impulse, encouraged with facing views, they can lead the others, even to reveal the courage. But always they are leaders for an hour because they give in unexpected difficulties, give friends easily, immediately lose all enthusiasm when deprived of admiring glances. They also try to rise among peers, «blowing dust in their eyes» with fabrications about their former «luck» and «adventures». Comrades soon recognize the inner emptiness behind external effects. Therefore, hysteroid teenagers do not tend to stay long in the same peer group and are willing to rush into a new, asserting that «disappointed in former friend».

Interests are entirely due to egocentrism. To this amateur can be selected (especially those of species that are popular among peers). But for the same goal yoga, gymnastics, fashionable philosophical currents and unusual collections can serve, unless it requires too hard work and allows to show off to others.

Sexual desire does not differ with neither power, nor strength. There is a lot of theatrical play in the sexual behavior. Young men often hide their sexual experiences, avoiding the discussions on these themes, feeling that in this area among comrades they can easily not be on the «height», Girls, in contrast, tend to advertise their real and invent non-existent connections, are capable on self-incrimination and slander, can play the role of harlots and whores while enjoying stunning impression on the interlocutor.

Self-esteem is far from objectivity. Usually they represent themselves as possible to attract attention in the current moment.

Impacts on egocentrism are the most sensitive to hysteroid nature. Failure to occupy a prominent position among peers, exposing the fiction of decorating with prospect to by mocked, frustration at a high level of harassment, loss of attention from the important persons — all this can lead to acute affective reactions of

demonstrative type, including suicidal demonstrations and hysterical neurosis, and demonstrative behavior disorders. The combination of hysteroid accentuation with hyperprotection, with family care in a style of «idol family» easily leads to psychopathic development.

Unbalanced type. Since childhood these persons differ with disobedience, they are restless, climb to everywhere and everything, but they are fearful, are afraid of penalties, easily obey other children. The elementary rules of behavior are digested with difficulty. They have to be under control all the time. Some of them have symptoms of neuropathy (nocturnal enuresis, stuttering and others).

From the first classes of school they do not get the desire to learn. They reluctantly obey to strict control, but always are looking for the case not to attend classes. Full absence of will appears when deal is concered with any work or duty, achievement the goals that the older put in front of them.

An increased craving for pleasure, entertainment, idleness early reveals. They escape from lessons to the movies or just to walk down the street. Instigated by more stheniac friends they can for the sake of company escape from the house. They willingly obey and follow those whose handling promises the pleasure, fun and easy changing of impressions. They are ready to spend all days in street companies. Being children they start smoking. It is easy to go to petty theft.

When they become teenagers, former entertainment, like movies, do not attract longer. They are searching for sharper and stronger impressions (rowdy behavior, alcohol and drug consumption). Behavioral disorders, delinquency are primarily due to desire to have fun. Drinking starts early (sometimes 12-14 years) and always in the company of antisocial friends. Search for unusual experiences easily pushes on offense.

Reaction of emancipation is closely connected with the same desire of pleasure and entertainment. They never feed deep love for the close. To family concerns they are treated with indifference. Relatives to them — are the main source of money for entertainment. Reaction of grouping is marked in an early attraction to street asocial companies. Unable to take themselves they tolerate loneliness very poorly and in

these companies they are primarily looking for a place for entertainment. Cowardice and lack of initiative bring to that these unstable teenagers easily become an instrument of such groups. In group offenses they have to «pull the chestnuts» out of the fire, and more stheniac group members reap the fruits.

All captures that require some work for them are incomprehensible. Only informative-communicative type of hobby and gambling manifest as affordable. Hence there is many-hours-long empty chatter with occasional friends, detective adventurous interests — all these are powered with thirst impressions, new easy information that does not requires any intellectual processing. They prefer slight acquaintance. Merry company is always more important than devoted friend. Obtained information is easily forgotten, they do not delve into its content, do not make any conclusions. They feel disgusted to sports. Only car and motorcycle are seemed attractive as a source of almost hedonic pleasure with reckless speed with wheel in their hands. But persistent classes here also are pushed. Theft of motor vehicles and motorcycles in order to ride is preferred. Amateur does not attract, even fashionable ensembles become boring soon.

Sexual desire does not differ with power but staying in street groups leads to early sexual experience, including familiarity with perversion. Sexual life becomes the same source of entertainment as drinking and rowdy adventures. Romantic love passes throught unstable adolescents, feeling of falling in love for them remains unfamiliar.

Studying is easily thrown. Any job does not attract. They work only because of extreme necessity. Indifference to their future impress - they do not plan, do not dream of any profession or position for themselves. They live only in the present, wanting to extract maximum pleasure from it. From difficulties, troubles and tests they are trying to escape. The first escapes from home and boarding schools are linked with the threat of punishment. Repeated escapes are often due to craving to «free life».

Weakness and cowardice allow to keep «unstable» in conditions of strict and tightly regulated regimen. When idleness threatens with punishment, they

reluctantly obey and work. Self-esteem is usually not objective: they ascribe hyperthimic or conformal traits to themselves. The main «weak link» of unstable accentuation - is to remain without close supervision, to be left to oneself.

Hidden accentuation of unstable type appears when a teenager, who is being under strict care to a certain moment, by force of circumstances is suddenly deprived of direct control. He/she immediately falls in asocial enterprise and begins to drink alcohol and makes the offense.

At upbringing for type of hypoprotection psychopathy develops from unstable accentuation.

Conformal type. The main feature is constant and excessive conformity to their proximate familiar environment. Vital rule is to think «like everyone else», to do «as all» so that everything would «like everyone else» - from clothes and manner to behave, to the outlook and opinions on burning issues. Thus the term «all» means the usual environment. They try anything to keep up with it but do not like to stand out, nip on ahead. This is especially manifested in relation to fashion and clothing. When any new fashion appears, there are no more detractors of it, then the representatives of conformal type are. But as soon as their environment masters a new fashion, they dress in these clothes, «having forgot»what was said earlier.

In life, they like to be guided by maxims and in severe cases they seek solace and justification in them («lost not return», etc.). In an effort to always meet the environment, he/she can not resist to it. So they are entirely the product of their microenvironment. In the beautiful surroundings they are quite good people, diligent workers. But, caught in a bad environment, then they learn all its customs, manners and rules of behavior, as if all this would not be contrary to the former mode of life and as if it would not be detrimental. Although adaptation to the new environment is slow and difficult at first, but when it has been realized, new environment becomes the same dictator handling, which it had been formerly. Therefore conformal adolescents «for the company» easily become an inveterate drunkard, they may be embroiled in a group offense.

Conformity is combined with a striking lack of critical. All that familiar surroundings say, all that usual channels of information bring — this is the truth. And even though these channels begin to come information that clearly contradict to reality, they are still perceived as good coin.

Conservatism goes hand in hand with conformity. They dislike the new, because they can not adapt to it quickly. It is hard to adapt to new environment for them. However, in new conditions, they openly will not admit in it, because in the vast majority of microcollectives the feeling of new is highly appreciated, and innovators are encouraged etc. But a positive attitude to the new remains only in words. In fact, the preference is to stable environment, once and for all established order. Dislike of the new breaks out in form of unreasoning hostility to strangers. It concerns the beginner, that appeared in «their» group, and especially the representative of another surrounding, another manner to keep themselves and even other nationalities.

Custodianship by adults in childhood does not give excessive loads for conformal type and and passes without violations. Therefore, only in adolescence conformal features begin to appear. Studying with its clear regulation and stable regimen does not represent excessive hardship.

Conformal teenagers are very cherished the place in common peer group, stability of this group, constancy of environment. Often decisive in choosing a career or choosing the place where to continue their studies, is the fact that a particular institution most of their comrades enter. If the common youth group ignores the conformal teenager, it is perceived as one of the most difficult psychic trauma. Emancipation reaction is evident only when parents or educators tear teenager from usual surrounding of peers, when they oppose his/her desire to be «like everyone else», adopt to teen fashion, that is spread, hobbies, manners and intentions. Interests of conformal teenager are entirely determined by environment and the dictate of time.

The weak point in the conformal character is intolerance of abrupt changes. Breaking of life stereotype, depriving usual society can cause reactive states. Strong

preference to acute affective reactions is not found. Negative influence of the surrounding often pushes to alcohol abuse.

Psychopathy of conformal type does not happen. Hypoprotection, neglect, antisocial surrounding can lead to psychopathic development on unstable type. Education in conditions of harsh relationships leads to epileptoidisation. Self-esteem of conformal teens can be adequate. Most of them are quite correctly notes the main features of their character.

Conformal-hyperthimic type is a variant of conformal type. Apart expressed conformity increased vital self-esteem is inherent. These young people are slightly euphoric, they emphasize their health, vitality, good appetite and sleep. They are characterized by overly optimistic assessment of their future, belief in the fulfillment of desires. But in this their similarity with hyperthimic type is limited. They do not show any activity, any vividness, any initiative or leader's abilities. In all other cases conformity reigns - such teenagers are malleable to discipline and regulated regimen, especially if surrounding people adhere to this.

Mixed types. These types are nearly one half of cases of explicit accentuations. Their features can be easy presented on the basis of previous descriptions. The occurring combinations are not random. They obey the certain laws. The features of some types are combined with each other quite often, while others almost never. There are two kinds of combinations.

Intermediate types are caused by endogenous laws, primarily by genetic factors and possibly by special needs in early childhood. They include already described cycloid labile and conformal-hyperthimic types and also combination of labile type with asthenic-neurotic and sensitive, asthenic-neurotic with sensitive and psychasthenic. Such intermediate types as schizoid-sensitive, schizoid-psychasthenic, schizoid-epileptoid, schizoid-hysteroid, hysteroid-epileptoid can be attributed here. Due to endogenous patterns transformation of hyperthmic type into cycloid one is possible.

Amalgamate types - are also mixed types, but of another kind. They are formed as a consequence of layering of features of one type to the endogenous nucleus of

another one because of wrong education or other chronic acting psychogenic factors. There also not all ones are possible, but only some layerings of one type on another. It should be noted that hyperthimic-hysteroid types are accession of unstable or hysteroid traits to hyperthimic base. Labile-hysteroid type is usually the result of layering of hysteroidity on emotional lability, and schizoid-unbalanced and epileptoid-unbalanced- of unbalance on schizoid or epileptoid basis. The last combination differ with increaced criminogenic danger. At hysteroid-unbalanced type instability is only a form of expression hysteroid traits. Conformal-unbalanced type arises as a consequence of education of conformal teenager in antisocial environment. The development of epileptoid traits on the basis of conformity is possible when the teenager grows up in a brutal relationship. Other connections almost never occur.

Intellect, abilities, nature of abilities

Intellect is an inherent to every person level of ability to use the operations of thinking (Leont'ev O.M., 1981; Claub G., 1976). The person who has intellect - is the one who «judges correctly, understands and thinks» and who can well cope with life's circumstances due to these abilities, i.e. to *adapt* to the environment and the circumstances of life (A. Binje, T. Simon, 1905 and D. Veksler, 1939).

In recent years the popularity has been gained by theory where while considering the issues of intellectual development of human being *two different types of intellect* are considered. Moreover, it is believed that these two types of intellect can be relatively easily measured by conventional intelligence tests.

The first type of intellect, that combines a fairly wide area of intellectual functioning, is called *the current intellect*. These are the abilities with a help of which a person learns something new. These include the speed and efficiency of storing, inductive judgments, handling with spatial imageries and perception of new connections and relationships.

Most authors, who are considering the issue of intellect in the framework of this theory, believe that the gradual development of current intellect continues until

the end of the period of youthful life, and then it is a gradual decline. This type of intellect, according to scientists, reflects the biological capacity of the nervous system - its working capacity and integrativity.

The second type of intellect is crystallized intellect that comes to a person with experience and education. Acquiring this form of intellect is associated with person's awareness and the knowledge he/she has acquired over a long lifetime. This ability of person to establish relationships, formulate opinions, analyze problems and use learned strategies for solving problems.

Unlike the previous type of intellect, crystallized one often increases during life as people retain the ability to receive and store information. When tests of cognitive skills are being conducted, involving the use of this type of intellect, the subjects often show in their 50 years old higher results than those that were in 20 years old.

Two types of intellect, that we are considering, get different character of development dynamics. Current intellect reaches its maximum in adolescence and in period of middle adulthood its indicators are reduced. Another feature is typical for crystallized intellect. Its maximum development becomes possible only upon reaching of period of middle adulthood. This pattern of dynamics of development of current and crystallized intellect has been confirmed by a great number of different studies.

However, the development and preservation of intellectual ability goes in different people differently.

Thus, S. Pako believes that optimum of all human intellectual functions achieved in adolescence - early youth, and the intensity of their involution depends on *internal and external factors*.

The internal factor is talent. In more talented people intellectual progress is long and involution occurs later than in less gifted.

The external factor that depends on socio - economic and cultural conditions, is *education,* which according to S. Pako, resists aging, slows involutive process.

Therefore, features of intellectual development and indicators of intellectual capacity of person depend on his/her personal characteristics, life attitudes, plans and life values.

According to some psychologists, solving of some problems require concrete, and others - abstract intellect.

Concrete or practical intellect helps us to solve everyday problems and orientate in our relations with different objects. In this regard, Jensen refers to the first level of intellect and so - called *associative abilities* that allow to use certain skills or knowledge and all information stored in memory. As for *abstract* intellect, then with its help we are dealing with words and concepts and Jensen relates it to the second level of intellect — level of *cognitive abilities*.

According to Jensen, the ratio between these two levels in each person is determined by hereditary factors.

People differ from each other not only with congenital individual traits, but also difference in development that associated with the passage of life. Human behavior depends on which family he/she grew up, which school they learned in, who they were in profession, which circle they rotate in. Two people with initially similar natures may subsequently have very little in common with each other, on the other hand, the similarity of life circumstances may develop similar traits, reactions in persons that are fundamentally different.

People differ from each other irrespective of which way this difference arises. Just like in appearance one person is different from another, so psyche of every person is different from other people.

However, there are not so many individual traits as it seems. Traits that define individuality can be attributed to the different psychic spheres:

1) sphere of directivity of interests and aptitudes,

2) feelings and will,

3) associative and intellectual sphere.

To understand the nature of human beings, it is needed to look closely at different inherent to them features of mentioned spheres.

It is not always easy to draw a clear line between traits that shape accentuated personality and characteristics that determine the variations of human individuality.

Abilities are a set of psychic characteristics of person, allowing him/her to successfully acquire and engage in one or more activities and continuously improve them. Abilities are marked, operate and develop only in activity.

Researches of scientists, that are based on modern methodology, reveal a complex structure of abilities. Firstly — social side of abilities is revealed in the character of social relations, established type of activity and chosen specialty, are mental peculiarities of cognitive, emotional and volitional processes, display of living conditions and services, etc. Secondly — psychological side of abilities that properties and qualities, the presence of mental formations, etc. Thirdly — physiological side of abilities is the anatomical and physiological characteristics of the organism and human nervous system. These are inclinations that are innate characteristics.

Classification of abilities

All human abilities can be classified based on their internal structure.

The first group has a biological basis of abilities, which are different:

elementary abilities are connected with peculiarities of primary cognitive processes (sensation, perception, attention, memory);

sophisticated abilities are associated with features of such forms of mental reflection as thinking, imagination.

For example, the ability to think critically, analyze the situation quickly and make the best decision is related to physiological characteristics of the human body.

The second group is based on a social basis and is divided into *general* abilities, which in one or another degree all people endowed with. These are capacites to common to all mankind types of activity, communication with each other. This is a combination of many favorable characteristics and personality traits, manifested in the activity; *special (professional) ones*, that make it possible to achieve high results in a particular activity, chosen profession; partial ones - are the abilities in nonbasic

for him/her field of activity. The connecting link between the abilities of first and second groups is a special kind of abilities — *creativity*. Creativity - activity, generating something new that has never existed before. It is not orientated on adaptation to formed by concretely social, logical, psychological stereotypes, etc., but on their transformation that is often associated even with risk. The creative abilities of person are marked in any activity - scientific, artistic, industrial, public, military.

Levels of abilities. Based on the definition it is shown that the abilities allow people to engage in one or more activities. Depending on the complexity, diversity and importance of activity three levels of abilities are distinguished.

Giftedness is enabling communication of abilities of both groups that allows people to engage multiple activities successfully. For example, academician L.D. Landau finished school in 13 years old, in 14 - year - old university student days he was involved in two facultes: physico-mathematical and chemistry. In 18 years, Landau became a nontenured postgraduate of famous Leningrad physical - technical institute, even though he did not get a university diploma.

Talent is a set of abilities that allow to obtain a product of activity that differs with originality and novelty, high performance and social significance.

Genius is the highest degree of giftedness that allows the person to achieve socially significant results with revolutionary significance.

The internal picture of disease

The internal picture of disease (IPD) as a «product» of its own inner creative activity of subject is being formed in its more or less detailed forms at any somatic suffering- starting from a single episode of pain, discomfort to serious somatic manifestations of disease (for severe chronic diseases). The study of the nature of this process is the most important condition for the successful study of personality and its changes.

The study of IPD allows to consider largely the complicated process of self knowledge of sick person, identify the tools that people use to implement this

cognitive process. At the same time IPD opens the possibility of understanding the specific methods, techniques of overcoming, mastering his/her own behavior that are used by persons in a difficult life situation. Thus, analysis of internal picture of disease opens up the possibility of penetration to the individual compensatory potential.

Illness as a pathological process in the body in two ways is involved in the construction of internal picture of disease:

1. local and general bodily sensations give rise to sensory level of mapping of picture of disease. The degree of involvement of biological factor in the development of internal picture of the disease is determined by the weight of clinical manifestations, asthenia and pain;

2. illness creates a difficult psychological situation for the patient. This situation includes many diverse aspects: procedures and medication intake, communication with doctors, alteration of relationship with close relatives and colleagues.

These and some other points make impact on own assessment of disease and form final attitude to disease.

In scientific literature for description of subjective side of disease a large number of terms that have been introduced by different authors is used, but they are often used in very similar way. E.K. Krasnushkin reveals the subjective side of disease in the term «disease awareness», R.A. Lurija calls it «internal picture of disease» and E.A. Shevalev – «experience of illness». German internist Gol'dshejder wrote about the «autoplastic picture of disease», highlighting two interacting parties: sensitive (sensory) and intellectual (mental, interpretive).

Deepening of knowledge about mental side of illness in the domestic theory and practice of medicine has led to appearance of a multitude of different conceptual schemes that reveal the structure of the inner world of the sick person.

Levels of internal picture of disease. Types of reactions to disease

In the majority of modern psychological studies of internal picture of disease, at various nosological forms, some interdependent parties (levels) stands out in its structure:

1. Sensory side of diseases (sensual level) - localization of pain and other unpleasant sensations, their intensity, etc.

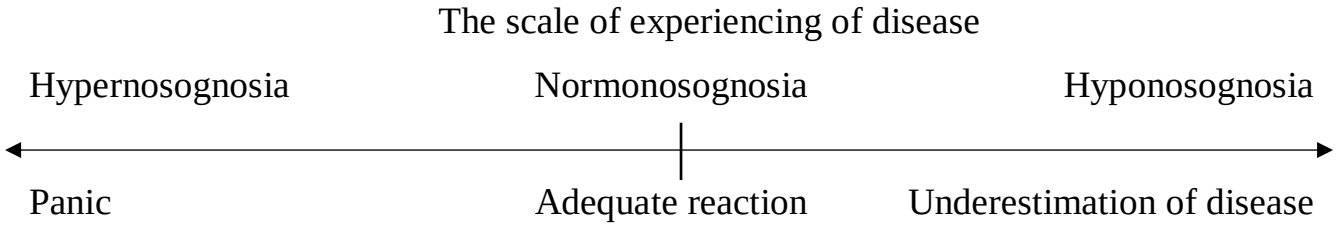
2. Emotional side of illness that is associated with different types of emotional responses to certain aspects, symptoms, disease in general and its consequences.

3. Rational and informative level (intellectual side of illness) is connected with the representation and knowledge of the patient about his/her illness, considerations about its causes and consequences.

4. Volitional side of illness (motivational level) is associated with a specific patient's attitude to his/her disease, the need to change behavior and habitual way of life, actualization of activity to restoration and preservation of health.

Based on these aspects a model of the disease is created by patient, that is understanding of its etiopathogenesis, clinical features, treatment and prognosis, determining «the scale of emotions», his/her behavior in general.

The distance between the real state of affairs, health and «disease model «may be as exaggerated as diminished, until the complete denial of it.



At adequate type of reaction (*normonosognosia*) patients properly assess their condition and prospects, their assessment coincides with the assessment of physician.

At *hypernosognosia* patients tend to overestimate the significance of separate symptoms and disease in general.

At *hyponosognosia* they tend to underestimate the gravity and seriousness of the disease, that is in contradiction with objective data.

Anosognosia — patients deny the existence of the disease or with a goal of dissimulation or under the influence of fear of possible consequences of the disease, refuse to take medications, do not adhere to the regimen.

There are three major patient's response to the disease: *sthenic, asthenic* and *rational*.

1. At active position of the patient to treatment and examination it is said about sthenic response to the disease. There is, however, a negative side of this behavior: the patient may be poorly able to perform the necessary restrictions of stereotype of life due to disease.

2. At asthenic reactions to the disease patient's inclination to pessimism and suspiciousness is observed, but they are relatively easier than patients with sthenic reaction adapt to the disease psychologically.

3. At rational type of reaction realistic assessment of the situation and rational withdrawal from frustration take place.

Some authors (Rejnval'd N.I., 1969, Stepanov A.D., 1975, Lezhepekova L.N., Jakubov P.Ja., 1977) describes the types of attitude to the disease, bearing in mind the character of interaction between doctor and patient.

The next ones have influence on the reaction of personality and support of this reaction:

1. the character of the diagnosis;

2. the change of physical usefulness and appearance;

3. the change of the position in the family and society;

4. vital restrictions, deprivations that are associated with the disease;

5. the need to be treated, surgery.

The structure of the personality to the disease primarily affects the behavior and response of the patient over illness. Many authors believe that the adequacy of the response depends on the maturity of the individual and his/her actual capacity. So infantile, immature personalities with traits of childishness have frequent

suppression and denial of illness or «flight into illness». In asthenic, anxious people very severe disease cause stormy reaction of anxiety, agitation with following depressive - hypochondriac and persistent violations. Reaction to illness depends on the age of the patient. That is, the response of the personality is different, from a complete ignoring of disease to tragic perception, «escaping into illness» and hypochondriacal fixation. Determination of the individual on recovering or disease gets important, if not the main importance for the development and course of various diseases.

The types of personal reaction to the disease (Jakubov B.A., 1982)

Consensual response. This reaction is typical for patients with advanced intellect. They become «assistants» of doctor from the first days of their illness, demonstrating not only obedience, but also rare punctuality, attention, kindness. They infinitely trust their doctor and are grateful to him/her for help.

Calm reaction. This reaction is typical for people with persistent emotional and volitional processes. They are punctual, they adequately respond to all doctor's instructions, exactly perform therapeutic measures. They are not just quiet, but even are seemed as «solid» and «statical», they easily come in contact with the medical staff. They may sometimes not be aware of their illness, that prevents the physician to identify the impact of psyche to disease.

Unconscious reaction. This reaction, with pathological basis, in some cases takes the role of psychological defense, and this form of protection is not always necessary to remove, especially in severe diseases with unfavourable outcome.

Afterimpression. Patients are in the power of prejudice, bias. They are suspicious, incredulous. It is difficult to come into contact with the doctor, they do not attach serious importance to his/her instructions and advice. They often conflict with the medical staff. In spite of the mental health, they sometimes show the so called «double reorientation».

Panic reaction. Patients are in the power of fear, they are easily suggestible, are often inconsistent and treated in different hospitals at the same time, as if

checking one doctor by another one. They are often treated by witch doctors. Their actions are inadequate, false, affective instability is characterized.

Destructive reaction. Patients behave recklessly, ignoring all instructions of the attending physician. Such persons are not willing to change their lifestyle, professional load. This is accompanied by refusal from taking medications, from hospital treatment. The consequences of such reaction are frequently unfavorable.

In typology of reaction by N.D. Lakosina and G.K. Ushakov (1976) as a criterion, taken for basis of classification of types, system of needs that are frustrated by disease is allocated: vital, social - professional, ethical or associated with intimate life.

Other authors (Burn D.G., 1982) believe that the response to the disease is largely determined by the prognosis.

In any case, in order to overcome the state of health, that has changed, and various manifestations of the disease, the person makes complex of adaptive practices. E.A. Shevalev (1936) and O.V. Kerbikov (1971) define them as a reactions of adaptation that can be both compensatory (artificial limit of contacts, subconscious masking of symptoms, conscious change of day regimen, character of work, etc.) and pseudocompensatory character (denial and ignoring the disease). In other words, in some way the patient changes accustomed lifestyle, his/her career on the basis of own concept of disease and in this respect a variety of somatic diseases can create similar life circumstances to person.

R.Barker (1946) identifies five types of attitude to the disease: avoidance of discomfort with autization (is typical for patients with low intellect), replacement with finding new means to achieve life goals (persons with high intellect), ignoring the behavior with displacement of defect recognition (in people with average intellect, but with a high level of education), compensatory behavior (tendencies of aggressive transferring of inadequate experiences to others and so on.), neurotic reactions.

In the content of internal picture of the disease not only existing life situation (the situation of the disease), but premorbid personality characteristics of the patient,

his/her character and temperament are reflected. Premorbid personality traits can largely explain the advantage of emergence of various forms of response to disease in patients.

The main types of attitude to the disease

Type of attitude to the disease. (Lichko A.E., Ivanov N.Ya., 1980)

1. *Harmonic* - correct, sober assessment of state, the reluctance to burden other with hardships of care of self.

2. *Ergopathic* - «a departure from disease to the work», desire to keep working ability.

3. *Anosognostic* - active rejection of thoughts about the disease, «everything will be right».

4. *Anxious* - continuous anxiety and mistrust. Belief in omens and rituals.

5. *Hypochondriac* - an extreme concentration on subjective feelings and exaggerating their importance, fear of side effects of remedies, procedures.

6. *Neurasthenic* - behavior of type «irritant weakness». Impatience and flashes of irritation on the first counter (especially at pains), then the tears and remorse.

7. *Melancholic* - disbelief in recovery, oppression by illness, depressed mood (threat of suicide).

8. *Apathetic* - complete indifference to their fate, passive submission of procedures and treatment.

9. *Sensitive* - sensible to interpersonal relationships, full of fears that the surrounding people avoid him/her due to illness, fear of becoming a burden to loved ones.

10. *Nosophilic* («immersion into disease») - with a parade of sufferings, the requirement of special attitude to them.

11. *Paranoiac* - confidence that the disease is the result of someone's intent, and complications are the result of the negligence of medical staff.

12. *Disphoric* - melancholic and malicious mood, jealousy and hate to healthy people are dominated. Explosions of anger with the requirements from the loved ones to please in everything.

Diagnostics of the main types of attitude to the disease. Additional psychological techniques, interpretation of research results

To diagnose the aforementioned types of reaction to disease *psychological diagnostics of types of attitude to the disease* that is developed in the laboratory of clinical psychology of St. Petersburg psychoneurological Institute of V.M. Behterev (1987) is used. There are also several other methods to identify the type of reaction to disease: SHS — *Spilberger - Hanin Scale* is a standard generally known psychological test for self - evaluation of emotional tension of human being according to data about personal (PA) and reactive (situational) anxiety (RA); RSCS — *Rating Scale of Concerns of the Sick* - the original test for determination of the characteristics of reactive anxiety (RA), that are features of emotional perception of initial stage of staying on treatment. It consists of 30 claims and is built similarly to SHS, but unlike SHS it allows to determine not only integral level of RA, but also its integral components; *Personality Scale of Manifestations of Anxiety* (PSMA). The range of questions - assertions allows to form an objective opinion about the qualitative features of anxious state that is concerning various aspects of a condition of the patient and the environment: A — Somatic anxiety that is caused by subjective self-evaluation of the degree of severity of certain physical symptoms that concern the patient; B — Psychological anxiety which is caused by patient's assessment of own neuropsychological status during disease; C — Social anxiety that is caused by analysis by the sick person of capabilities of deterioration of their social and public situation and so on.

The impact of attitude to the disease on further course of disease and prognosis. Aggravation, simulation, dissimulation, hospitalism

If the disease becomes chronic course, the lifestyle of the patient associated with the performance of the role of «patient «is largely preserved: restrictions in diet, physical and emotional burden, in work - rest regime that is supporting therapy. How strictly and punctually the patient observe doctor's recommendations, it largely depends on the subjective evaluation by them of their condition, what he/she thinks about their illness, how they assess the prospects of recovery and their role in such process.

There are different psychological reactions to the disease, which are implemented in appropriate forms of behavior, depending on adaptation method of the patient to the disease, internal picture of disease formed by them, psychological defense mechanisms used in medical practice.

Dissimulation. It is one of the possible form of psychological reaction in situation of illness. Aware of his/her illness, the patient consciously hides the symptoms of malaise and makes considerable efforts to hide them: continues to perform in the same volume their professional, family and social responsibilities. Despite the fact that over the development of disease it becomes more difficult to hide symptoms, the patient persistently continues to follow the selected line of behavior. In medical practice dissimulation behavior is common in cases where the disease threatens disability, loss of professional, social and material status: for example, open form of tuberculosis in lecturer or teacher. Often in such cases, patients begin to use behavior of turning away or immersion into activity. Dissimulation reaction also occurs in individuals suffering from «socially demeaning «diseases, they feel ashamed, fear and guilt before people around. Dissimulation is characteristic for patients with venereal diseases and especially with AIDS. To persons suffering from AIDS the people around relate really negatively, often violently, accusing them of immorality, promiscuity, antisocial lifestyle. According to Aleksandrova's observations, there were cases when neighbors of such patients stopped to communicate with them and even willfully

attempted to evict them, singeing doors, breaking windows. In such situations, patients reacted with strengthening of guilt and shame, or showed aggressive behavior that led to the conflict. Dissimulation behavior may occur at mental illness that is associated not only with the fear of condemnation from the side of surrounding persons, but also with social consequences of the disease, which impose restrictions on certain professions. Dissimulation reaction occurs in oncological patients who will better tolerate the pain and discomfort associated with the disease than agree to be surgically treated or undergo courses of chemotherapy.

Aggravation is exaggeration of symptoms, severity of the condition that exhibited by the patient. At aggravation the patients tend to present really existing disease or sickliness harder and more dangerous than they really are. Aggravation may occur in patients with hysteroid traits of character. The disease is used by such patients for demonstrative and blackmailing purposes: to attract attention and sympathy, achieve any benefits by manipulating of feelings of people around them. Aggravation behavior is characteristic for older patients who feel fear of loneliness, being afraid to appear in a helpless state at any time, tend to attract attention of doctors, medical staff and to extend hospital stay. Aggravation is not completely unconscious psychological reaction: objective and reasons for such behavior can be conscious by patients.

Simulation. Behavior of simulation is not a reaction to the disease because there is no illness. Simulation is defined as conscious presenting of symptoms of disease, which the person does not suffer. Simulation is observed in cases where the disease brings people any benefit: it eliminates the need to perform military service, allows to get group disability, etc. Behavior of simulation occurs mainly in two categories of persons: or in people with low educational level, not informed in medicine, naive and socially immature, or, on the contrary, in experienced people, who have medical education or work in health care (psychologists, pedagogues, social workers), that have studied well the represented type of pathology.

Hospitalism. Syndrome of hospitalism is defined as a set of mental and somatic disorders caused by prolonged stay of the individual in hospital in isolation from the

loved ones and home. This phenomenon has been described for the first time ever in infants and children that were in the hospital long, at whom it was primarily due to separation from their mother. Most effects leading to hospitalism, are united under the name of psychic deprivation. Langmajer and Matejchek give the following definition: it is «a condition that develops as a result of such life situation when a subject is not provided the conditions for gratification of his/her vital psychic needs sufficiently enough and for a long time». Psychic deprivation may manifest in sensory sphere — poverty of impressions due to lack of various sensations; in emotional sphere — at deficiency of warmth, love, care, emotional support, as well as in the intellectual sphere — in connection with a decrease of inputs promoting exercise and development of mental abilities.

Symptoms of hospitalism in children include: slowing of mental and physical development, retardment in body and language acquisition, low level of adaptation to the environment, weakened resistance to infections. Consequences of hospitalism in infants and children are long lasting and can often be irreversible, leading to death in severe cases. Hospitalism of the adults is characterized by social maladaptation, loss of interest to work and occupational skills, decrease and deterioration of contacts with others, the tendency to protracted course of disease. If an elderly or chronically sick person is for a long time in hospital, his/her life and their disease become as «lifestyle», he/she gets out from home life and makes significant efforts to return to the hospital again. Among younger patients ones with neurosis, psychopathy, especially patients with psychosis, that the hospital protects from vital shocks and challenges, exhibit apparent tendency to hospitalism.

Relations between doctor and patient are formed in each case individually, depending on the characteristics of the state and personality of patient, his/her nosological affiliation and individual psychological characteristics of doctor. Sex and age differences, level of education, social status influence on the formation of the relationship.

Age peculiarities of internal picture of disease

The biggest differences between the subjective evaluation of the disease and its objective manifestations are pronounced in young and old age (Kvasenko A.V., Zubarev Ju.G., 1980).

At evaluating of subjective side of diseases *in children* the child's age, matching the degree of mental maturity to passport age should be always taken into account. Prolonged physical illness in children often becomes a source of delay of overall physical and mental development. In addition, not only a delay in development, but also the phenomena of regression (returning to the types of mental reaction that is characteristic for younger age periods), which is seen as a psychological protective mechanism occur often at diseases in childhood. The protective activity of the personality of the children ensures that the objective meaning of notion «disease» is not often absorbed by them, there is no awareness of its severity and consequences for later life.

In children up to 6 years old you can often meet with fantastic views about disease, inspired experience of fear of injections and other medical procedures. In adolescents protective effects of the «retreat into the past «are forming most often, which are assessed by them as a happiness criterion, or «withdrawal» from disease in phantasy and unique focus into future (then the disease is perceived as a temporary obstacle).

As concerns a sudden serious illness, which is not accompanied by longstanding asthenia, the idea of L.S. Vygotskij (1983) that any defect is always a source of strength is fair. At the same time with defect these «psychological tendencies of opposite direction, these compensatory possibilities to overcome the defect; ... just they perform at the forefront in the development of the child and should be included in the educational process as its driving force». Orientation on compensatory opportunities and tendencies to overcompensation is very important in rehabilitatation action with children who suffering from chronic serious illnesses. Diseases in elderly age are tolerated physically harder and worsen the overall health

of patients for a long time. With age a whole range of age psychological phenomena comes to person: resentment against old age and a significant personal transformation of personal reactions and life patterns are here, Uncertainty, pessimism, resentment, fear before loneliness, helplessness, material difficulties appear. Interest to the new and in general to the outside world with the fixation on past experiences and their transvaluation is noticeably reduced. With the aging mental reactivity decreases. But and here, it can not be talked only about the regression of personality in elderly age, as many people keep their positive qualities and creative possibilities till extreme old age. Physician should remember that somatogenic influences of physical disease on the psyche are expressed much more intense in old age. Sometimes signs of deterioration of mental state of elderly age person are the first sign of physical illness or complication of its course.

Thematic plan for self-control

1. The psychic structure of personality
2. Classification of temperaments
3. Character and its structure
4. Intellect, abilities. Classification of abilities
5. Determination of accentuation of personality. Classification of accentuations by K. Leongard and A.E. Lichko
6. Tactics of doctor with patients with different types of accentuation of personality
7. The internal picture of disease and its levels
8. Diagnostics of main types of attitude to the disease
9. Impact of attitude to the disease on the course of the disease
10. Aggravation, simulation, dissimulation, hospitalism

Section III. State of mental functions and disease. General characteristics of cognitive processes

Clinical and psychological aspects of cognitive activity

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

There are three main spheres of mental activity: cognitive, emotional and effector-volitional. Cognitive processes are 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 disappears 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 necessary 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 — neuropsychiatric 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.

The impact of features of patient's intellect on the treatment process: infantilism, mental retardation, dementia

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 causes that are present during the intrauterine period or in childhood under the age of 3.

Depending upon the degree of expressiveness, it is customary to divide oligophrenia (congenital mental deficiency) into idiocy, imbecility and debility. Oligophrenia has different causes: hereditary factors (50 % of all cases of oligophrenia); mother's diseases during pregnancy (intoxication, infection); a physical injury of the foetus; a difficult childbirth causing a cerebral haemorrhage or brain injuries in a newborn, etc. Unlike dementia, oligophrenia has no progra diency, i.e. a further destruction of the nervous system. In oligophrenia a regular deficiency of all aspects of the intellect is the most frequently observed, while dementia is characterized by a lack of correspondence between fragmentary remainders of knowledge, testifying to abundance of the person's former experience, and a general decrease in reasonableness and criticism. Moreover, in oligophrenia there is underdevelopment of the whole body rather than of the psyche only.

Patients with a deep degree of idiocy are characterized by absence of speech, they do not recognize the surrounding people, their facial expression is vacant, their attention is almost not attracted by anything; they swallow food without chewing it well. A sharp decrease in all kinds of sensitivity is noticed. Such patients begin to walk late. Their movements are poorly coordinated. They do not respond to other people's facial expression and gesticulation, they are slovenly in relieving nature and are not capable of self-servicing. Sometimes it is possible to observe stereotyped movements, e.g., pendulum-like swings of the head or trunk from side to side.

Idiocy of the moderate and mild degrees is characterized by an ability to laugh and weep, some understanding of other people's speech, facial expression and gesticulation. Such patients are able to fix their look on objects. There is some development of the orientation reflex in them. They can independently eat food, but do it untidily; they may comprehend some simplest situation, and though they orientate themselves in a familiar place, they absolutely lose any orientation in time. Their vocabulary is limited by several dozens of words. They recognize their relatives and friends and may demonstrate an elementary attachment.

In case of imbecility, the patient's speech is more or less developed. But its development takes place with a delay, the patients begin to talk during the 3rd-5th year of their life. The stock of words is extremely poor. The patients understand other people's speech, facial expression and gesticulation within the range of their constant use. They do not comprehend a new situation to the end and need help, directions and guidance. They master the simplest skills but display them carelessly. With difficulty, they learn counting up to 20, can learn letters of the alphabet by heart, but are not able to master reading and writing.

Debility is a mild form of oligophrenia. The patients possess a significantly larger vocabulary than in imbecility, but lack flexibility of speech and mostly resort to stereotyped expressions, hackneyed phrases, learned turns of speech. It is not in rare cases that speech defects in the form of lisping and agrammatisms are observed. Differentiated movements are insufficiently developed, but simple forms of labour activity may be mastered. It is possible to teach such patients in conditions of auxiliary school.

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

Dementia can occur when:

1) vascular diseases of the brain;

2) the impact of traumatic brain injury;

3) brain tumors, epilepsy;

4) some metabolic diseases;

5) atrophic age - related processes;

6) hypovitaminosis;

An acquired mental deficiency is caused by epilepsy, as well as organic diseases characterized by atrophic processes in the cerebral matter (syphilitic and senile psychoses, vascular or inflammatory diseases of the brain, severe brain injuries), schizophrenia.

In schizophrenic dementia any severe disturbances of memory are never observed; a deficiency in schizophrenia concerns the emotional life and thinking in the form of the increasing apathy and splitting, disintegration in the unity and integrity of mental processes.

In epilepsy, a foreground of the picture of dementia contains changes in thinking: excessive thoroughness, «stickiness», stiffness, prevalence of the concrete - descriptive element over the generalizing one.

Lacunar and total dementiae are distinguished. The former is characterized by a decrease in the capacity for work, a progressive loss of knowledge and skills, an irregular weakening of memory, poor judgements, affective instability, loss of flexibility in mental processes, deterioration of adaptability and decrease of self-control. As a rule, the patients critically assess their intellectual defect. But the patient's attitude to the surroundings, his relatives and friends remains like it was before, a sphere of interests undergoes little changes, the convictions formed before are preserved. The personality becomes poor, but preserves its own system of relations, basic moral - ethic properties. In such cases one says about an organic decrease in the level of the personality, formation of «a residual personality».

In total dementia, a complete disintegration of the personality takes place. It is characterized by a sharply expressed narrowness in the sphere of interests coming to satisfaction of the elementary biological necessities. In the first turn, the highest levels of the personality and higher emotional manifestations suffer here. The patients are roughly uncritical to their mental deficiency. In some cases, the lacunar and total dementiae are stages in the development of a pathological process. The

clinical picture of cerebral atherosclerosis and syphilis of the brain may demonstrate development of lacunar dementia into total one.

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.

The impact of speech disorders on the treatment process

Thinking is expressed through oral and written speech whose disturbances occur in various diseases.

Two main forms of the oral speech disturbances are distinguished:

a) those caused by mental disorders (affect, delirium, a cloudiness of consciousness, etc.)

b) those caused by an organic lesion of the brain, where first of all sensory motor «instruments» of the speech suffer. Sometimes, speech disturbances caused by neurotic states are distinguished too.

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 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).

Ankylognosia (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.

Clinical and psychological aspects of emotional and effector-volitional sphere. The impact of disease on the emotions and effector-volitional sphere

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

Emotional reactions are the most often psychological manifestations of every 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.

Classification of disorders in emotions and feelings.

1. Disorders in the strength of emotions.

1) Pathological strengthening:

a) hyperthymia

b) euphoria

c) hypothymia

d) ecstasy

e) depression

f) alarm

g) irefulness

2) Pathological weakening:

a) paralysis of emotions

b) apathy

c) emotional flattening

d) emotional bluntness

2. Disorders in the motility of emotions:

1) faint - heartedness (unrestrained emotions)

2) lability

3) inertness (stickiness) of emotional feelings

4) explosiveness.

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).

Apathy: 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 disturbances 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.

Phobiae: 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.).

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 somatic - neurological 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 autorelaxation. 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.

Nosogenic states. Painful changes of emotions: anxiety, depression, emotional lability

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.

Anxiety

Anxiety is an emotion characterized by an unpleasant state of inner turmoil, pacing back and forth, somatic often accompanied by nervous behavior, such complaints and rumination. It is the subjectively unpleasant feelings of dread over anticipated events, such as the feeling of imminent death. Anxiety is not the same as fear, which is a response to a real or perceived immediate threat; whereas anxiety is the expectation of future threat. Anxiety is a feeling of fear, uneasiness, and worry, usually generalized and unfocused as an overreaction to a situation that is only subjectively seen as menacing. It is often accompanied by muscular tension, restlessness, fatigue and problems in concentration. Anxiety can be appropriate, but when experienced regularly the individual may suffer from an anxiety disorder.

People facing anxiety may withdraw from situations which have provoked anxiety in the past. There are various types of anxiety. Existential anxiety can occur when a person faces angst, an existential crisis, or nihilistic feelings. People can also face mathematical anxiety, somatic anxiety, stage fright, or test anxiety Social anxiety and stranger anxiety are caused when people are apprehensive around strangers or other people in general.

Depression

The depression is particularly augmented in the morning up to melancholia with despondency. The person would complain of poignant melancholia with squeezing pains in the heart region, substernal heaviness, «precardiac melancholia». It is impossible to distract the patient from this state and cheer up, under the influence of positive external stimulants the mood remains as it was before. People are inhibited (up to depressive stupor), not mobile and spend all the time in similar mournful postures. They would answer questions with a low monotonous voice, showing no interest in talks, express ideas of self - humiliation, self - condemnation,

being sinful, in severe cases these ideas become delusions. They regard themselves as criminals, wretched and useless people, some «worthless stuff for the society and family», a source of various evils and troubles for other people nearby. The patients interpret their previous behavior in a delirious way, assigning themselves the most negative part. It is not in rare cases that the patients refuse to sit at a common table, to shake their interlocutor's hand, to lie in bed, motivating it by the fact that they are not worth of it. As a rule, suicidal thoughts and attempts to realize them are observed. The patients do not make any plans for future as they do not see any prospects in it, they do not express any wishes but to die, but the latter may be concealed and dissimulated. The persons attention is concentrated on their own feelings; external stimulants do not cause any adequate responses. The instincts are suppressed (anorexia up to absolute rejection to eat, reduced libido, attempts of self - injuring and suicide). The patients do not feel the taste of their food, satiation, sensation and saturation with sleep. Against a background of an increased depression and despair they may develop psychomotor excitement with suicidal attempts, a «melancholic explosion». The patient would hit his head against a wall, scratch his face, bite his hands, etc. Suicidal attempts may be both impulsive at the moment of a melancholic explosion and more purposeful.

Volitional qualities of personality: self-possession, determination, perseverance, initiative, self-discipline and their role in the treatment process

Effector - 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) effector 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/her 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/her state.

The changes of will, instincts and behavior during illness

The special attention is demanded by patients with disorders of volitional sphere.

Classification of effector - volitional disturbances

I. Disturbances of drives

1. Disturbances of food drives:

a) intensification (bulimia, polyphagia)

b) weakening (anorexia)

c) polydipsia

d) perversion: parorexia (coprophagy, etc.)

2. Disturbances of sexual drives:

a) intensification (hypersexualism: satyriasis, nymphomania)

b) weakening (hyposexualism, frigidity)

c) perversion (narcissism, exhibitionism, voyeurism, transsexualism, transvestism, onanism, fetishism, sadism, masochism, pedophilia, gerontophilia, homosexuality, etc.)

II. Disturbances of volitional motives

1. hyperbulia

2. hypobulia

3. abulia

4. parabuliae

5. ambivalence 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 purpose. 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.

Consciousness, self-consciousness, their levels

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/herself out of the nature, to cognize and seize it. Consciousness is carried out by a language, words that 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/her out of the surroundings, to determine his/her attitude to it, to organize his/her 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

perceptions, memories, thinking, emotional to «ego» of all mental processes - 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).

The theory of the unconscious. Psychodynamic approach

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. Frejd who asserted, that unconscious is the leader in human behavior. Unconscious is not realized 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 behavior. As examples of the unconscious instinctive reactions of self - defense, 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 behavior depends on instinctive promptings, unconscious.

Criteria of unimpaired consciousness

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/her, he cannot name the date, his surname, name, age, profession.

The disturbances of consciousness that can be caused by different therapeutic, surgical, gynecological 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. Motionlessness, 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 torpor 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 lasts for several seconds while at deep syncope it lasts for several minutes. The causes of syncope are different. One of the main causes is acute cerebral hypoxia.

The states of altered consciousness in patients: with fatigue, lethargy, affective narrowed state

The doctor should be able to determine the physiological changes of his/her 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 require 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 pervertedly. 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 the unconscious forms of mental activity also occur. This can explain some well - known facts of the scientific discoveries made at sleep (D. Mendeleev's discovery of the periodic table). 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. Frejd 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 form of anger, fury, horror, delight and despair without loss of censorship.

Specific states of consciousness

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 form 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/her punishment.

Thematic plan for self-control

1. Clinical and psychological aspects of cognitive activity
2. The impact of the disease on human cognitive processes
3. The impact of features of patient's intellect on the treatment process
4. The impact of speech disorders on the treatment process
5. Clinical and psychological aspects of emotional and effector - volitional sphere
6. The impact of disease on the emotions and effector - volitional sphere
7. Painful changes of emotions: anxiety, depression, emotional lability
8. Volitional qualities of personality and their role in the treatment process
9. The changes of will, instincts and behavior during illness
10. Consciousness, self - consciousness, their levels

Section IV. Psychology of health care workers

The main reasons for choosing the profession of medical workers

There are several reasons for choosing the medical profession according to A.P. Vasil'kova:

- desire to treat people;
- desire to alleviate the suffering of seriously ill patients, the elderly patients, children;
- ability to care about the health of loved ones; job prestige and family traditions;
- desire to solve scientific medical aims;
- ability to take care of one's own health;
- the ability to influence other people;
- availability of medicines;
- financial interest.

From the beginning stage of future doctor's education, it is inculcated to the student the basics of medical ethics, the respectful attitude to the patient, kindness and sense of responsibility for the work. So the true doctor can be only the blameless person, the person who is endowed with not only the knowledge but also the ability to charity. Crucial importance in the formation of medical ethics social environment gets. A person who devotes himself/herself to the medical profession certainly should have talent, compassion and desire to help others, in other words to have a sense of humanism. The future doctor should be a reserved person who can keep temper in the extreme conditions. Formation and improvement of more skilled colleagues, professional skills, adoption experience from communication during the consultations, medical meetings, clinical reviews, conferences and others get the great value.

The quality and efficiency of modern medical assistance is determined not only by the high qualification and professional competence of health care workers of

different specialties, but also by their personal characteristics, attitudes, motivations, psycho - emotional and physical condition. The treatment of many diseases is impossible without social and psychological characteristics of the individual, human relationships with the environment, which requires a doctor's ability to build trusting relationships with the patient. The Edinburgh Declaration of the World Federation of Medical Education decided that every patient should have the opportunity to found in doctor the person, prepared as an attentive listener, a careful observer, effective clinicist and the person who is highly susceptible in the field of communication.

Elements of medical and psychological impact can be seen in the features of approach to patient by physicians since ancient times. In the arsenal of Egyptian medicine remedies together with chemical, physical and biological medicaments are used the mental forms of impact on patients, including verbal, mimic and pantomime. For guidance of Persian medicine, doctor should not only study deeply the medicine, but read a lot and educate, to accumulate experience as much as possible in the specialty, to have the ability to listen a patient, to recognize his illness thoroughly and carefully, and to treat with good faith. During the meeting with a patient physician must use soft speech, be careful with him, to be friendly.

In the text of Gippokrat oath, the famous physician and philosopher of Greece, the special attention is paid to the approval of high moral qualities of doctor providing the most humane forms of communication with patients.

In a medical relationship the psychological characteristics of the patient are contracted with the psychological characteristics of health care workers. In this regard, there are primary and secondary aims of medical services. Traditionally to primary ones the interventions aimed at the medical care for the patients are included. To secondary ones measures aimed at the providing of medical personnel needs are included. And, therefore, the qualitative treatment of patients is possible only after the realization of these two goals.

It is paid more and more attention to the personality of health care worker and his importance in modern medicine. The use of new medical and rehabilitation

technologies using the multidisciplinary teams of specialists requires from specialists the possession of certain personal skills and the capacity for the common hard work with colleagues, representatives of social organizations, patients and their relatives. Psychological characteristics of members of therapeutic teams are strong and effective therapeutic environmental factors.

Studying of patient's psychological characteristics, health care workers and the dynamics of their interactions are the necessary initial condition for the creating of effective diagnostic and treatment process.

The value of professional orientation in choosing of the medical profession. Psychological features of professional development of doctor

Professional guidance with regard to the skills, the final determination of one's vocation and choice of future profession occupy a very important place in the life of everyone, especially future medical worker. The correct choice of profession largely determines the entire future way of living of person, his/her successes and failures, joys and sorrows, happiness and satisfaction of the fruits of his work or disappointment in it. The sooner a person finally determine his/her calling, the better he/she will prepare themselves for a future profession with great application and moral satisfaction, penetrating into its content, learn to overcome the difficulties encountered on the way of the intended target. Maybe the love to the medical profession must be inculcated from school, from children and teenage years. Important benefits can be obtained with a focused reading fiction, visiting of theaters and cinemas, devoted to the life and professional work of health workers.

Professional activities that are aimed to help people and to ease their suffering in difficult situations during the disease, imposes special requirements for its specialists. Professional education of doctor begins of his/her psychological characteristics and aspirations during this childhood and adolescence. The image of the «ideal physician» pictured in the dreams of a young man, to which it must comply, faced with strict requirements and difficulties in the way of professional growth. During the own formation doctor has to overcome some crises of

professional formation, which are closely related to individual development and, at case of their successful overcoming, they determine the transition to a higher level of professional skill.

Considering the study of psychosocial development and labor activity of the person there are the following **stages of professional development of doctor:**

1. Formation of professional aims stage

At this stage, young person (15-17 years old) meets with the need to determine the basic direction of his/her further training to get some profession. This person faces with question of identity, evaluation of desires and abilities. Typically, in this period, it is chosen only a common field of activity (medicine), rarely specific profession (surgeon, pediatrician, psychiatrist). At this stage the first crisis of professional development is possible.

2. Stage of basic professional education

In this period (17-25 years) student of medical college gets basic medical education and must make his/her first professional choice in favor of a specific profession. The presence of professional choice crisis that may be shown by symptoms of mental maladjustment, some emotional, volitional and cognitive impairment, autonomic dysfunction, changing of motivation and correction of professional plans is possible. In this period a group affiliation, friendship, peer recognition, love, search for congenial soul is particularly important. The emergence of social exclusion may be a problem. The dominant problem at this stage (after A. Maslou) is affiliation need and love.

3. Stage of professional activities

It covers the period from 26 to 64 years. The needs for self - esteem, self actualization, self - improvement dominate. This stage can be divided into three stages:

1) *Professional development stage*. It covers the first 4-5 years and includes acquisition by doctor of his/her professional identity and determination of his/her professional role. This period is characterized by a strong psychological dependence of young specialist from the teachers and more experienced doctors, doubts in his/her abilities and skills, the need in affection and approval of others. If during this period the young physician has some therapeutic or communication problems with patients, with their relatives, colleagues, it leads to a crisis of professional identity. In successful overcoming of the first stage a doctor becomes psychologically independent specialist with needs, which dominate in self-assertion, self - realization, professional growth. In the absence of prospects of professional development the crisis occurs, which may end by a job or profession changing.

2) *Phase of professional growth*. It comes after about 5 years of work and continues during 10-14 years. Ideally, at this stage the doctor become a professional who make his/her work productively and qualitatively, professional self - esteem is increases. Most of the doctors already get relatively stable family and home situation. Further professional development can be characterized by satisfaction in the achieved with the termination of improvement or the fight for the professional autonomy, rejection of authority and career growth. The contradictions between desirable career and real prospects lead to the development of the professional career crisis.

3) *Professional skills stage.* It comes after 14-20 years of work after the specialty. The doctor is already respectable and a full member of the professional community, has a large set of developed therapeutic strategies, a sense of professional identity and competence, has the creative approach to the patient treatment, he/she becomes a teacher for younger colleagues. It may happen that such doctor will cease to learn, believing that «there is nothing new to hear, «forgetting that the information about new approaches to diagnosis, treatment, disease prevention is renewed every seven years. Gradually unrealized necessity in professional self - actualization can lead to a crisis of unrealized possibilities, leading to dissatisfaction with themselves, others, and life circumstances and in profession.

4***. Professional readaptation stage***

It comes with the achievement of physician the retirement age and is accompanied by *crisis to lose the profession*. Work leaving can provoke deterioration of health. To elude the crisis it is advisable to find a replacement for the lost work or continue it in a new quality.

The important professional qualities of a doctor

The basis for the formation of positive, trusting and productive relationship between patient and doctor is the qualification, experience, specialist personality characteristics. Medical worker has credibility if he/she is a harmonious personality, calm, confident, capable to the empathy and sensitivity.

The term of «medical duties»

Before the term «medical duties» will be examined, it is necessary to understand the meaning of human responsibilities before the society in general.

Social responsibility is a category which is not exhausted by morality; it also focuses at professional duty in wide sense. Therefore, the *«medical duties» is a complex of needs and requirements which govern the doctor - patient relationship, among the doctors, doctors and society*. It should not be confused with medical ethics, which has more narrow meaning. Medical duty embodies the fundamental principles of medical ethics - humanism, according to which a doctor should never refuse in medical care. Medical duty means the obligation in professional or social work. Medical duty is a moral imperative side, however, it needs to be implemented in an internal demand, which impulses a doctor to its execution. This is a doctor personal interest that based at the relationships that have developed as a conscious need. The notion of medical duty is an essential part of medical ethics. Doctor should not refuse somebody in medical care, he/she should not take part in actions against the physical and mental health or which can endanger the human life. Doctor is

obliged to help all patients apart of gender, ethnic and racial origin, political beliefs and religion.

Performance of medical duties is related with medical moral self - awareness of a person with an understanding of his/her role in society. This turns a regulating impact of morality on the doctor's understanding of such terms as goods and evil, duties, conscience and responsibility.

The term «medical confidentiality»

The most important requirement of medical duties is a necessity to keep medical confidentiality. In the articles 16 and 17 of «Fundamentals of Laws of Ukraine about public health» the duty and responsibility of medical workers for the safeguarding *«… information about the disease, as well as the intimate and family side of life of the patient that have become known due to professional duties»* have been formulated. But if the information to which a doctor received the access gets the danger for life or health of the others, affects the interests of state, the doctor must take all necessary measures to prevent the becoming of the patient as a source of the dangerous diseases, without harming the patient feelings.

Medical errors, causes and types

All actions of doctors that are associated with negative consequences for the patient, can be divided into three groups:

- medical errors;
- accidents;
- criminally punished omissions and professional crimes.

Medical error is one of the most frequent causes of the negative result of treatment. Mistakes are possible in the activities of any specialist, however, the society reacts more aggressively on medical errors that are associated with human health and life. According to N. Davydovs'kij,»... *the major criteria of medical error are the mistakes judged from certain conditions based on or the imperfection of the current state of medical science and its research methods, or on the development of*

the disease in the context of concrete patient due to lack of knowledge and experience of the doctor without elements of negligence. professional ignorance».

There are several classifications of medical errors. The lawyer 1. Krylov, determines the medical errors, based on the reasons of their occurrence, by the following way:

diagnostic medical errors - unrecognized or incorrectly recognized disease;

tactical medical errors - incorrectly defined indications for surgery, a. wrong choice of the time of its implementation, the surgery scope etc;

technical medical errors incorrectly used medical equipment, diagnostic tools and so on.

It is necessary to supplement this classification by deontological mistakes that can cause conflicts not only between the doctor and his/her patient and relatives, but also the indirectly diagnostic errors, tactical and technical.

The causes of medical errors can have objective and subjective nature.

Objectively the difficulties in the diagnosis of diseases may occur due to hidden, atypical course of the disease that often can be linked with other types of illness or stimulate the other diseases. The symptomatics of severe diseases and abdomen injuries are often masked under the picture of alcohol intoxication, and due to it the disease is not recognized on time, its symptomatics is mistakenly connected with hard intoxication state and the time to provide the effective medical care is lost.

The subjective errors are associated with the doctor actions. The improper conduct of health care worker may have a negative impact on the psyche of the patient, so it appears a number of new painful feelings and shapes that can overrun at the independent forms of diseases. It depends not only from the lack of the doctor experience or ignorance, but of his/her inattention, lack of tact and even lack of behavior.

Therapeutic errors for which the doctor is responsible are:

intervention without diagnosis or misdiagnosis;

ignorance of properties and mechanism of action of any of the applied drug substances;

absence of patient consent to the proposed plan of treatment or lack of information

absence of treatment control.

Preventing of medical errors risk requires:

full competence (in relation to the applicable methods, measures and treatments) as the highest form of professional integrity;

the need for constant careful attention to the patient (not only in case of serious diseases);

rational prudence and the respect of the principle «do no harm», which today is particularly important in view of the wide range of pharmacological drugs;

the ability to take actions and decisions in difficult situations (risk in the interest of the patient);

constant diligence in relation to the professional duties.

In the prevention of medical errors, we should be based on the deontological criteria. It is necessary to compare the concrete scientific realities of medical and biological fact with abstract nature ethical and legal norms and principles.

The professional and legal responsibilities in relation of medical ethics are the constant insistence of doctor to himself/herself. The respect of moral and ethical principles allows to protect the interests of the patient and society as a whole, contributes to the progress of medical science and stimulates useful doctor's initiative in the interest of the patient.

Accidents in medical practice. Sometimes an unfavorable result from one or other medical intervention occurs incidentally and the doctor is unable to prevent the negative consequences. Under the meaning of the accident in the medical practice the unfavorable medical intervention related with the mistaken circumstances which doctor cannot predict and prevent, but he/she operates correctly and on time, in full accordance with the accepted in medicine methods of treatment should be understood. Medical activity is always associated with some risk for health and life of the patient, the degree of professional risk can be different. One is for the

patient, who was operated in time, the other one – at supply of the emergency care to the patient in critical condition. It should be noted that there are certain risks in the treatment of rather simple well known diseases such as appendicitis. The reverse trend that is associated with the reluctance to risk justifiably, fight fearlessly for the life and health of patients, leads to irresoluteness, indifference and is a sign of professional unsuitability.

Professional crimes. At the heart of the professional medical crimes dishonesty underlies. There are the following violations:

- the refuse to provide a medical care to a patient;
- illegal abortion;
- illegal treatment;
- negligent attitude to one's duties;
- violation of sanitary and anti-epidemic rules;
- handling and issuing of false medical documents;
- unacceptable experiments on human beings;
- extortion and bribery;
- violation of the production rules, storage, delivery, registration, transportation and transmission of drugs and superpotent substances.

The mentioned above shows that at the base of professional crimes there is the negligence which is associated with low moral level of specialist and this fact is the criteria for punishment. At the basis of professional crime there is an activity that is contrary to the accepted medical rules. The correctness or incorrectness of medical actions are established by the departmental commissions and forensics tests.

Thus, the distinctive side of medical errors from the professional crimes is the conscientious desire of doctor to help the patient, although in fact his/her actions may be wrong. Lasting expert practice shows that the vast majority of «medical cases» in the process of previous judicial examination terminates for the lack of evidence. This suggests that the majority of the negative results are not related to the actions or inaction of medical workers or are indirectly related, and can be

considered as the medical errors and therefore they are not punished by criminal law. The generic character of some errors is often not made known to the wide medical society but even the minimum information could prevent their recurrence in the future.

Psychological types of doctors

There are the following **pairs of characteristics that make the types of doctors:** sympathetic and emotionally neutral, directive and nondirective (V.A. Tashlykov).

The concept of *compassionate type* of doctor includes such qualities as the ability to deeply understand the problems of the patient, to empathize with a patient the variation of his/her state, to share his/her psychological problems, sometimes to take the disease concept that is put forward by the patient.

Emotionally neutral type of doctor combines such qualities as emotional aloofness of doctor from the deep medical problems of the patient, orientation on the symptoms, the unwillingness to support the patient in his/her «subjective» emotional crises with a focus on the technical approach to the treatment.

The directive psychological type of doctor acts as a teacher, who indicates how to act and what to do in situations of illness. The directive doctor is not prone to debate with the patient on the professional topics. He/she establishes the unequal relations, defining a more significant role for himself/herself. In his/her career, he/she *is guided paternal model* of medicine which deals with the relationship between the doctor and patient as the relationship of teacher and student, father and child. The directive doctor excludes the possibility of patient's doubts in his/her abilities, to apply negatively to the re - verification of diagnoses by other doctors, is prone to take offense and gives the negative emotional reactions to the patient in cases of criticism of his/her actions.

Non-directive psychological type of doctor includes the orientation on the partnership compared to the focus on leadership, inclined to take into the

consideration the views of the patient as on the diagnosis and the choice of methods and measures of treatment.

The represented pairs of doctor characteristics may be divided into four types:

- sympathetic non - directive;
- sympathetic directive;
- emotionally neutral non - directive;
- emotionally neutral directive.

The patient orientation for the one or another standard of doctor type is associated with personal experience of interaction with a number of influential people in different periods of life. During the finding of the ideal doctor the patient is checking the image of doctor with images of beloved parents, respected teachers and other important people.

Professiogram

Professiogram (from the Latin. Professio - specialty + Gramma - record) is a system of signs that describes a particular profession, and includes a list of standards and requirements which are required by this profession or specialty to the worker. In particular, professiogram of medical worker includes a list of psychological characteristics to which a doctor must correspond.

Professiogram of the doctor includes the following necessary skills:

high level of voluntary *attention* development (ability to detect even the little signs of symptoms of the disease);

well - developed *verbal and logical long-term memory* (the ability at the right time to provide the medical care, to recommend medicaments necessary for this disease);

nimbleness during the various medical procedures;

quick reaction capability;

psycho - emotional stability and ability to take the great physical exertion;

verbal abilities (to express their views correctly and at the same time lucidly to the patient).

For highly professional activity of the doctor, the following *individual and personal* qualities are necessary (M.V. Klyshhevs'ka):

- *ability to establish a contact with people* (communicative competence);
- *the ability to control their feelings* and emotions;
- *determination, optimism, caution, activity, self - confidence*;
- *high ethical standards* in relation to patients and others;
- *low proneness to conflicts and the appropriate emotional expression;*
- *low level of aggressiveness and hostility*, lack of antisocial tendencies;
- *low level of anxiety*, the ability to take quickly the difficult decisions;
- *responsibility*;
- tolerance, professional courage, ability to empathize, to take the position of another (*the ability for empathy*), the desire to help.

In contrast to it *the qualities, standing in the way of effective professional activity* are necessary to specify:

- irresponsibility;
- distraction;
- selfishness;
- emotional outburst;
- cruelty;
- disgust;
- intolerance;
- absence of mind.

The term «professional deformation

«A variety of medical practice raises an acute problem of its impact on the mental life of doctor as a professional. So for the first time in the USA in the 60s the term of «professional deformation» has been introduced. It is gradually formed along with the process of adaptation of a person in conditions of his/her unregulated impact on others. The doctor has such impact, because patient's physical and

spiritual health and even life depends from him/her. Gradual reduction of emotional empathy to the patient, the loss of empathy contributes to the foundation of professional deformation. Therefore, it is very important that doctor will save the norms of deontology and medical ethics in his/her daily work. Shining example of the professional deformation is perception of the patient as a bearer of symptom or syndrome when the patient is estimated by doctor as «an interesting case». Such phenomenon applies to many medical specialties, such as: Therapy, Narcology, Psychiatry, Gastroenterology, which a big part of probability «to attach the labels» in the designation of various states of physical condition of the patient is in. Such statements are perceived literally by the patients, and have psycho traumatic consequences. Particularly negative impact of such designations arises in such situations where it comes to human mental states when to the determination of the simple signs of character accentuation psychiatric signs of description are added, such as: sadness and sorrow are defined as subdepression, anger as dysphoria, enthusiasm as paranoia, productive work as affective insanity, indecision as ambivalence, modesty and shyness as autism or schizoidity. These phenomena are often accompanied by professional physician incompetence in the form of the mistaken understanding of the phenomenon and the corresponding overdiagnostics.

The doctor deals with two realities spiritual (phantom models of how to do) and living reality (people life). If the doctor gradually takes such phantom as a reality, when his/her perceptions of the others and the consciousness become static, he/she begins to pass through the feeling of dissatisfaction regarding himself/herself and his/her profession.

Syndrome of emotional burnout of medical workers

The achievement of the productive therapeutic alliance is impossible without the worldview and as personal characteristics of the patients, as medical workers. However, in some cases the work related with the intense communication and help to the others may cause the professional deformation. I. Hardi, studying the interaction in the triad of «doctor-nurse-patient», describes the specific conditions

that are distinctive for the medical workers, which were called by him as «poisoning by people». They appeared by the emotional stress, irritability, protective behavior in the form of coldness and indifference to the patients. In contrary, some doctors are deep in work trying to elude the life problems.

According to the WHO (2001) *the burnout syndrome* is a physical, emotional or motivational exhaustion, which is characterized by the violence of work productivity, fatigue, insomnia, increased sensitivity to systemic diseases, and alcohol or the other psychoactive drugs abuse with the aim to obtain a temporary relief that has a tendency to development of physiological dependence and suicidal behavior (in many cases). This syndrome is usually regarded as a stress reaction in response to the relentless productive and emotional demands that come from the excessive devotion of person to the with concomitant neglect of family life and rest. Professional burnout syndrome is a personal deformation caused by emotional difficulties and the rigorous relationships in the system man-man.

Factors leading to the development of burnout syndrome:

- tight schedule (more than 45 hours per week);
- low personnel and management support
- low wages which is not correspond to the strain rates;
- high uncertainty in the work estimation of (the same result can be estimated in different ways depending on the situation);
- inability to influence to the work result (the patient can die apart the high qualification of doctor, factors that do not depend from the doctor (broken and old equipment, lack of medicines);
- two valued and conflicting claims to work;
- work under the constant threat of sanctions;
- drab, monotonous, unproductive work; the need for the external manifestations of emotions that do not correspond the internal content;

- lack of personal time, the need to engage in professional activities and interests in the spare time;
- constant negative evaluation of work;
- the chaotic organization of working time;
- the existence of an unhealthy «competition» on the workplace.

Personal qualities which increase the susceptibility of burnout syndrome origin:

- emotionality and sensitivity to the problems of others;
- high self - control;
- high personal responsibility and high personal standards;
- suppression of negative emotions and rationalization of one's own behavior;
- predisposition to the anxiety reactions, especially if something goes wrong, or the situations do not meet the «personal standards» and demands of others.

There are five groups of burnout syndrome symptoms:

1. *Physical symptoms:* fatigue, physical exhaustion; change of weight; insufficient sleep, insomnia; ill health (wheezing, shortness of breath, nausea, dizziness, excessive sweating, tremor, increased blood pressure, ulcers and inflammatory skin diseases, diseases of the cardiovascular system).

2. *Emotional symptoms*: shortness of emotions; pessimism, cynicism, insensitivity in work and personal life; apathy, fatigue; sense of helplessness and hopelessness; aggression, irritability; anxiety, increased irrational anxiety, inability to concentrate; depression, feelings of guilt; hysterical reaction, distress; loss of ideals, hopes or professional prospects.

3. *Behavioral symptoms:* working time over 45 hours per week; during the work it appears fatigue and desire to relax; indifference to food; reduce to the endurance

to physical exercises; justified smoking, alcohol and drugs; accidents falling, injury, accident, etc; impulsive emotional behavior.

4. *Intellectual state:* interest decrease to the new concepts and ideas in work, to the alternative approaches in problems resolving; boredom, depression, apathy, decline of interest to life; the choice in favor of standard samples and routine than to creative approach; cynicism or indifference to the innovation; refuse to participate in the developing experiments trainings, education; formal work performance.

5. *Social symptoms:* low social activity; decline of interest to the rest, hobbies; social contacts are limited by work; scarce relationships at work and at home; feelings of isolation, misunderstanding of others and by others; feeling a lack of support from family, friends, colleagues.

Key features of emotional burnout syndrome:

- extreme depletion;
- stangeness from clients (patients, students) and from work;
- feeling of inefficiency and failure of one's achievements.

Burnout syndrome can be considered in terms of stress theory of G. Sel'e, according to which the reaction to stress has a three-stage dynamic (stage of anxiety, resistance and exhaustion), then it is the third stage of stress - stage of exhaustion.

The nosologic affiliation of burnout syndrome has not finally determined yet. Some researchers consider it as a disease of modern society or estimate it as one of the variant of chronic fatigue, and the others consider it in the limits of diagnoses «adjustment disorder «or «neurasthenia» (ICD - 10).

In general, based on the facts from literature the burnout syndrome can be considered as a long - term stress reaction of a person on the chronic occupational stress effects of medium intensity.

R. Smirnov and D. Gould are marked four *stages of burnout syndrome* - depersonalization, undervaluation of personal contribution, isolation, emotional and physical exhaustion.

Depersonalization stage (loss of identity) is characterized by emotional suspending, avoiding of contacts with colleagues, distancing from them.

At the stage of the undervaluation of personal contribution a person feels that he doesn't fulfill his functional duties, doesn't get satisfaction from work.

The main features of isolation stage are the voluntary exclusion of professional from colleagues and failure of the assigned duties and obligations, and he always finds the excuses, «objective reasons» of his behavior.

At the stage of emotional and physical exhaustion a person feels himself/herself completely «destroyed» physically and emotionally, he/she does not feel neither the desire nor the strength to continue the work.

M. Burysh identifies six phases of professional burnout syndrome and describes the psychological, psychiatric, behavioral and psychosomatic characteristics of each of them.

1. *The warning phase*. It is characterized by excessive participation - excessive activity, a sense of indispensability; the refuse from requirements, which are not-related with work, the displacement of failures and disappointments; restriction of social contacts. Then the exhaustion comes - fatigue, insomnia, the threat of accidents.

2. *The reduce of the level of one's own* participation in relation to the colleagues, students, patients, the loss of positive perception of colleagues, the transition from help to supervision and control; attributing of the blame for one's own failures to others; domination of stereotypes in professional behavior, manifestation of the inhumane approach to people. Similar changes in relation to others: lack of empathy, indifference, cynicism, and also in relation to his own professional activity: unwillingness to perform the duties, extension of work breaks, arriving late, leaving from work too early, cycling on the material side of the activities with the simultaneously dissatisfaction in it. There is loss of life ideals, concentration on his own needs, the envy to the others.

3. *Emotional reactions:* depression - feelings of guilt, the reduction of self-esteem, the unfounded fears, mood labiality, apathy; aggression - protective actions,

accusation of other, ignoring of its role in failures; lack of tolerance and the ability to compromise, suspicion, conflict with the colleagues and patients.

4. *Destructive behavior phase*: in the intelligence sphere - reduction of concentration, attention, inability to perform the complex tasks, rigidity of thought, lack of imagination; in a motivational sphere - lack of initiative, the reduction of effective activity, performance of tasks purely for instructions; in emotional and social sphere - indifference, avoidance of informal contacts; lack of participation in the life of others or the excessive attachment to a particular person; avoiding of topics related with the work; self-sufficiency, loneliness, rejection of interests, boredom.

5. *Psychosomatic reactions:* decrease of immunity, inability to relax in no working time, insomnia, sexual disorders, high blood pressure, tachycardia, headache, pain in the spine, digestive disorders, dependence on psychoactive substances - nicotine, caffeine, alcohol.

6. *Disappointment:* negative life setting, helplessness and meaninglessness of life, existential despair.

Prevention and correction of professional burnout

Each specialist working in medicine may face with burnout syndrome. Therefore, medical workers should know the precipitating factors, symptoms, stages, the possible consequences of professional deformation; understand own affective and cognitive feelings, have the skills of self-help.

The primary prevention of burnout syndrome should begin already during the university studies. During the study of various clinical disciplines the student can learn the requirements for the physical and psychological qualities which are necessary in a particular specialty (surgery, pediatrics, psychiatry, etc.). Knowledge acquisition of professional communication skills by students and interns, training of control of own time, confidence, portability of improving of professional stress is reasonable.

The World Health Organization recommends the following strategies for the primary prevention of burnout syndrome of medical workers:

- prevention of too high requirements for the persons who attend to the other people;
- ensuring of equal distribution of tasks between the employees;
- training of personnel to staff distribute the time and relaxation techniques;
- modification of work, causing big stress;
- formation of support groups;
- presence of opportunities to work on the part of rate;
- to encourage employees to participate in taking of the decisions that may affect at the working conditions.

There are the following basic strategies for prevention and correction of burnout syndrome:

- Organization of studies and interviews with new employees to familiarize them with real difficulties and situations that can arise in this department during the speaking with patients and their relatives, providing of practical recommendations.

- Regular meetings and conferences with staff to discuss the specifics of work with a concrete contingent of patients and to solve the complex situations which arise in the department.

- Organization of psychological trainings with staff to improve the communication skills, control their own time, the increase of self - confidence, awareness of emotions, relaxation.

- Professional development, self - improvement, a removal from unnecessary competition.

- Periodical voluntary personnel examination to identify a burnout syndrome. • Creation of support groups that join people who perform a similar work and have the same type of problems.

- Providing of the opportunities for unstructured communication during a lunch break or collective rest.

- Organization and supervision a Balint groups where it is possible to discuss the staff problems that arise during the speaking with patients and colleagues, emotional reactions and psychological protection, alternative plans of patient treatment.

- Organization of debriefing is the discuss of traumatic events and situations (death of patient, suicide cases, work with relatives of seriously ill patients, inform of a fatal diagnosis), during which the medical workers can express their thoughts, feelings, associations; that can reduce the likelihood of inappropriate reactions and facilitate the feeling about these cases.

- Changing of the treatment process style from a purely biological to the introduction of rehabilitation approaches.

- Correction of medical subculture, in which it is adopted to deny the personal health problems. A clear separation between the work and personal life.

- Establishing of the interaction between personnel and the administration with provision of opportunities for employees to influence on the organization of work process.

Awareness in proper psychological features, the ability to recognize personal emotional reactions and manage them, competence in communicating with patients. and colleagues with respecting the rules and norms of medical ethics and deontology, knowledge of features of professional burnout syndrome and possible methods of its prevention and correction are necessary for the future doctors of any specialty. Such knowledge, skills and abilities contribute to the professionalism of doctor, tolerance to the professional stresses, increasing of motivation to personal development and improvement of cooperation in team form of work.

Communication in the treatment process

More than 25 centuries in European culture different moral principles and rules that accompanied the centuries - long existence of medicine have been formed and changed. Different moral regulators that functioned at the different stages of society development, are – religious, cultural, ethnic, socio-economic – influenced on the formation of ethical models in medicine. On the basis of the diversity of medical moral experience, four coexisting models can be distinguished:

1. Gippokrat model (the principle of «do no harm»);
2. Paracel's model (the principle of «do good»);
3. Deontological model (the principle of «adhering to obligations»);
4. Bioethics (principle of «the respect of rights and dignity of the personality»);

Modern Medical Psychology is based on the general medical ethical principles in all its sections. However, the medical psychologist in his/her work faces with specific ethical issues.

Firstly, it is the question about the need to inform the studied about the purpose and content of the psychological examination before his/her execution. Medical psychologist has to respect confidentiality during the discussion of results of the study, receive the patient's consent in expedience of the familiarization with his/her results by other specialists, except his/her doctor, show the correctness during the study or in case of refuse from the last.

Secondly, it is necessary to respect the rule of «limits». Considering the nature of interpersonal interaction between patient and medical psychologist, it is necessary to identify clearly the professional limits of communication at psychological consultation and during the psychotheraputic meetings, because the «crossing» of limits can lead to the destruction of the treatment process and harm the patient. The range of violation limits of professional interaction is very wide, it includes advices, recommendations and issues that enter beyond therapeutic contact limits. For example, during the admission, the patient's condition has been deteriorated and he/she was provided with medical assistance. Experiencing about this situation, psychologist calls to his/her patient in the evening to know about his/her health. A

patient considered it as a violation of his/her «limits» and the invasion on his/her autonomy. However, under the certain circumstances «violation of limits» may have the constructive character, so it is important to take into account the context of the interaction. Thus, the patient having entered into the office of the medical psychologist and informing about the death of his/her son, receives from the last the condolences to his/her grief. Failure to identify in such situations the empathic sympathic attitude pushes off a patient and will break up the interpersonal interaction. «Violation of limits» arises when somebody tries to use the patient for personal purposes.

Empathy is a conscious felling with the emotional state of another person, without losing the sense of external origin of this feeling. In medicine empathy is often called as fact that Psychology calls «Empathic listening»- the understanding of the emotional state of another person and demonstration of this understanding. For example, during the interrogation of the patient by doctor, the manifestation of empathy means firstly, the understanding of words, feelings and gestures of the patient, and secondly, such manifestation of understanding that it is clear to the patient that the doctor realizes his/her experiences.

Thus, the emphasis is made on the objective side of the process, and the possession of skills of empathy means the ability to collect the information about the views and feelings of the patient.

The purpose of this empathic listening is to give understanding to the patient that he/she is listened to and encourage him/her to better expression of feelings, allowing the doctor, in his/her turn, to make a better visualization on the discussed topic.

Thirdly, the formation of emotional attachment of the patient to the medical psychologist is a difficult ethical issue, which is one of the characteristics of professional interpersonal interaction. This form of commitment is the basis for the deterrence of affective disorders that accompany the disease. However, the attachment, becoming the dependence, causes the adverse reactions in the patient that lead to the destructive forms of behavior. Therefore, medical psychologist must

control carefully the interaction with the patient, realizing his/her professional actions so that the emotional support will not undermine to the provision of the patient by the proper means for the independent fight with difficulties and realization of the own life goals.

The relations in the medical team are characterized by the originality of general moral standards. They are particularly appeared in groups of physicians of various specialties, along with an understanding of medical and ethical obligation not only during the work in hospitals, but also in the period of education. The relationship between the doctors and complying *subordination* should be considered as one of the most important requirements for the effective working conditions that allow to spine out health and emotional pose of all team members. The difference in the ages, competence and position can build a complex hierarchy of the relation between the colleagues, subordinates and managers, doctors and middle and junior medical staff (therefore the terms of partnership between the manager and his/her staff, doctors and nurses, the capacity for the mutual empathy - are very important). Their absence leads to negative consequences. The empathy must be understood not only as a way of notion of the emotional state of others, but also as the ability to correct the identified negative impacts.

The conditions for the *self-actualization* of each medical worker with use of principles of *humanistic approach* must constantly grow in the team, so that it will lead to the pleasure of contacts between team members and contribute to the personal growth of each individual.

Medical workers who are disrespect one to another; lose, in the first place, the trust of patients, because they see in it a possible type of future relationship with these doctors. Secondly, these contradictions lower the prestige of medicine in general. Thirdly, the overall work efficiency is reduced due to confrontation and lack of support. This leads to the stress of all employees, in addition it depletes them, contributes to the «burnout syndrome» and psychosomatic illnesses. A disrespectful attitude to the another thought during the meetings also can lead to medical errors. Therefore, for the most efficient work it is important that the needs of the each

member of the team must be fulfilled. It is important to destroy the hostile attitude of the microteam (departments, laboratories, etc.) as competitive in relation to other divisions.

Organization of periodic meetings, peer discussions of problems, interactive learning permits to reduce this confrontation. Interactions as «magician and his/her pupil» should not be persent in the team because the idealization of relationships does not permit to see or eliminate even the simple problems. That would not have happened, from the beginning of team formation, the relationships based on mutual respect and support of outside opinion on controversial issues should be built. The cases of mutual antipathy of some employees that even does not reach the degree of conflict, but does not assist to the productive work should not be ignored. The best way to avoid this semi - conscious confrontation - is to share such employees, because it is known that the feelings of antipathy decrease on the distance. So the communication atmosphere among the team members should be penetrated with *deontological principles,* ethics of medical worker.

Types of communication in the medical environment

Actually there are several types of communication in the team:

1. Interpersonal;
2. Individual and grouped;
3. Collective and individual.

Communicating is the process of establishment and development of contacts between people, caused by the needs of common activities and includes information sharing, developing common strategies interaction, perception and notion of others.

Communication is a mental aspect of social interaction, information share (including) among individuals.

Interaction is a co-operation between those who communicates, mutual influence on each other.

Interpersonal communication is a perception, understanding and evaluation of one person by another one.

Role is a concept of a meaningful human behavior in certain situations that correlate with certain states (for example: health worker may be in the role of a doctor or nurse).

Group has great influence on the individual in particular, which refers to a small association of people involved in a common action. Therefore, the dependence of psychology and behavior of the personality from the social environment has the displays just in the relations within the group.

Group is a part of system of social relations, reflected in the specifics of direct interpersonal contacts, development of these is mediated by the factor of social activity, leads to the choice by group of diverse socio-psychological characteristics (R.L. Krichevs'kij, Z.M. Dubovs'ka, 1991).

The group is separated from the simple clot of people by: (Taylor H.F., 1970):

1. Quite long duration of existence;
2. The presence of general purpose or purposes;
3. Interaction of members;
4. The presence of even rudimentary group structure;
5. Notion of the individuals who are the members of the group (or membership in the group) as a concept «we».

Signs of the group as a system of social and psychological interactions, are due to its structure and dynamic characteristics. Group structure is associated with the status of individuals who are its members.

Status (from Lat. Status state, rang) of the person in the group, his/her rights and obligations (including medical worker) are determined by the system of interpersonal interactions. Its leader and manager has the highest status in the group.

The group leader has the following features:

1. He/she determines the right decision in the situations that are meaningful for the group;
2. He/she plays a leading role in the organization of common activities and relationships;
3. Usually he/she comes forward as a candidate spontaneously;

4. He/she has not formal rights and responsibilities in the group;

5. He/she does not get the official sanctions of influence on the subordinates;

6. He/she is separated by the intra - group relations in the sphere of his/her activities;

7. He/she is not officially responsible for the state of affairs in the group.

Advancement in the leadership position is determined by contribution efficiency of group member in solving of special group tasks (including the medical issues), this is so called instrumental activity (Bales R.F., Sloter P.F., 1955).

The basis of manager influence can be specified by emotional or professional characteristics. Due to leadership the system of informal relations in the group is ordered.

The manager acts directly as a factor of organization of the official group structure.

The manager (including medical establishments) has the following differences from the other members of the team:

1. He/she is appointed officially;

2. He/she has the official authorities;

3. He/she has the sanctions of impact on subordinates;

4. He/she decides the outside formal questions of the group;

5. He/she is officially responsible for state of affairs in the group.

The main functions of manager are:

1. Organization of the subordinates and control for them;

2. Making decisions;

3. Official representation;

4. Educational function;

5. Expert and consultative functions.

Manager can act in the group in the role of as leader as authority at the same time or separately. The authority in the group can be as official person (official authority) as informal (real person) who is respected by others for his/her personal

qualities. Therefore, the position cannot ensure the authority; it must be wined and confirmed.

An integral part of interpersonal relations is the periodic occurrence of more or less significant conflicts. The most appropriate strategies of behavior in conflict situations were developed by K.U. Tomas and R.H. Kilmen. According to their opinion, the style of behavior in conflict situations is determined by the measure which the person aspires to satisfy own or others' interests, thus acting passively or actively, individually or together.

The efficiency of relationship between the patient and medical worker depends on the style of interpersonal communication. The motives and values of the doctor, his/her idea about ideal patient as well as the patient's expectations from diagnositic process, treatment, prevention, rehabilitation and behavior of the doctor or nurse, influence on such interactions.

There are the following *types of communication* (S.I. Samygin, L.D. Stoljarenko, V.D. Mendelevich):

1. *Masks contact* is the formal communication in the absence of desire to understand the personality features of interlocutor, the conventional masks (courtesy, politeness, modesty, compassion, etc.) are used – is a set of facial expressions, gestures, standard phrases, allowing to hide the real emotions. In the limits of diagnostic and therapeutic interaction such contact is shown in the cases of low interest of doctor or patient in the results of interaction. This event can occur, for example, during the obligatory preventive examination which the patient feels spoon fed in, and the doctor does not have necessary data for carrying the objective and comprehensive examination and making a reasonable conclusion.

2. *Primitive communication* is a kind of manipulative communication of doctor and patient, when, for example, the purpose of access to doctor becomes to receive any dividends (sick list, certificate, formal expert opinion, etc.). On the other hand, the formation of a primitive type of communication can occur after the doctor's desire – in cases when the patient is a man, from which the welfare of a doctor may

depend. In such situations, the interest to the participant of contact disappears immediately after the obtaining of the desired result.

3. Formally - role communication is the action when the content and the means of communication are regulated and instead of knowledge of interlocutor's personality they are limited by the knowledge of his/her social role. Such choice of type of communication on the doctor's side may be determined by the professional overloading (for example, at district doctor's visit).

4. *Business communication* is a dialogue that takes into account the personality, character, age, mood of interlocutor with the determination on the interests of affair, but not on the possible personal differences. Such kind of interaction becomes unequal during the communication between the doctor and patient. The doctor examines the patient's problems from the perspective of his/her own knowledge and he/she is prone to make decisions directively without the consent with the other participant of communication and the interested person.

5. *Spiritual interpersonal communication* happens rarely in the doctor patient system. It means the possibility for each participant of the conversation to discuss any topic during the conversation and tell about intimate problem. Diagnostic and therapeutic interaction does not provide such intimate contact because of the professional orientation of health care worker. It occurs in psychotherapy practice.

6. *Manipulative communication*, as well as the primitive is aimed at the receiving of profit from the interlocutor with use of special methods. There is a known method, called «hypochondrization of the patient «in medicine. Its idea is in supply of doctor's opinion about the health of patients in the way of apparent exaggeration of the severity of diagnosis. The purpose of such manipulation can be: a) the reduce of patient expectations of the successful treatment related with avoiding by health care worker of responsibility in case of unexpected deterioration of the patient's health b) demonstration of the necessity of additional qualified impacts from the side of medical worker with the aim to obtain compensation.

The expectations from interaction between doctor and patient are not always positive in the real situation. *Interpersonal conflicts* are possible that manifest

themselves in a big quantity of different options. Essence of the conflicts in the system of doctor (medical worker)-patient is in the collision of opinions, views, ideas, interests, points of view and expectations of interaction participants.

Thematic plan for self-control

1. The main reasons for choosing the profession of medical workers.

2. The value of professional orientation in choosing of the medical profession. Psychological features of professional development of doctor

3. Stages of professional development of doctor.

4. The term «medical duties» and «medical confidentiality».

5. Medical errors, their causes and types.

6. Psychological types of doctors.

7. The concept of «professional deformation».

8. Syndrome of emotional burnout of medical workers: risk factors, symptoms, prevention and correction.

9. Basic models of communication in the medical process.

10. Types of communication in the medical environment.

Section V. Psychology of treatment and diagnostic process

Psychological foundations of communication in the treatment process

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 as 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 specific features of information process between people as active subjects, that is with the account of the relations between the partners, their purposes, aims, intentions, which results in information transmission and enrichment of the knowledge, thoughts, ideas with which the communicants exchange. The means of the process of communication are different systems of signs, language, in particular, as well as non-verbal means: mimics, gestures, pantomimic, posture of the partners, paralinguistic systems (intonation, non - verbal elements of speech, e.g. pauses), the system of organization of the space and time of communication, eye contacts. A very

important feature of communicative process is intention of its participants to influence one another and to provide the ideal presentation in the partner with influencing the behavior of the partner (personalization). An important condition of this is not only the use of a uniform language but also similar understanding of the essence of the communicative situation.

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

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

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

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

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

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

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

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

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

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

Personal contacts are the form of human activity. The human being is surrounded not only by the world of objects, but also by people. He is connected with the both. These interrelations are established and develop through the work, training, that is through activity. Common activity is not possible without personal contacts and information exchange that is without communication. The main characteristics of communication as a sort of activity 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/her 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/herself.

The functions of communication

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

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

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

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

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

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

From the moment of the birth, the adults encourage the child to establish contacts. The need in communication develops in stages. The child uses different

means to attract the attention of the adults before starting speaking (cry, smile, gestures).

When the child is brought up properly, he/she gradually changes his/her mode of communication from aspiration to attract the attention of the adults to cooperation. At 2 months the child starts to smile in response to special interjections and words addressed to him, at 5-6 months he starts to babble. The first words are pronounced at approximately 1 year. With the development of speech, communication becomes more effective.

An important component of the appearance (in addition to anatomical features) 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 modern and smart. The fashion changes quickly that is why the person has to have his own style of clothes. The difference in clothes demonstrates generation gaps. The style of the clothes can underline the individual character of the person, to hide shortcomings and emphasize the advantages.

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

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

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

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

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

One of important characteristics of the personality is self-estimation, that is the ability to evaluate him and the attitude to the others. Self-estimation allows analyzing the actions. It depends on education and cultural level. If a person has no desire to self - estimation, he cannot understand the rest and form interrelations; show such qualities as tact, and delicacy.

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

Interrelations can become richer if the people acquire the skills of communication and observe the rules and principles of cultured communication.

Showing respect to a personal dignity and individuality of the personality allows improving the interrelations. «Treat the people as you would like to be treated» is the main rule of morals which should be the credo of any doctor.

The role of psychological characteristics of doctor and nurse, «ideal physician» and «ideal nurse»

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/her own knowledge. The doctor must be a person of high moral standards whose authority is established by profound knowledge in his/her field, a personal charm, modesty, optimism, honesty, truthfulness, justice, selflessness and humanism.

The patient loses his confidence and the medical worker loses his authority in the case when the patient gains the impression that the medical worker is a so-called «bad person». Such an impression may be created by the doctor's behavior if he/she 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 coziness 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 activit is displayed through the absence of such streaks as mercifulness, kindness, as well as through rudeness, a disgusted attitude towards the patients and malicious jokes.

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

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

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

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

In making contact with the patient, the first impression created by the doctor on him is important. It is also influenced by the general atmosphere of the medical institution and behavior of all its workers: auxiliary personnel, administrative staff, the nurse on reception and registration of the patient. During the first contact with the doctor the patient must gain the impression that the doctor wants to help him. The doctor is obliged to control himself to such an extent that all common norms of the social contact were observed. It means that he must personally introduce himself

to the patient, if the latter is not acquainted with him, and hold out his hand. Such behavior calms the patient, develops a feeling of safety in him and increases his consciousness of the personal dignity.

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

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

A psychological problem arises also in those cases when the doctor notices that his relations with the patient develop in an unfavorable direction. Then the doctor

should behave with restraint and patience, resist any provocations, do not provoke himself and try to gradually gain his patient's confidence with calmness and understanding.

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

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

1. Practical type, characterized by accuracy and strictness, sometimes forgetting the humane side of the patient. In a paradoxical form it may be sometimes manifested by the fact that she awakens a sleeping patient in order to give him some soporific.

2. Artistic type, characterized by affected behavior; without any sense of proportion, such a nurse tries to impress the patient and be pompous.

3. Nervous type; such a nurse is often tired, irritated and the patients do not feel calmness near her. She subconsciously tries to evade some duties; for example, out of apprehension to be infected.

4. Male type of the nurse, with a strong constitution: she is resolute, energetic, self-confident and consistent. The patients characterize her behavior as «military». In a favorable case, she becomes a good organizer and successfully trains young

nurses. In an unfavorable case, such nurses may be primitive, aggressive and despotic.

5. Maternal type of the nurse, a «sweet nurse», often with a pyknic constitution.

6. Nurses-specialists who work, e.g., on an electrocardiograph of 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.

Psychological characteristics of the stages of the diagnostic process. 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 behavior for the doctor and other medical workers conditioned by the specific character of their activity (care for other people's health, treatment, etc.) and position in the society.

Deontology (the science about the due) is the teaching of behavior principles of the medical personnel contributing to creation of the necessary psychoprophylactic and psychotherapeutic situation in the diagnostic and medical process excluding negative consequences (it is a part of the medical ethics). The

medical deontology and ethics also envisage a high level of training of the nurses, their accuracy and honesty in carrying out the doctor's administrations with regard for the age, individual peculiarities, disease and morbid state of the patients, tactfulness and a psychotherapeutic approach of the nurses and practical nurses in attending to the patients and work with their relatives.

The very atmosphere of the medical institution should dispose the patients to a frank and heart-to-heart talk, arouse their faith in recovery; as early as in the registry the patients should understand that everything at the polyclinic is directed to help them and alleviate their sufferings. It is necessary to calm the patient and give him the feeling of confidence. One should exclude any conditions of strictness and ostentatious business - like efficiency. Visual aids at the polyclinic (stands, posters) must not arouse any feelings of fear and alertness in the patients or remind them of their diseases. The polyclinic should be comfortable and clean, the rooms should be located proceeding from the patients' comfort.

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

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

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

Conflicts in the medical sphere

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:

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 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/her about it. It is enough for you that your problem knowledge is more thoroughly in comparison with his, and you know this. It happens

that for good it is necessary to tell to the partner he is not right, but in this case it is always necessary to do that in the presence of witnesses, insist on his public agreement of wrongness and confession. It is necessary to be firm as for the discussed problem, following the task requirements, as well as to be kind towards the partner on conversation. If you do not agree with idea, supposition, partner's decision, do not hurry to deny it at once. Think at first. First agree, and then say: «But maybe it is better to do ...» or «And there is one more understanding ...» With such an objection the partner is better to agree, because herewith he «does not lose his face».

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

One of conditions for prevention of conflict at hospital is a strict following of rules of deontology and subordination. E.g., at initial period of young doctor's 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.

Thematic plan for self-control

1. Psychological foundations of communication in the treatment process.

2. Communicative competence, its role in an effective and conflict free interaction.

3. The functions of communication: informational and communicative, regulatory and communicative, affective and communicative.

4. The role of psychological characteristics of doctor and nurse, «ideal physician» and «ideal nurse».

5. Psychological characteristics of the stages of the diagnostic process.

6. Informing the patient about diagnosis.

7. Interaction and communication of doctor with patients and their relatives.

8. Paternalism, its role in the diagnostic process.

9. Deontology of relationships with patients.

10.Conflicts in the medical sphere, their types, characteristics. Scheme of the conflict. Methods to resolve and prevent conflicts .

Section VI. Psychosomatic disorders

Psychosomatic approach in medical psychology and medicine. Psychosomatic approach as a principle of medical activities

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

Psychosomatics is the brunch 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 necessary. 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.

Theories of psychosomatic relationships

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 respiratory 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.

Emotional stress as a factor in the pathogenesis of psychosomatic disorders

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 features 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. hypertension, 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 plays 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.

Mechanisms of psychological protection of the individual

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 dozen 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* out 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 phenomenon when the person notices somebody's errors and faults and achieving forces out his own. In other experiments the subjects were given tests on 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/her anger to the members of the family (rationalization can frequently

take place). The person during an existing talk crumples a sheet 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/her 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 the persons. An example of it can 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. Hypochondriac 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» purposes 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 psychosomatic disorders

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

Essential hypertension. Main properties of the personality, prone to development of essential hypertension, are intrapersonal conflict, interpersonal strain between aggressive impulses on the one hand and feeling of dependence on the other hand. Development of hypertension is due to the wish to manifest hostility at a simultaneous need of passive and adaptive behavior. This conflict can be characterized as a conflict between contradictory personal 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 cam 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, the 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 injuring the mental state determine the increasing anxiety of the patients and fixation on the activity of the heart, which increases the belief in the presence of a serious heart disease and fear of death. At first increasing affective strain, anxiety and suspicion, fears as well as constitutional and developed peculiarities of the personality are the basis for development of acute cardiophobic attack. Vital unbearable fear experienced by the patients with cardiovascular disorders cannot be compared with the ordinary sensations in their intensity and character. Feeling of a close death is the only reality for the patient. The obvious fact that dozens of attacks did not cause infarction or cardiac failure does not mean anything. As it has long been known that it is dreadful to be dying not to die, the life of the patients which «died» several times is tragic. Especially important in this case is rational psychotherapy and suggestion. The life of the patient depends on their correct use and administration.

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

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

«release their anger to the air» and provoke attacks of suffocation. 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.

Thematic plan for self-control

1. Psychosomatic approach in Medical Psychology and medicine.
2. The biopsychosocial concept of disease.
3. Emotional stress as a factor in the pathogenesis of psychosomatic disorders.
4. Theories of psychosomatic relationships
5. Mechanisms of psychological protection of the individual
6. The concept of adaptation and malajustment.
7. Classification of psychosomatic disorders.
8. Classic psychosomatic disorders («Great Chicago Seven» by F Aleksander)
9. Non-pathological psychosomatic disorders.
10. Principles of prevention and treatment of psychosomatic disorden.

Section VII. Psychological characteristics of patients with various diseases

Psychological changes at diseases of the cardiovascular system

Psychosomatic component first of all is typical for next diseases of the cardiovascular system:

- Essential arterial hypertension
- Coronary heart disease
- Irregular heartbeat.
- Cardiac neurosis of fear

The heart and the vessels are involved in all forms of the life, although people do not understand it normally.

Pathological disturbances in the cardiovascular system are associated with fear, anger, rage anguish and other negative emotions. The formation of the adrenaline happening this time causes vasoconstriction, increasing of the heart rate and increased myocardial contraction, which, in turn, leads to the condition of the anxiety and fear.

If the prepared activation of blood circulation is not realized for a long time because of external delays or internal inhibition, violations associated with expectation of the action occur in some cases. There is also the opposite situation: an installation on the action that pushed out of consciousness leads to emotional stress that has an effect on the circulatory system.

The main role in the pathogenesis of cardiovascular diseases hostility plays (Barefoot et al., 1996; Barefoot et al., 1994; Benotsch et al., 1997; Siegman, Smith, 1994; Siegman et al., 1992) and the behavior of type A (Booth-Kewley, Friedman, 1987).

The value of neurogenic and psychogenic factors was noted in the development of ***heart attack*** and ***myocardial infarction*** since ancient times.

In psychosomatic medicine someone allocated «coronary type of the personality» (Danbar) or *type of the personality* A, that is included to the coronary

disease. For the people of this type the ambitiousness, aspiring to success, vulnerability, impatience, aggressiveness are typical; that are combined with an increase sense of responsibility and suppression of internal motives by controlling the emotions, that leads to the constant affective stress. These patients are characterized by anxious-agitated behavior that is accompanied by internal tension, fear and anxiety before a possible attack of the angina pectoris. Asthenic conditions, emotional lability and also hysterical and phobic reactions can arise in them.

There are several *stages* in the development of mental activity violations in myocardial infarction. In the *prodromal stage* there are some changes in mental activity, associated with the cerebral ischemia. Anxiety, foreboding danger, depression, euphoria appear in the emotional sphere sometimes. These disorders have a «signal value» (L. G. Ursova).

The main manifestation of an *acute period* is the painful syndrome that is often accompanied by a subconscious fear of death. In this state sick people lie motionless in the state of a certain detachment from the environment or they are observed by anxiety, motor restlessness, fussiness, confusion. There is some correlation between the infarct localization and the nature of mental activity changes. Fear of death, anxiety, depression is frequently observed for the infarction of the posterior myocardial wall. Euphoria, hyponosognosia or anosognosia are observed in most cases of the infarction of the anterior wall or in the combined myocardial lesions. Euphoria is always a sign of more severe lesions of the heart muscle and more profound mental disorders. During the first days after a heart attack some patients may be prevailed by apathy and weakness. Such signs may indicate about their development of the depression with a negative prognostic value. In the acute stage of this disease all patients complain about sleep disorders. appearing psychogenic experience in dreams, in the meaning of which we can often find psychological conflicts that hidden by the patients.

In *the subacute period* phenomenon of irritable weakness grow with the improvement of condition. At recovering patients have asthenic manifestations and also some behavioral disorders can occur. In some of them there is a hypochondriac

fixation on the past feelings and the attitude to a pain syndrome changes. If many patients did not give a lot of importance to the pain in the heart before the myocardial infarction, then after it even minor pain in the heart causes fear. These patients have a special treatment, strictly follow the doctor's prescriptions, limit themselves with responsibilities and acquaintances, focus all of their interests on the disease and become selfish. If these forms of behavior are fixed, a hypochondriac development of the personality arises.

Essential hypertension belongs to the typical psychosomatic diseases. The role of the psychological factors in the pathogenesis of an essential hypertension has been proven by as cardiologists (G. F. Lang, F. L. Mjasnikov, etc.) as well as psychiatrists and psychologists (A. Vol'f, F. Danberi, etc.) There was described such premorbid personality traits as anxiety, vindictiveness, isolation, vigilance, perseverance, frequent internal conflicts and constant emotional stress due to containment and suppression of emotions of the anger and the anxiety.

This disease is a psychic trauma for a number of individuals, which makes its course more difficult. At the same time, mental disorders associated with essential hypertension can lead to the difficulties in relationships with others and the conflicts that also cause its deterioration. Emotional reaction becomes inactive, a tendency to the «stuck» on unpleasant experiences appears which, in their turn, they create conditions for the high blood pressure. Thus, a vicious circle is being formed: mental violations lead to the systemic disorders that complicate and increase these mental violations.

Mental changes in essential hypertension are so various; they depend on the characteristics of the individual of the patient, the severity and the stage of disease. In the early stage of the development of disease, when the diagnosis has not made and the high blood pressure has not detected yet, there can be observed such asthenic symptoms as irritability, sleep disturbances, fatigue, headaches. Most of the patients perceive correctly their disease and belong adequately to the doctor's prescriptions and recommendations. Anxious persons perceive the high blood pressure as a tragedy, catastrophe, breaking of all their hopes and life plans, especially if they had

already have an idea about the hypertension. Depressed. anxious fears for their health, fixation on the health are observed in these patients. Another group of the patients denies the fact of illness, refuses the treatment or carries out it irregularly. Such attitude is more common for people with low intellect and for those who abuse alcohol.

Against the background of complex of asthenic symptoms there can occur other neurotic disorders, the most common of which are obsessive and hysterical, often associated with hypochondriac symptoms. In addition, essential hypertension promotes the aggravation of premorbid traits and the appearance of pronounced pathocharacteristic disorders, often excitable type, that leads to the maladjustment.

With the progression of essential hypertension psycho - organic disorders are increasing, which are expressed in exhausting, fatigue, cowardice, impaired memory, mood swings.

Psychological changes at diseases of the bronchi and lungs

Bronchial asthma is the most famous psychosomatic disease. Most researches consider that trauma and emotional stress have the certain value in asthma occurrence. Thus, among the factors that are important in its development, 30 % belongs to psychological factors, 40 % - to infections and 30 % - to allergies.

An acute or prolonged (chronic) psychological trauma can be the starting factor as in the presence of somatic predisposition (heredity, allergies, chronic respiratory tract infections), so well in its absence. It is shown that not alone life events, how severe they are not, but the active avoidance of these events discussion, the desire to tone down the hard efforts of experience are the factors of deteriorating of the physical condition. The aggravation of the disease happens usually, as a rule, when it is necessary to show courage, responsibility, independence or to be able to endure sadness, loneliness, when there is a danger of losing the object of affection.

When bronchial asthma occurs then the leading emotional state is a pathological anxiety (consistently elevated level of individual anxiety). There is a partial unconscious displacement of the disturbing material, but some part of anxiety

can be detected. However, the forced out part maybe create a constant tension that is similar to the chronic uncontrolled stress with the relevant changes in noradrenergic neurotransmitter system that leads to some changes in the immune system and, as a result, to the development of bronchial asthma.

Psychology and behavior of patients with asthma are largely determined by personal reactions to the disease, which are manifested as hyper- or hyponosognosia. Neurosis-like disorders in asthma appear in the form of patient's reactions to the attack or in the features of subjective experience of illness.

The expressiveness of disorders in most cases is caused by the severity and the suddenness of an attack. With a sudden acute attack fear of death from asphyxiation or heart failure, fear of attack that can not be stopped often appear (Kostjunina Z. G., 1971). The patient focuses on his/her breathing. During the attack he/she is not available for a productive contact, he/she keeps themselves aloof. So rare, but severe asthma attacks are accompanied by stronger manifestations of fear that happen not only during the attack, but also in the waiting of it. Short mild asthma attacks are not associated with the most common triggers (mental factors, allergens, etc.) which are removed easily by the asthma inhalation drugs, but, conversely, are often accompanied by the hyponosognostic reactions.

With further chronic course of disease and the need for long-term treatment, including a somatic hospital, many patients can focus their attention on their feelings and experience with the formation of anxiety-phobic and depressive reactions. An expressed fear concerns not only the possible attack, but their health in general, their subsequent destiny. Patients are fixed on their own breathing, analyze constantly their feelings. In some of them there are fears not only before the asthma attacks, but other hypochondriac fears, such as «for heart», neurotic expectation of repeated attacks. Chronic asthma is characterized by increasing tendency of patients to self-isolation. Rarely there are various hysteric-formed disorders, which are usually associated with sensor-motor and autonomic paroxysms without the expressed hysterical behavior. After the attack of the disease there may be lowered mood,

moodiness, irritability, increased excitability, fatigue, mood instability, tearfulness, sometimes hysterical disorders, anxiety.

Psychological changes at diseases of the digestive tract

Gastroduodenal ulcer is related to the classical psychosomatic disorders. There are many hypotheses of etiopathogenetic relationships and interactions of mental and physical factors at ulcer disease.

The picture of personality

There is the following division in the typology of patients with gastroduodenal ulcer (Overback, Biebl, 1975):

1. *Mental healthy patient with ulcer*. Persons with good function of «I am» and with the substainable object relationships, or with non-specific or specific (coming from the sphere of oral experiences) workload, with a strong regression «I am» , with over somatic process and with the certain predisposition to diseases of the stomach fall ill with ulcer as a single psychosomatic reactions.

2. *Patients with ulcer that have neurosis of character*, formation of pseudo independent reactions or the obsessive-depressive traits, oral conflicts which are visible for surrounding (for example, the leader which extends around himself/herself an aggressive tension).

3. *Sociopathic patients with ulcer*. These passive-dependent patients with a weak poor mind of «I am» and with an excessive dependence from objects are predisposed to the break of instincts. These patients can also have paranoid-litigious type of the behavior which show outwardly their oral conflicts as in «antisocial patients» (for example, alcoholics or neurotics with ulcer) and which fall ill even at small external failure in love or referring to themselves. Their disease of gastrointestinal tract is clear, as an appropriate modus organ to their mental needs or as physiological correlates.

4. *Psychosomatic patients with ulcer*. These are vague individuals with poor imagination that is seem by peculiarly rigid and mechanical lifestyle and object

relationships, that are subjected the feeling of utter emptiness of relations. They are prone to see only themselves in the state of surrounding, but they usually respond psychosomatic at specific loads and crises (often due to the loss of object). Often other psychosomatic disorders are observed along with the ulcer such as fever, cardiac symptoms, rheumatic fever, etc. In addition, accidents and surgery interventions are often stated in these patients.

5. *«Normopathic» patient with ulcer*, who focuses overly on «normality» treatment, who is adaptive and with the expressive limitations of «I am» on the basics of tendencies to deny (for example, the reality of his own exhausting). As workers or clerks that often work part-time in addition, they are in the state of chronic stressful overload, which destroys them, against what the symptoms of the peptic ulcer often suddenly appear.

The founder of psychosomatic medicine F. Aleksander pointed out that the basic conflict between the desire for autonomy, independence and rooted need from childhood to protect, support and care took part in the formation of gastric ulcers. He explained it this way: dissatisfaction of the desire to be loved becomes the desire to be fed, so the stomach reacts with increased motility and hypersecretion as before feeding and that, in fact, is the development of cell destruction. Chronic frustration with the obvious need in depending forms the distinctive unconscious conflict. The latest one turns into the intense oral-receptive need from the depending, caring, that cause chronic unconscious regressive «hunger», or an anger. This reaction is manifested by the physiologically stable vagal hyperactivity which leads to the hypersecretion of gastric juice and causes the development of ulcers. V. I. Simanenko identifies passive-heteronomous type of personality in patients with gastroduodenal ulcer, which is characterized by the dominance of motivational tendencies «fear of failure», predisposition to addiction and conformity. An unconscious fear of being abandoned is in the foreground in the passive type and it leads to the constant stress. These patients resort to the passive defense mechanisms - repression, regression in situations that require responsibility and independence. The second personality type, called active-autonomous with its motivational and

behavioral focus on «success» is less common among patients with this disease. The desire of independence is very strong in hyperactive types, but it is denied by the patient. Usually they actively try to overcome difficulties and negative experiences using coping strategies, psychological defense of the objection or aggression types, accusation others in the occurrence of their problems (in this the feeling of guilt is displaced).

M.V. Korkina and V.V. Marilov studied premorbid features of patients with peptic ulcer disease, for which an increased anxiety, vulnerability, susceptibility to dreary reactions, vulnerability, helplessness in critical situations, insecurity, inability to verbalize their concerns, the need for protection and social support, reduced communicativity (introvertion) and self - esteem are characteristic. Along with external restraint, dedication, balance, that are observed before the disease, these patients have rigidity, straightness, formal understanding of duty. When conflicts happen, they often have reactions of anger, irritation, than anxiety concern.

A.I. Zhigulina, V.A. Lipatov found that such traits of character as high communicability, pedantry, demonstrativeness, irritability, volatility of character in patients with peptic ulcer disease are relatively stable their characteristics and with increasing duration of ulcer history they practically do not change. Vulnerability, emotionality, anxiety, which are considered as premorbid personality traits, may increase in patients with peptic ulcer disease with increasing of history of ulcer and be characterized as manifestations of the disease.

Mental disorders are expressed as anxiety, panic, anxious depression with symptoms of motor excitation at the acute peptic ulcer with distinct pain syndrome (prediagnostic phase). At this time, an excessive irritability is often manifested itself in elements of brutality against the closest relatives. On the background of a pain syndrome patients often construct the scheme of their heavy or perhaps fatal disease. In the first period patients experience a distress condition, that is accompanied by massive vegetative-vascular disorders (high blood pressure, acceleration or deceleration pulse, cold sweat). The fear of possible death is accompanied by expressive neurotic (hysterical) symptoms (clod in the throat, numbness, whisper

speech, sobbing, farewell to relatives). However, hysterical symptoms change acutelly in patients after doctor's persuasion that he/she has «only an ulcer».

Over time, the «sudden» fear of death is disupdated in patients. Anxiety still dominates in the psychical state and there is depression without acute motor component. There may be formed unstable cancer-phobic experiences, the existence of which is supported by the presence of pain syndrome, as well as the stories of other about the possibility of transformation the ulcer into the malignant tumor.

In general, *the acute phase* of mental disorders ends by forming more or less stable depressive background often with episodes of dysphoria. Mental disorders in the acute period are limited by primarily psychogenic disorders.

Subacute beginning of the peptic ulcer. The leading factors in the clinical picture are the various asthenic symptoms, mainly hypersthenic type. Patients complain on irritability, weakness, decreased performance, fatigue, excessive sweating, shortness of breath, aching pain in the stomach, as well as frequent headaches, decreased libido and potency, poor sleep or insomnia. They have constantly the decreased mood, although the full depressive triad is not found. In the future obsessive fears of possible transformation ulcer into the cancer can appear. In this affective disorders amplified significantly (depression, often with elements of agitation, situational and «free floating anxiety, the fear of death»).

Some patients have hypochondriac fixation on the gastrointestinal tract. Patients switch to a healthy lifestyle but if their demands are not satisfied they give the dysphoric reactions. Frequently these psychopathic reactions become generators of pathocharacteristic personality development.

Thus, at the beginning of subacute ulcerative process we can mark the set of psychogenic, neurotic and psychopathic disorders.

At gastroduodenal ulcer in cases of their slow start and sluggish flow mental disorders are usually limited by somatogenic asthenia.

When peptic ulcer disease is severe and there are occurrence of bleeding, weight loss, pain, disability then reactive state of anxiety, despair, sometimes with suicidal thoughts, may appear. In this state hysterical reactions are rare. If these

reactions are, they are characterized by sensor-motor and autonomic disorders (as sweating, jerking, clod in the throat, etc.).

Somatonosognosia at the ulcer depends on the severity of clinical manifestations. Severity of pain, progressive weight loss contributes to the appearance of phobic (often phobia of cancer) or hypochondriac (obsessive or overvalued) disorders. However, the weak severity of clinical signs may cause the appearance of «hyposomatonosognosia».

The need of a surgical intervention can occur suddenly. In this regard, an emotional reaction to anxiety and disquiet appear in the patient. The psychic of a patient is injured by as the inevitability of the operation as circumstances that surround it: necessity to take quick decisions, type of hospitals, doctors, frightened relatives. Conversations with other patients, the news of the fatalities during the operation can not only cause the patient's fear, but also have an adverse effect on the outcome of the operation.

Psychoses of the postoperative period in the patient with ulcer are rare and they are situationally somatogenic by origin. Disturbances of consciousness can be observed at severe intoxication and somatic exhaustion.

The syndrome of the «irritable bowel». In recent years, the syndrome of the irritable bowel got a wide distribution, which is a complicated psychosomatic complex. This syndrome is manifested by the violation of the motor function of the colon and the pain that occurs at the background of urges to defecation and which disappears after the defecation. Among the mental disorders that accompany this syndrome the most characteristic of them are neurotic state as an obsessive fears (the fear of incontinence of gases and the urge to the defecation in public places) and neurotic depression or hypochondriac disorders, that occur with severe painful and autonomic disorders (weakness, fatigue, irritability, dizziness, headache, tremor, pain in the back, sleep disturbances). The feature of the syndrome of irritable bowel is an excessive fixation of the patients on the «pathological processes» in the gastrointestinal tract. A dissatisfaction in the negative results of studies, anxiety about their health led to the attempts to make themselves a diagnosis independently

and to treat themselves. All of it is based on experiences and information gleaned from the popular and professional literature. Hypochondriac neurotic personality development, that is manifested by disturbing patient fixation on its existing disorders and causing often turn to different specialists, does not lead to severe maladaptation. The hypochondriac development by the type of overvalued hypochondria which is manifested in insistence to numerous tests and treatments in combination with distrust of doctors, helps to limit the behavior of the patients and causes their maladaptation. There is often a connection with fears in the situation that is caused by the disease: before an exam, at misunderstandings with teachers, managers or parents.

Premorbid personality traits of these patients are presented by features of rigidity, rigor, exaggerated tendency to the order, which are combined with the tendency to anxiety reactions at the forced changes in the established way of life. These people control all expressions of feelings. They look outside cheerful, arranged and hide their fears skillfully. In most cases, a feeling of the fear is supplanted from the consciousness and it manifests isolated at the somatic sphere.

Ulcerative colitis. In the premorbid stage of the persons, which are suffering from the ulcerative colitis, there are described the soft with severe «feelings of inferiority» in the life situations, that requires decisive actions (Aleksander F., 1950). V.P. Belov often showed an irritability, anxiety and decreased active attention in his studies of the patients with ulcerate colitis. According to V. Belov, the most characteristic form of mental disorders in the ulcerative colitis is a mental fatigue, but along with that these patients have such following features as «mercantile practicality that is covered by the modesty»; sentimentality together with anger; the desire to highlight their hard work. In the mild cases there are anxiety, perplexity and confusion sometimes; in the severe cases there is an expressed apathetic depression. Patients are in the formally clear consciousness, but completely they are indifferent to others, they are dull, their sadness is combined with the hopelessness. According to B.A. Celibeev, this depression is always somatogenic, but the reactive aspects play an important role even. It was established that the severity of depression

correlates with the severity of colitis clinic. Pain, bleeding, physical exhaustion contribute to fixation of patients in their health, increasing anxiety, lethargy, dullness, a sense of hopelessness. Hornsby notes the presence of «obsessive-compulsive nature with the watchful affectiveness and covered infantilism» in adult patients with the ulcerate colitis. Children suffering from ulcerative colitis are named as «little adults with dominant and emotionally cold mother». Diseases of the liver and biliary tract, as a rule, are accompanied by asthenic symptoms, which may be the first manifestations of the disease. Severe physical weakness, lethargy, weakness are present since early morning. Also, there are often typical sleep disturbances, daytime sleepiness and insomnia at night. Expression of asthenic symptoms, decreased performance lead to the fixation of attention on their health, depressed mood. Most often the type of affective disorders with constant dissatisfaction, grumbling, and sometimes violent manifestations of anger is celebrated. Due to the long course of the disease and its associated constraints patients often have psychopathic disorders in hysteron-excitant type. Patients are overly sensitive, moody, they demand greater attention to themselves and they are prone to explosive reactions. With an increasing of cirrhotic changes with the hepatic impairment and due to the chronic intoxication, manifestations of the psycho-organic syndrome become the leading ones in the clinic of mental disorders. The patients are often associated with indifferent to their health, dismissive attitude to the mode and their treatment and sometimes all of it turn into the complacency. This type of response to the disease (hyponosognostic) is particularly typical for patients with the alcoholic cirrhosis and who also have alcoholic changes of the personality («gallows humidity»).

Psychological changes at patients with infectious diseases

The result of infectious diseases is an interaction of microorganisms with the body. The severity and the nature of an infectious disease depend on the characteristics of the causative agent on one side, and the state of the human body

defenses on the other, that they are caused by the interaction of the pathogen, its virulence and the resistance of an organism.

Patient's behavior and mental disorders are associated with features of the infection. Today virus hepatitis, tuberculosis and AIDS are the most common infectious diseases that cause mental disorders and psychological changes of the personality of patients. Then we will focus on them in more detail.

The largest part of hospitalized patients into the infection hospital is the patients with virus hepatitis. Despite the tendency about increasing the proportion of patients with virus hepatitis, which are treated ambulatory, virus hepatitis often requires stationary treatment both of clinical and epidemiological considerations.

Taking into account that the majority of patients with viral hepatitis are young persons, light forms of the disease often prevail and a restoration of the heals usually precedes to clinical recovery, so there is a specificity of the psychological difficulties, with which a doctor have to deal in the treatment of these patients more often. In the clinical practice often there are variants of inadequate attitude of the patients to their disease and their treatment. The most frequently such variants of hyponosognosia are diagnosed, in which there is a rejection to the treatment and staying in hospital. There are also hypernosognostic variants of the attitude to the disease (hypochondriac, obsessive-phobic, neurasthenic, paranoiac, etc.) In any case if the patient's perception of the situation, which is connected with the disease, is not the reality then there will be a threat of understanding between the doctor and the patient and, ultimately, it will affects negatively to the completeness of the treatment and will increase the risk of the development of complications and adverse effects. The formation of inadequate «settings» about their disease and the formation of pathological behavior reactions are influenced by several factors. The most important of them are the owned personal factors (cognitive, motivational and psychological factors). The lack of basic knowledge about their disease and possible complications can be included to the cognitive factors. Some patients have no idea about the need for a strict diet, limited physical activities, but the doctor often can deal with the difficulties in an assigning of the certain drug because the patient has

a misconception about the side effects of the product and he refuses to take it. Often patients motivate their attitude to the disease and treatment by the references to the experience of their friends, which are also sick with the virus hepatitis. The most common factors, which are harmful for the treatment, are family problems, the solution of which is not compatible with the continuation of a treatment, according to the patient's mind.

Certain personality characteristics of the patient should be referred to their own psychological factors, such as suspicion, distrust, stiffness, lightness, conflict, which complicate also the providing of effective treatment for patients with virus hepatitis.

These factors certainly exist in close relationship that requires a differentiated approach to the treatment of individual patients and an establishing of the leading reason of negative patients ' attitude to the treatment. However, in all cases it is necessary to establish good relations with the patient, to determine his personal characteristics, social and psychological status. Each patient with viral hepatitis needs the providing of the comprehensive information on his disease, the explaining of the necessity of taking a particular drug, and the need of staying in hospital.

Tuberculosis is an infectious disease caused by several varieties of Mycobacterium. Every year 9 million persons are sick by tuberculosis worldwide and 3 millions of them die from its complications. 75 % of TB patients are people 20-40 years old, and they have the working and childbearing ages. At the stages of TB, mental disorders are manifested by an increased sensitivity and irritability, decreased performance, mood instability, phobias, depression which moves in euphoria at the later stage of TB. There are also weakening of memory and intellect, occasional hallucinations, susceptibility to the reasoning, pathological isolation. There are such hypochondriac disorders as a fixing of the patients on their physical functions, a greater tendency to the retreat in a disease, a predisposition to hysterical reactions under stress, which have the prominent place in the psychological picture of TB. Different versions of inadequate attitude of patients to their disease and the treatment are quite common. There are neurotic reactions, a tendency to exaggerate the severity of the disease, a fear of its «taint» in these patients. But the reverse

picture is more common – an underestimation of the danger of the disease, a refusal of treatment and staying in hospital. Harmonic and euphoric types of the reaction are the most common in the physician's practice in the working with TB patients.

TB disease and hospitalization reduce dramatically the quality of the life of patients. An analysis of factors of reducing the quality of life in these patients shows, that the main ones are the need to limit physical efforts, the need to be treated, the reducing of an activity in daily life and constraints in contacts with friends and family. The manifestations of social disadaptation as antisocial tendencies, the disregard of accepted norms are often found in these patients. In any case, if the patient's perception of the situation, that is connected with the disease, is not real, there will be a threat of mutual understanding between the doctor and patient, that, ultimately, will affect negative on the completeness of the treatment and will increase the risk of complications and adverse effects.

Etiopathogenesis of mental disorders in AIDS has mainly two mechanisms of the development:

- «Nosogenic» one that is associated with the stressful state after the news about a presence of an incurable disease.
- «Somatogenic» one that results from the growing of an intoxication and from the severe lesions in the brain tissues and, especially, nerve cells.

Mental disorders in AIDS are so various and they almost include all kinds of psychopathology from neurotic reactions to severe organic damages of the brain. Mental disorders occur in patients both with AIDS and seropositive carriers of the virus, which are in the risk factor, but this does not always indicate about the presence of a disease in this person.

Risk groups are consist of people having seropositive reaction to AIDS but without any signs of this disease, and persons without seropositive reaction to AIDS but which have a particular lifestyle (homosexuals, drug addicts, bisexual, those who lead an unordered way of sexuality).

Mental disorders of individuals from risk group are primarily psychogenic disorders with neurotic symptoms or neurosis-like symptoms that sometimes come

into psychotic character. There are anxiety, restlessness, irritability, insomnia, loss of appetite, sometimes with very severe weight loss. Decreased performance with violation of active consideration, sometimes full focus on concerns about AIDS are characteristic. Also typical signs are a constant re-read of the literature about the disease, the endless search of certain symptoms, the hypochondriac fixation on the own condition. An initiative is significantly reduced; there is a sense of hopelessness, decreased libido. These disorders are more peculiar for seropositive carriers of AIDS.

However, the part of people at risk (especially among seropositive ones) reveals the frank antisocial tendencies, trying to expand their sexual relations as much as possible or to transfer AIDS the other way. There are also common such typical reactions as apathetic, anxious, sad depression with frequent ideas of self-incriminations (below the degree of a delirium) and suicidal thoughts, although these suicidal attempts are rare in the persons of at risk group. Sometimes a depression becomes the psychotic character with an agitation.

Individuals of at risk group often describe the emergency of psychosomatic diseases, in which the first place is a diverse pathology on the gastrointestinal tract.

The virus of AIDS with lymphatic and neurotropic properties and with the ability to infect directly the cells of the central nervous system can cause mental disorders before the first signs of decreased immunity of the patient.

Apathy, sleep disturbance, deterioration of performance, depressed mood, reducing social circle can be present in many patients of AIDS for several months and sometimes even years before the manifestation of the disease. However, at this stage mental disorders are often manifested in the subclinical level. All of these mental disorders become clinically well - defined and visible, when such severe clinical manifestations of the disease as fever, profuse night sweating, diarrhea, pneumonia have arisen. The fact of the AIDS presence is regarded as a manifestation of an expressed psychological stress with the domination of both psychotic and neurotic mental disorders on the early stages of the disease. This period is also characterized by obsessive-compulsive disorders, which arise at the same time with

depression or isolation. There is often compulsive fear of death, obsessive ideas about the process of dying, memories of sexual partners, which could cause the infection. Some patients are very concerned by the idea (which can have often an obsessive nature) about the possibility of infection the relatives or friends by household way, although these patients understand about the absurdity of this idea. Despite the predominantly psychogenic nature of mental disorders during the realization of the disease, at this stage organic symptoms «sound» clearly; there are dysphoria, psychopathic forms of the behavior with explosiveness, anger, aggressiveness and epileptiform attacks. Sometimes anxiety, which occurs in people in the diagnostic of AIDS, is accompanied with agitation, panic, anorexia, insomnia, feelings of hopelessness and anger, which are often directed at doctors. Later, when the disease is progressing, symptoms of the organic brain damage become more pronounced. The physician, which works with mentally «difficult patients» with infectious diseases, should remember, at first, that the patient's inadequate behavior is provided by the degree of perception of the illness, the attitude to this illness and personality traits of the patient. So the doctor does not show an aversion to these patients, but, conversely, he/she have to relate to them with understanding and support.

Psychological characteristics of the patients in endocrinology

Today, there is no doubt, that there are various mental disorders of different levels of the reaction in many endocrine diseases. These diseases are results of response to the impact of etiologically significant factor, or it is a result of acute metabolic disorders, or it may be a manifestation of the disease and a need of the treatment.

M. Blejler (1948-1954) identified the symptoms, in *a non-specific psychosyndrome,* which are common to all. This syndrome is characterized by such symptoms as change of trains, distortion instincts, emotional disturbances. However, personality changes are not as deep as in mental diseases and there are no primary-intellectual disorders. Today acute exogenous reactions, which are caused by

endocrine disorders, and psychoses, which are caused by the endocrine pathology, which debuted in an early childhood, are not belonged to the endocrine psychosyndrome.

Asthenic syndrome is the leading one in all endocrine disorders. However, along with non-specific features of the endocrine psychosyndrome and characteristic dynamics in general, there are some patterns of the development and the course of mental disorders for each disease.

One of the most severe endocrine abnormalities is **diabetes mellitus**. The role of mental parameter (stress) in the occurrence of diabetes has been already proved. Results of the recent studies show, that often there are a number of psychological problems and mental disorders in persons suffering from diabetes. Such violations not only cause suffering, but also these affect the treatment and the result of diabetes. *Frustration, loneliness and depression* are the significant psychological factors, which contribute to the development of diabetes. However, there may be the cases of the diabetes in health persons after an acute psychotrauma. By the other side, most physicians consider that an acute emotional trauma or prolonged psychological stress can only detect the latent diabetes by the moving of it into clinical condition.

In the pathogenesis of psychiatric disorders in diabetes such factors have a great importance:

- primary disorders of the nervous system (brain hypoxia in cerebral vascular lesions, hypoglycemia, intoxication as a result of kidney and liver damages, immediate impression brain tissue);
- social-psychological factors (decreased performance, daily injections, lower sexual function);
- premorbid personality traits;
- unfavorable external influences in the form of overstraining and mental disturbances, the impact of long - term drug treatment;
- impact of the desynchronosis on the patient's psyche (discrepancy between individual biological rhythm of insulin secretion and its exogenous introduction).

The type of diabetes, its duration and the extent of weight also affect on the formation of mental disorders, but beginning of the disease in childhood or adolescence and long course of the disease (more than 8-9 years) create some preconditions for the pathological development of the patient's personality.

Asthenic-depressive, hysteric-formed syndromes and hysterical variant of the personality development are usually present in diabetes of type 1 (insulin dependent one), but asthenic and asthenic - hypochondriac syndromes and obsessive, explosive and psychosomatic variants of the pathological personality development are often present in diabetes of type 2 (insulin - independent one). Patients with diabetes are chronically ill people which can difficult react to the disease and treatment. These reactions these reactions may be caused by an awareness of the chronic illness with acute or prolonged complications and the need for a self-treatment. The diagnosis is a shock for many patients, especially children and adolescents, as well as for their families. The result of it can be depressions, disorders of the self-esteem and the development delay of self-identification. Diabetes is associated with a number of acute and long-term complications. Hypo - and hyperglycemia are severe metabolic disorders that can be a source of not only primary (physical) complications, but also secondary (mental) ones (e.g., fear of hypoglycemia). Prolonged unfavorable metabolic disorders can lead to the severe injuries of nerves, minor or major blood vessels (macro- and microangiopathy, neuropathy). Patients usually know about the possibility of such severe complications as blindness, kidney lesion with the need of dialysis, amputation of the legs. The fear of such probable complications is the most severe and frequent mental burden of these patients. Along with the disease and its complications, another source of emotional overloads is an awareness of the need of restricting the whole life, which is subordinated to the requirements of self-treatment.

Patients with diabetes have the particular personality structure which differentiates them from the patients with other chronic diseases and from healthy people. They are characterized by such traits as self-absorption, irritability, moodiness, incontinence, anxiety, stubbornness, arrogance, addiction, some

intellectual inflexibility and a tendency to «get stuck» on various emotional conflicts.

In addition, many scientists noted, that children, who had being suffered from diabetes, had differed by high integrity, seriousness, lack of child serenity before start of the disease. They are often observed by the violations of contacts with adults and the conflicts with relatives. There is also a difference in personality profile based on the gender: males are characterized by hypochondria, depression and the need in external input; women – by self-isolation, the stiffness of behavior and thinking.

Asthenic syndrome, which is found in almost all patients with diabetes, is characterized by increased fatigue, decreased ability to work, sleep disorders, headaches, emotional lability, irritability and exhausted nervous processes, weakening of attention, memory loss, increase the lability of the autonomic nervous system, cowardice, crossness and more. Mental disorders are most pronounced during the prolonged disease course with hyper- and hypoglycemic states in the history. Repeated comas contribute to the development of acute and chronic encephalopathies with the growing of intellectual and memory disorders and epileptiformed displays. The most common reactions to disease in diabetes are harmonious, anosognostic, «ergopatios», anxiety-phobic, neurasthenic and asthenic-hypochondriac types. It is interesting, that if the duration of the illness is more than 5 years then the decrease of experiences to this disease will be observed. but the focus of personal characteristics will not be changed.

Psychological and psychiatric disorders are often found in the clinical picture of **hyperthyroidism.** So this gave a reason to distinguish the nerve form (neuro-psychological, neuro-vegetative) of hyperthyroidism. Disorders of an emotional sphere of these patients appear to the fore. There is the heightened affective lability. This is associated with the «incontinence passion» – from cowardice and tearfulness to severe affective predisposition to the violent outbursts and rages. Lability of the mood is accompanied by a constant inner tension, restlessness, anxiety. Externally it is manifested by excessive vitality, increased excitability, irritability, crossness, sometimes unproductive physical activity. Patients can perform inconsistent and

unwarranted actions. It should be emphasized that patients often do not notice changes in their personalities and fix attention on the changes in the external world: everything around them is seemed as unstable, volatile and unusually fussy. Also there is often a significant representation of hysterical manifestations in the form of egocentrism, ambitions, high aspirations, and so on among the personality traits.

Mental disorders in case of **hypothyroidism** are very important in the clinical picture of the disease; it determines largely its specificity. At the beginning of this disease and in the case of relatively mild cases, there may be only a mental flabbiness. Deep dementia develops in the case of the most severe disease development. Manifestations of such nonspecific endocrine syndromes as psychopathic one and disorders of memory and passion are closely intertwined in the clinical picture of mental disorders in myxedema. Disorders of memory and intelligence (violations of the organic type) are manifested more in the case of myxedema, than in the case of all other endocrine diseases. These disorders often lead to the development of the pronounced dementia. In the case of the severe myxedema of adults the most common mental disorders are loss of memory, slowness of thinking and speech, perseveration, loss of acquired skills, abilities and interests, a decline in intellectual and motor activity. lethargy and increased fatigue. The behavior of such patients becomes even more peculiar because of the deaf, which characterizes this disease. In milder cases there are only slowness of speech and thinking, aspontaneity, fatigue. Then these patients may be seemed more mentally retarded than it actually is because of the retardation and the characteristic facial changes (little swelling). While the memory of the patients is reducing progressively it is difficult to focus on anything, they have understood their disease, have betrayed many somatic complaints and have often described their own feelings yet

Psychological changes in female patients in gynecological hospital

Clinicians identify two critical biological periods in the women's life: puberty with the first menstruation and ability of childbearing (it means the transition from the childhood to the maturity) and menopause which is characterized by the fading of an ability of childbearing and menstrual function, and then it marks about the onset of old age.

Premenstrual syndrome (PMS) can be regarded as a functional disorder of the central nervous system as a result of unfavorable external factors on the background of congenital or acquired lability of the hypothalamic - pituitary - ovarian system, which is characterized by different psycho - emotional, vegetative - vascular and metabolic - endocrine disorders.

PMS frequency is ranged from 25 % to 90 %. In the study of age - grading of PMS scientists have found, that this condition occurs in 20 % of women aged 19-29 years, 47 % of women aged 30-39 years and 50 % of women aged 40 years suffer regular from PMS.

On the basis of the current literature, there are the following risk factors for PMS:

- Caucasian race
- Accommodation in large industrial and administrative centers
- Intellectual work
- Late reproductive age, manifestations of PMS displays in the first generation
- Frequent stressful situations
- Frequent pregnancies or its absences
- Abortions and/or abortions in the anamnesis
- Toxicosis of pregnant women and/or postnatal depression in the anamnesis, receiving of the combined oral contraceptives
- Inflammatory diseases of the genital or gynecological operations in the anamnesis, genital candidiasis

- Traumatic brain injuries or neuroinfections in the anamnesis
- Neuro - endocrine diseases, especially obesity
- Hypodynamia
- Unbalanced diet (lack of calcium, potassium, microelements, vitamins B and C, polyunsaturated fat acids, antioxidants in the diet).

Today, several theories of the genesis of this disease are reviewed: hormonal and allergic ones, the theory of «water intoxication» and others. Scientists, which made a theory of psychosomatic disorders which lead to the PMS development, consider, that somatic factors have the main role, and psychological ones are the result of biochemical changes that occur as a result of hormonal changes.

In the domestic literature there is a classification of N. M. Kuznecova for an assessing the severity of PMS. The number of symptoms, their duration and intensity are considered in this classification:

- *mild form of PMS* – an emergency of 3-4 symptoms for 2-10 days before the start of regulus with significant severity of 1-2 of them; asthenic and asthenic-depressive syndromes with the presence of full critically to the state.

- *severe form of PMS* an emergency of 5-12 symptoms for 3-14 days before the menstruation with significant severity of 2-5 of them; there is some reduction of the critics. Large cohesion of symptoms with the personalities of patients, the relative frequency of hysterical and hypochondriac complains.

According to this classification *three stages* of PMS are distinguished:

1) compensated stage – PMS symptoms do not progress, these symptom appear in the second phase of the menstrual cycle and disappear with the onset of menstruation;

2) subcompensated stage – severity of the disease become worse over time, and PMS symptoms disappear only with the termination of menstruation;

3) decompensated stage – PMS signs last for several days after menstruation.

There are about 150 different symptoms of PMS that exist in different combinations. They were classified on next *symptom complexes* that were united depending on the function of the organism that was damaged:

- psycho-emotional disorders: emotional lability, irritability, excitation, aggressiveness, hypochondriac thoughts, vindictiveness, increased demands to others, isolation, depression, tearfulness, apathy, downgrade of memory and concentration, fatigue, sleep disorders (insomnia/lethargy), fear, a sense of sadness, suicidal thoughts, increased or decreased libido, hypersensitivity to sounds and smells, olfactory and auditory hallucinations;
- neurological symptoms: headache, migraine, dizziness, dystaxia, hyperesthesia, appearance or aggravation of epilepsy attacks, cardialgia, arrhythmia attacks, appearance or aggravation of asthma attacks, vasomotor rhinitis;
- disruption of water and electrolyte balance: peripheral edema, weight gain, thickening and painfulness of mammary glands, bloating, diuresis changes;
- gastrointestinal symptoms: changes in appetite (up to anorexia or bulimia), taste disturbances, nausea, vomiting, flatulence;
- cutaneous manifestations: changes of skin oily, sweating, urticaria, itch, hyperpigmentation;
- bone and muscle symptoms: pain in bones, joints, muscles, lumbodynia, decreased muscle strength.

Personality and characteristic qualities sometimes have tendency to aggravation on the first half of the menstrual cycle. There is some dependence between expressiveness of psycho-vegetative disorders and personality characteristics of women. Affective saturation of complaints and defects of personal response are the most pronounced in emotionally unstable individuals with demonstrative features. PMS often characterized by availability of hypochondriac symptoms.

V.D. Mendelevich identifies the following psychopathological symptom complexes among the variety of premenstrual syndrome manifestations: asthenical,

anxiety-depressive, hysteric-hypochondriac, dysphoric and mixed variant. He pays special attention to dysphoric form of PMS, that can be a cause of a criminal behavior. There are such character properties of women with premenstrual dysphoria: rigidity, resistance of affects, unpredictability, pedantry.

Climacteric syndrome (CS) is a peculiar complex of symptoms that can be characterized by vegetative-vascular, neuropsychic and metabolic-endocrine disorders. The most international epidemiological researches indicated that the pathology of climacteric period occurs in 55-80 % of women. CS can occur in premenopausal period, on the beginning of menopause, and during 1-5 years after menopause. The average age of the menopause beginning is 46-55 in most European countries. Early menopause occurs at the age of 35-45, the late variant - at the age of 56-65.

The individual age of menopause beginning depends of various factors: genetical, biological, psychological, environment factors. Such factors as pregnancy, childbirth, abortion get major effect on the age of the beginning of menopause. Marriage, childbirth in the past and availability of children contributes to the later beginning of menopause. There are several behaviors types during the climacteric syndrome: indifference, adaptation, active overcoming, neurotic behavior. According to data from modern researchers, that explored the clinical manifestations of climacteric syndrome, women at the age of 45-54 with duration of disease within 5 years had psycho - emotional disorders in 78,4 % of cases.

Clinically, climacteric syndrome consists of three groups of symptoms:

1. Vegetative-vascular disorders (fever, sweating, increasing or oscillation of blood pressure, headache, dizziness, palpitations, chills, numbness, sympatho-adrenal crisis).

2. Metabolic-endocrine disorders (fattiness, thyroid dysfunction, dishormonal hyperplasia of mammary glands, genital atrophy).

3. Mental disorders, which are always present in the structure of the climacteric syndrome, and are dominant in some cases.

Psychopathological manifestations are nonspecific, their nature and severity determined by various external and internal factors. There are some important factors of the psycho-emotional disorders progress during menopause: psychotrauma, stress, social status (material wealth, the availability of job, relationships with children, husband, friends), self-esteem, life satisfaction, quality of sexual relations (availability of sexual partner, problems in sexual life), mental disorders in anamnesis. The most often forms of climacteric syndrome are: hysterical state (34,6 %), depressive state (25 %), asthenic state (23,1 %), phobic state (10,3 %), paranoia (6,4 %).

Asthenic syndrome is characterized by weakness, fatigue, irritability, tearfulness, sleep disorders, decreased activity and efficiency, decreased concentration of attention, forgetfulness, intolerance to sound and olfactory stimuli.

If the feeling of inside discomfort, anxiety, that can be subjectively described as «inside trembling» are present, this status is classified as *phobic*. When the frequency and strength of phobic attacks are increasing, different fears can occur: a fear of dying from sudden cardiac arrest or myocardial infarction (cardiophobial syndrome), a fear of cancer (cancerophobia), etc. It can lead to restriction of behavior: patients do not go out, they can avoid to use some types of transport and avoid to stay alone.

Depressive disorders is characterized by low mood with tearfulness, decreased interest in self and environment (including the sexual life while libido is normal). Depression is characterized by dysthymic disorders with a pessimistic outlook on life, a sense of age-related changes, a fear of oldness, anxious fears about his health, decreased activity and social adaptation. Depressive symptoms often combined with asthenic complaints (astheno-depressive syndrome) or anxiety inclusions (anxiety-depressive syndrome). Most often, this disorder does not reach psychotic level and accompained by somato-vegetative manifestations of the climacteric syndrome and in most cases, depends of their severity and duration.

Hysterical disorders during menopause are presented by polymorphic symptoms: discomfort in the throat, dyspnea that sometimes can simulate an asthma

attack. Patients often feel a lack of understanding of the family that increases their demonstration of «difficult» situation. If the demonstrative traits was present in patient's premorbid, symptoms becoming more grotesque: convulsion seizures, astasia-abasia, etc. Menopausal disorders will back away, giving a way to a variety conversial and pathocharacterological manifestations. An additional effect of psychogenic factors promotes the decompensation of patient's status, even if those factors are minor. In addition, hysterical disorders often occur when the women had sexual problems before the beginning of menopause. Hysterical disorders often occur at the early stage of climacteric disorders, a long time before the beginning of menopause.

A special group of patients among women with psychopathological manifestations of climacteric syndrome contains of patients with overvalued and delusional ideas that occurs on the period of menopause and after it. In most cases we can observe ideas of jealousy and ideas of relationships that are associated with conflict situations at work. We can see aggravation of character traits, increasing of affective rigidity, suspiciousness, susceptibility, predisposition to conflicts after the beginning of women's menopause. Vegeto-vascular manifestations are faintly expressed on these cases.

Described psychopathological syndromes are usually observed at the first years of climacteric syndrome. Long passing of climacteric syndrome with increasing of vegeto-vascular and metabolic disorders, effects of additional psychogenic and somatogenic factors can lead to accession of hypochondriac symptoms.

Psychological specifics of women during pregnancy and childbirth

Many researchers considered that pregnancy and childbirth can be triggers of latent mental disorder progress. However, there is a view that a normal pregnancy and childbirth can do a positive effect on different disorders.

Mentally ill women get complications during pregnancy and childbirth 6 times more, then the rest of the population.

Researches of psychological specifics of pregnant women indicates the presence of compensated form of psychovegetative disorders during physiological pregnancy, that manifested by depressed mood, difficult psychological adaptation, emotional instability. So, the fact of pregnancy produces some psychological problems. Increased level of individual anxiety that fully depends of pregnancy duration was indicated in process of women emotional status exploring.

There is an opinion, that pregnancy status is located on the edge between norm and psychical pathology. Many women report changes in health with the onset of pregnancy. That changes correlates with asthenic syndrome manifestations. R. Kumar named this disorders as «Psychosomatic reaction on pregnancy», that observes in 13,7-33,3 % of cases.

Analysis of the test showed that healthy pregnant women in 73 % of cases have prenosological mental changes: *subcompensated and decompensated* women's response types to pregnancy. Subcompensated type manifested by decreased mood, bad self-feeling, a lot of different complaints, abnormal attention on self somatic status, emotional instability, desire to find compassion from others. Decompensated type manifested by traits, than never was exist of was a latent (hypochondriac fixation, increased level of anxiety, susceptibility to affective attacks, psychosocial difficulty on adaptation).

The effect of pregnant women prenosological psychical changes factor on the progress of gestacion complications was discovered and proved.

Clinical researching of boundary mental disorders showed that the most common are *neurotic reactions* (63 %). There are actually gestational mental disorders, when the pregnancy acts as a psychogenic factor, and neurotic reactions, when the pregnancy was not the main etiological factor, but only contributed to the progress of the disease. Violation of family relationships is the main cause of neurotic pathology in these cases.

Syndromological analysis shows, that there are usually 2 variants of above pathology: asthenic-depressive and anxious-depressive.

V.D. Ryzhkov did a lot of researches of structure and severity of pregnant women asthenic syndrome. *Asthenic status* was indicated in 10,5 % of examinee. V.D. Ryzhkov described such forms of asthenia: astheno-hypochondriac (55.2 %), astheno-anxious (24 %), astheno-vegetative (20 %). Leading role among the reasons that provoke asthenia, psychogenic factors based on the importance of pregnancy in a woman's life play.

Anxious syndrome during a pregnancy can be as common, as asthenic syndrome. Anxiety is a normal emotional status of human during uncertainly or expectation situations, that can be subjectively characterized as a feeling of internal tension with the activation of vegetative reactions. A certain level of anxiety performs catalytic function. A.Ye.Volkov considers, that anxiety is an adaptive process that is physiologically necessary during the pregnancy.

There are usually *several types of anxiety* during pregnancy:1) generalized; 2) physical, when the physical aspects of pregnancy are too difficult for woman; 3) fear for the fate of fetus; 4) fear before the need to the newborn care; 5) fear of childbirth; 6) fear of feeding of newborn; 7) psychopathological phenomena of anxiety.

Depressive status during a pregnancy manifested by psychopathological syndromes: asthenic-depressive, anxious-depressive. There are depression of neurotic level that includes depressive reactions and neurotic disorders and also endogenic psychotic depression.

It is noted that deep endogenic depression often progresses in the late stages of pregnancy and in the postpartum period. Neurotic depression can occur even in early stages. According to R. Kumar data, frequency of depressive neurosis is 10 % in the first trimester. The major factors that can lead to neurotic depressive status are: severe losses, miscarriages, marital and personal conflicts. Preterm birth and intranatal death become a main importance as a psychotraumatic factor on the late terms of pregnancy.

Female personality characteristics, combined with the motivation of childbirth, the level of personal anxiety, peculiarities of pregnancy and previous obstetric history have a major role in genesis of non-psychotic disorders. The lack of harmony

in the family relationships, when the child's birth is intended to correct violations of these relations, leads to disruption of the perception of the unborn child and leads to the progress of neurotic disorders.

Late gestosis and the *risk of preterm birth* have a special place among numerous complications. They are the reason of high perinatal morbidity and mortality. Violations of personal contacts, excessive concern of the own health with the reluctance to be treated in a hospital, uncritical valuation of the real somatic status and stubbornness are typical for women with late gestosis.

Women with the risk of preterm birth often have somatization of the anxiety that releases through intrapsychological processing of vegetative manifestations associated with anxiety. Anxious fears for their health are combined with uncomfortable sensations, leading to the formation of fixed fears.

Psychological specifies of sick children and elderly people

Psychological characteristics of sick children and their reaction to disease is significantly different from adult's, so doctor must have some special knowledge. There are few general psychological specifies of children:

- prevalence of emotional level on the general structure of disease's internal picture;
- lack of identification and opportunity to express their own feelings;
- significant suggestibility;
- lack of autonomy and dependence of the parents.

Child's chronic illness is a sophisticated psychotrauma not only for child, but also for the whole family. There are some regularities of progression and some consistency of changes of psychological reaction's to disease (especially chronic), concerning child and its family.

Shock and *denial of the disease* are observed on the stage of the diseases progression. As a result, regressive behavior and fear occur. This stage lasts from several weeks to few months.

The next stage is a *protest and suffering*. Such emotional reactions as anger, sadness, guilt, the emergence of depressive reactions can occur at this stage. Younger children can perceive the illness as a result of their bad behavior. Aggressive reactions, primarily caused by restrictions or some kinds of treatment can occur.

Child is calming down and begins to accept all restrictions submissively on the stage of *regeneration.* Relationships with other are harmonizing, belief in recovery appears. There are some specifies of children's reaction to disease, depending on the age of the child. Children under the age of 1 year can catch the hospitalism, if the somatic disease with the need of hospital treatment is presence.

Hospitalism is a broad concept that consists of unfavorable (primarily mental) conditions in the hospital and the result of their effect on the mental and physical status of the sick child. Hospitalism caused by deficiency of child's communication with adults, mainly in the first year of life. It can occur in case of long-term staying in hospital, where the pedagogical work with children is mostly poor. The most common effects that can lead to hospitalism was united and called «psychic deprivation». Deprivation means the lack of satisfaction of any human needs.

Children with psychic deprivation could have:

a) decreased mood, depression, crying;

b) noisy and angry protest, fuss, search for the mother;

c) isolation, autism;

d) inappropriate adaptation to the institution;

e) general intellectual decline.

We can see some dynamics in the hospitalism progression. When the child is leaving a mother, it firstly cries, requires the returning of mother, or someone, who can replace her (especially after the age of 6 months, when the normal need for communication occurs). The «escape» response occurs, if someone comes to a child after 1 month. On the next month It begins to avoid any contact with the world, child's reaction to the surrounding is minimizing, it is no crying any more, facial expressions disappears. The most common term that can describe that child's status

is «anaclytical depression» that consists of atony and apathy. There are also physical symptoms of depression: insomnia, complete or partial food refusal, susceptibility to infections, stopping of growth. Depressive manifestations are most obvious in child's behavior. Attention to inanimate objects and part's of own body are increasing on the background of decreased activity and indifference, when the child doesn't respond to people's faces, new toys, child doesn't scream when it's hungry. We can see the retardation in the psychoemotional development of child later.

Pre-school children often have different psychogenic reactions to disease, that is presented as a neurotic disorders with the domination of asthenic disorders, phobias, tics, enuresis, stuttering. Depressive reactions can manifest as a night horrors, motor excitation, anorexia, that significantly complicates the diagnostics and treatment of the thick child. Hospitalization is the most traumatic factor for all children. The response to it depends of the personal traits and specifies of upbringing.

Representation of hypochondriac type rises among other pathological reactions to disease in teenage years due to occurring of their recognition of the disease and on the hormonal changes background. Also, dysmorphomaniac disorders and nervous anorexia can occur on this period. Neurotic and pathocharacterological changes of personality with neurasthenic, anankastic, hysteroid and epileptic traits can occur, when the disease gets long - term and unfavorable course.

First meeting and discussion is the most important moment for the further effective contact during the communication with sick children. The doctor should give the child an opportunity to express his complaints independently and to demonstrate his emotional state, own relation to disease and understanding of life situation in which the patient came. The doctor should spend enough of time for it and shouldn't hurry up.

Old age is a special period in human life, which is characterized by suspension or restriction of employment, changes in values, lifestyles and communication, the occurrence of difficulties in social sphere etc. The elderly make up the majority of

clinics visitors and hospital patients, due not only to increased chance of disease in this period of life, but to specifics of their social status.

Aging is associated with changes in the organism, that lead to a weakening of biological and social functions of human, progressing of presence diseases and introduction of new diseases that could be severe very often.

There are some main psychological phenomena of old age period: reducing of mental activity, fatigue; instability of attention and easy distraction; reduced processing of information, difficulty in organizing of information while moving it from operative memory to long-term; difficulty in adaptation to changes; sense of loss of strength and health; feeling of loneliness; increasing of anxiety; irritability; suspiciousness; fear of being deceived; fear of death.

The main problem of old age is the general worsering of health.

Mental aging is various; the range of its manifestations is very wide.

There are such types of mental aging as (by F. Giz):

- negativist, who denies any signs of his/her old age;
- extrovert, who recognizes his/her old age due to external effects and by observing some changes: young generation grew up, their opinions are different; death of loved ones; changes in position in the family; changes in technologies, social life.
- introvert, who is much worried about the aging process. The person does not show an interest to new, he/she is living in the memories of the past, he/she is inactive, tends to the rest.

Socio - psychological types of old age (by I.S. Koni):

- active creative type, when the veterans, that are going to have a deserved rest, continues to participate in social life, on the education of young generation, they live a full life without any feeling of inferiority.
- the second type: pensioners deals with cases that was not available before due to lack of free time, such as: self-education, relaxation, entertainment etc. In other

words, this type of old people is also characterized by good social and psychological adaptability and flexibility, but their energy is directed mainly to themselves;

- the third type is mainly consists of old women. They are finding happiness in their family. The amount of homework is inexhaustible, so they just have not time to be bored. But psychologists notice that this group is less satisfied with their life than the first two.

- the fourth type – old people, whose sense of life is taking care of their own health. Various forms of activity and moral satisfaction connected with that. However, we can observe the tendency to exaggeration of their real and imaginary diseases, increased anxiety.

Classification of D.B. Bromlej is widely supported in the global psychological literature. There are five types of individual adaptation to old age:

1. Constructive attitude to old age, in which old and elderly people are internally balanced, they have a good humor and mood, they are satisfied with the emotional contact with others. They are moderately self-critical; the relation to other people and their possible shortcomings is very tolerant. They do not fall into despair due to ending of professional activity, the relation to the life is optimistic. They interpret the possibility of death as a natural event, do not show any aggression or depression and have a lot of interests.

2. Attitude of dependence. Dependent personality is a person that subordinates to someone (partner or a child) and does not have too high claims for life. That is why such person is leaving the profession so willingly. Family environment gives him/her a sense of security;

3. Defensive attitude, that is characterized by exaggeration of emotional restraint, some straightforwardness in his actions and habits, the desire for «self-sufficiency» and reluctant acceptance of help from others. These people avoid expressing of their own opinion; do not share of their doubts and problems.

4. Hostile attitude to the environment. People with this attitude are aggressive, suspicious, they tend to shift the guilt on and responsibility for their own failures on others, estimates the reality not very adequately. They are locking in themselves,

avoid contacts with people because of the distrust. The life of such people is usually accompanied by numerous stresses and failures. They are prone to acute reactions of fear, do not accept the old age, always thinking about progressive loss of strength that is connected with strong fear of death.

5. The hostile attitude of person to himself/herself. These people avoid memories, because there were so many failures and difficulties in their lives. They are passive, rebelling against their old age. Dissatisfaction in love is the cause of depression, sadness and claims to themselves, combined with a sense of loneliness. They estimate the aging realistically, interpret the death as a exemption from the suffering.

Firstly, let us observe a psychology of the normal *physiological old age*.

An aging person suffers from a gradual loss of vision, hearing and activity of all sense organs. He/she needs more and more strong glasses, those people, who previously could distinguish a squeak of mosquito gradually become able to respond only to a strong sound. Agility and mobility gradually disappear, active people become more passive. Reduction of vitality affects the emotional life. People, who lived a violent, emotionally intense life, are gradually becoming more and more calm, finding a joy in a narrow range of interests, their life becomes joyless. They focus on love of the family. The mood is also becoming more equal, these people are usually calm, and, in some cases, we can see a deviation in one of certain directions – oppression or excitation.

Sometimes we can observe a personality changes. Traits become sharper, sometimes people becomes like their own caricature. The person, who was economizer during all his/her life, can stay avaricious. Ben Jonson, Mol'er and Gogol' created a wonderful models of those types of people. Shy and timid people in old age become distrustful and pessimistic, who can refuse from everything, they can become hypochondriac and care only about their own health.

There are some observations that indicate that the old person begins to progress in the opposite direction. According to the classification of Jung, we can say, that the person, who was extrovert in youth, becomes extrovert in old age and conversely.

Special effect has a wealth of personality and the productivity of life on the harmonious life in the old age. That person, who was spiritually rich in youth, often finds a real treasure in the memories of his/her past, that promotes harmonious life in old age.

However, there are some cases of «falling in childhood». Someone says, that those old people experience a «second children's phase», «second childhood». Infantile traits become a major, old person expects for maternal protection, maternal attention from environment.

Sometimes, with the weakness of criticism, in severe cases we can observe the moral excesses. Instincts, sexual stimuli, which were compensated before, now can not find any obstacles in their path. Then we can observe an excessive intensity of sexual life, violence against children and young women, even homosexuality.

Sometimes, the behavior of old people can be difficult, they are not able to accept anything new and adapt to the new conditions. Even the most «flexible» person often becomes the fiasco, when they are trying to challenge with the young.

Senile loneliness is a painful feeling. Young people leave the family, becomes independent, all friends and relatives does from life. The old person is often becomes lonely, and it hurts. A much depends on how such a person is able to find an interesting occupation, to adapt to life among a new collective, to find a place among others. If he feels that he is useless and unnecessary, the feeling of loneliness and depression will become sharper.

All those phenomena become pathological in the case of *pathological aging*. Egocentrism, changes of personality, emotional atrophy, spiritual decline and dementia occur. There are also severe memory disturbances, mainly as a result of loss of ability to memorize. First, that is possible to remember the old experiences, new events are instantly fall out of memory, giving the way for unlimited imaginations. As a result of losing of ability to memorize, the night orientation is disturbing - we often have to hatch how old people are going to sleep to another's bed or going to another room. In severe cases, they are simply degraded to the level

of vegetable. The presence neurosis may progress in old age, because of adverse properties of this age increases the disease's picture.

Physical diseases (such as heart diseases, sclerosis, tumors, even a banal infections), that we can found in old age, can worsen the condition of person on the long term. These diseases, like a mental shock, can lead to anxiety, restlessness, confusion and can even lead to decompensation.

In most cases, changes in mood can lead to oppression, *depressive status*, *hypochondria*. In such cases, patients often blame themselves in imperfections, mistakes, sins, remember all their mistakes. Much less we can observe old people with pathological excitement, mood elevation. *Paranoid forms of the disease* are characterized by the presence of delusional ideas. For example, patients are always busy with thinking about «fact», that someone steals their letters, money, jewelry. Even old age does not prevent them to blame her husband (his wife) in infidelity, they can be insanely jealous.

We can do a lot to support mental and physical health of the elderly. First of all, we should create a *calm, peaceful family environment*. The usual environment of old person's life, that matches his/her abilities and needs, is the most appropriate place for his/her activity. Their health largely depends on the behavior of others, their relationship, ability to communicate. Knowledge about the psychology of older people, understanding of their problems, the ability to help them in the difficult situations is very needed factors to a doctor. So, considering the all psychological specifies of old people, we should create special conditions during the communication; nothing should distract them from talking. It is necessary to support the elderly person psychologically, do not leave his/her alone with their problems, to answer all their questions, encourage them and indicate the positive aspects of treatment. We should maximally assist in the realization of all old person's possibilities, it will necessarily lead to the improving of his/her psycho-emotional status.

Psychological specifies of patients in the surgical hospital

Surgical methods of treatment produced a great range of different psychic manifestations, such as: excitement, fear, anxiety, aggression, anger, ingratitude. We should perform a gradual psychological correction during diagnostic and treatment to avoid these manifestations.

There are few stages of treatment in **surgical hospital**:

Diagnostic stage. During this stage, doctor should think about the impression that the patient will develop, when he will find out about diagnosis. He should consider the patient's personal and premorbid specifies (vulnerability, emotional instability, anxiety, rigidity, etc.) Doctor should inform the patient about disease in available and clear form, without excessive using of medical terminology, this information should contain the prognosis and a reminder of possible complications (term of healing, possible infections, etc.).

Pre-operative period. We can divide features of patient's psychological status and his/her mental reactions into two stages: *first stage* includes examination, rectification of diagnosis and necessity of surgery, acquiring of the patient's agreement for surgery. The psychological status of patients at this stage is determined primarily by emotional reactions, the nature and severity of which can be varied and not completely exact (for example, the fear may have some shades of anxiety and worry, horror or even euphoria). The *second stage* of pre-operative preparation includes the waiting for operation, when a final decision was made, and the terms of it were notified. Psychological manifestations that occurred in the first stage can be compensated or progressed.

Most often we can observe some variants of patient's *normosomatonosognosia*: they feel the excitement and adequately relate to the future surgery as to the most acceptable way out of a morbid condition. They correctly estimate the chance of surgical risk and possible complications.

The most common variants of *hypersomatonosognosia* were noted by M.V. Vinogradov:

1. *Overestimation of the surgical risk importance*. It can be expressed by:

- depressed mood with the domination of anxiety, the fear of death or joining of postoperative complications;

- complete external calmness, indifference, which can hide a sense of hopelessness, passive waiting for death or poor result.

2. *Distrust* to doctor, to diagnosis or necessity of surgery that accompanied by low mood and anger towards others.

3. *Denial* of the necessity of surgery with the conscious dissimulation of symptoms in order to avoid it.

Hyposomatonosognosia or *anosognosia* manifested in the patient's underestimation of severity of hi/her disease. It is rare, but typical for patients that sick on alcohol or drug addiction, for people with serious changes of personality.

Anesthesiologist's and nurse's role is very important the day before and at the day of surgical operation.

The main manifestations of operational stress are emotional phenomena, in which the most often we can observe *anxiety*. It is characterized by: a) worrying «in myself», that manifested by external isolation of patient, depressed mood, the narrowing of interest's range etc.; b) panic status with the violation of self-control, severe anxiety, sense of fear, crying, fussiness, desire to communication with other patients, doctors, they are they often ask questions about the possible results of the operation.

The most common feature of the patient's psychology is an expectation of the postoperative status, accompanied by preoperative and postoperative anxiety. Preoperative anxiety is a typical psychological reaction to the message about the necessity of surgery. It is manifested by constant anxiety, restless, inability to concentrate on anything, sleep disorders. Anxiety is projected into the future, reflecting the expectations of surgical quality. Postoperative anxiety, which may clinically coincide with preoperational one, is associated with the operational stress and coincidence of expectations and reality.

Anxiety level	Characteristics of the preoperational attitude's type	Postoperative mental status	Mental premorbidity
Low anxiety	Denial of postoperative discomfort and complications	Agression, anger	Personal predisposidion: 1. neurotics with overcontrol 2. mentally healthy people, that are sensitive toexternal stimulations
Moderate anxiety	Objective valuation the danger	Low chance of mental disorders	Mentally healthy people with strong personality. High responsibility for external situation is typical.
Severe anxiety	The constant emotional stress	Lack of confidence in the successful result of surgery, fear procedures, hypochondria, punctuality	l. chronic neurotics 2. mentally healthy people with anxiety as a trait of character

External factors are essential in the prevention of these reactions: aesthetic design and the level of technical equipment of surgical clinic, the work style of all medical staff.

Surgeon must inform the patient about the diagnosis considering the personal characteristics during psychological preparation for surgery. Doctor shouldn't inform the patient about the details of possible complications, if it can intimidate him.

An adequate psychoprophylaxis and psychotherapy can minimize patient's pre-operative stress and even do a positive effect on the results of surgery.

Specifies of reactions, their severity and duration during the *postoperative* period depends of the type of disease, course of postoperative period (surgery associated disorders, complications) and the personal premorbidity. Pain syndrome can also effect on the mental state of the patient. Psychotic conditions may occur when we are talking about old people with symptoms of atherosclerosis, patients that

abused alcohol in the past, people with liver and kidney diseases, with pancreonecrosis.

Any operation (mild or severe) is naturally accompanied by the development of asthenic condition, when the patient is emotionally unbalanced, has reduced emotional background, all senses are increased (especially auditory and visual), the patient is very sensitive and vulnerable. Doctor's tactics during the postoperative period should be aimed at the creating of patient's positive emotions. He/she can obtain it due to such factors, as: patient must know the structure of treatment, recommended regime, diet, perspectives of prognosis and rehabilitation; rational distribution of patients in wards considering the severity of their condition and psychological compatibility; all medical staff must adhere to the principles of medical deontology.

Psychological support in the postoperative period is very important if the surgery was associated with resection, amputation, facial plastics after injuries and burns. We need to restore a patient's sense of inferiority, inspire hope for further palliative correction of the defect.

We can observe a common category of patients that want to spend a lot of lifetime in hospital; they require the surgery on various occasions. They try to swallow foreign objects in addition to the simulation of surgical diseases and self harm. This typical hypocrisy gives us reason to call this type of patient's behavior as «Mjunhgauzen syndrome».

There are three types of them:

a) acute abdominal – ends by laparotomy;

b) hemorrhage – bleeding simulation;

c) neurological – simulation of seizures and fainting.

Persons with «Mjunhgauzen syndrome» are distinguished from patients with hypochondriac progress by lack of a real care of their health, conscious aim to deceive and attract the interest to themselves, get free food, home and care. Of course, this category consists of patients with the pathology of personality.

Psychological specifies of patients in dentistry

The exploring of medical psychology of dental patients and psychotherapeutic effects on their treatment was conducted by many researchers (P.B. Gannushkin, 1933; K.I. Platonov, 1962; V.N. Mjasishhev, 1966; A.M. Izutkin, 1968; I. Hardi, 1981 et al.); V. Konechnyj and M. Bouhal, 1983). All doctors and psychologists recognized that expressive features of appearance and the face are in close connection with the feelings and ambitions of human. Facial expressions reflect the joy and psychological experiences.

Specifies of the contact with the patient in the dental clinic. Dentistry historically tends to of manual and technical aspects of treatment. However, she also progressed, which lead to more and more close relationships with a general medicine. The growing importance of psychology for modern professional activity that satisfies not only technical but primarily ethical and social requirements, particularly evident in the preventive dentistry (Fisch M., 1996). Mouth and lip area belongs to the intimate zone. It is directly associated with feelings and loaded by positive and negative emotions. The intervention is perceived very closely and personally. Psychological researches show that teeth play the role of power, potency and beauty in the broadest sense that goes beyond the anatomical structure and organization. Their symbolic value is comparable to the value of the hair. They are a sign of health and perfection, they effects on the aesthetic perception of self-worth and psychophysical wellbeing. Front teeth play an especially important role in this regard. The chewing function of back teeth is equally important, but they receive less attention than the front teeth.

There is an important psychological problem: despite the high value of the teeth and extensive work, done by media about this, we should still stimulate the desire of self-discipline and simple preventive measures to preserve an oral health in most patients. Coming to the dentist is often stressful for the patient. It is associated with the fear of waiting, tension and vegetative dystonia. Dental therapy, despite such opportunities of analgesia is still perceived by some patients as painful and even aggressive. We should also note that patients often going to the dentist with some

guilt, they suggest that they are guilty of their suffering. Fear and guilt are probably the most important factors leading to the absence of regular control examinations by a doctor. Instrumental caused difficulties of verbal communication and physical proximity to the doctor also leads to feeling of helplessness and powerlessness. This fear can be expressed in a variety of reactions, such as escaping from treatment or counseling, aggression, physical resist, biting.

The first contact and the first conversation between the dentist and the patient may be decisive for future behavior of the patient and the course of therapy. Doctor should be aware that he stands in the foreground of fear. According to modern psychology, this behavior isn't perceived as a pathological deviation of function, but as a normal, healthy response of our warning system. Therefore, doctor's objective is to encourage the patient to recognize his/her fear, to live with it and deal with it. The dentist should know that the patient wants to be perceived as a partner. The patient unwittingly waits for the doctor's emotional response, help and support. Manipulations in the mouth mean the interference in psychologically sensitive area. Near contact face to face can sometimes cause a feeling of sensing of conscience to the depths of the soul or ruthless disclosure of innermost feelings.

There are some groups of patients, who need increased requirements from doctor. They consists of children and teenagers with their age-caused lability and vulnerability, neurotics with their unconscious stress and conflicts and old and invalid people, who impose additional responsibilities on the dentist because of their own social and medical problems. Dental care for children should begin during the pregnancy in the form of the health education of mothers to prevent the possibility of damage of teeth. Parents view on these issues will significantly affect on appropriate behavior of a child. Children are especially predisposed to project the fact of dental treatment into their personal problems and fears. They much more perceive dental treatment as a conflict situation in which they are involved against their wish and in which they cannot resist impunity. The child sees itself before a problem that has no satisfactory solution. Correction of the position of teeth in children makes them much more demands than dental treatment because it catch

somebody's eye on the position of teeth and equipment and they often suffer from feelings of inferiority. Besides, there are unquestioned facts now that speak about psychosomatic aspects of mandibular orthopedics, which traditionally prefers technically oriented treatment. By forming jaw defects in children may be factors associated with heredity, unresolved personal conflicts and difficulties of social inclusion, deep early disturbances between mother and child. In dental practice common category of patients who complain of pain, discomfort in the teeth, jaw, tongue, lips and other parts of the face, the cause of which is not clear or objective changes do not meet the complaints of the patient. Some patients present to dentist persistent complaints of pain in the tongue (glossalgia) and various violations of tongue movements (glossodynia). Pains, burning in the tongue torture patients - they are take off the crown, asking for a dentist «to cut down the rough edges on the teeth» and to remove teeth that «interfere «to talk and to eat. Many of these patients may suffer masked depression. In this case actually mental manifestations of depression (oppression, «dullness emotions «depressed mood and vital functions) is difficult to perceptible even for an experienced psychiatrist, sometimes only a trial of antidepressant drug treatment helps correct diagnosis. Along with unstable patients that are moving from one dentist to another in search of a dentist, which they can trust, and pretentious patients who strongly insist on carrying out certain treatments, there is a certain type of severe patients. They are all distinguished neurotic fear that occurs within 4 personality structures. All this is hidden in the early biographies of the patient and can not be removed by simple arrangements. Patients with predominantly hysterical structure represent a source of the most pressing challenges.

Their fear is easily transformed into somatic condition, such as fainting. Increased suggestibility makes them available for psychological help. The calm, accurate, friendly, but firm position of the dentist has the good effect to the patients if it takes the form of some pampering combined with warmth, cordiality and humor.

Patients with obsessive features often are shy, full of doubt and timidity. Their inability to make decisions delays the visit to the dentist. Compulsive symptoms,

such as fear of contamination may complicate dental work, often making it possible only after psychotherapeutic intervention. The fear of patients often moves into the purely somatic sphere and arise in the form of pale skin, tachycardia. They need control of the cardiovascular system.

The patients with depressive structure willingly obey the instructions of the doctor, but they don't have to be misled about their limited capacity of the mental endurance. The teeth have a high symbolic meaning for them, and therefore they more tragic, than regular patients, perceive their defect or damage and the whole treatment. Crucial in this case is that the patient must be treated as the person, but not as the case of disease.

Schizoid patients due to early mental development disorders demonstrate the insufficient contact with the outside world. Their lack of «mental food» in early childhood creates the baseline distrust, which leads to chicanery, hypochondria, hostility and even provocation to the dentist. They are the cause of most severe interpersonal stress in dental practice. If the doctor will stand, showing a calm, friendly, empathic patience and accuracy then its psychological patience will be rewarded by loyalty.

Psychological features of patients with toothless jaws

The first psychological problem is the lack of teeth. The patient requires the changes and adaptation to the new conditions because of it is not easy to live in the changed circumstances. Often the patients are discouraged; they lose faith in themselves, that's why more than ever the features of psychology in this group of patients must be taken the account by the doctor during examining of patients with complete loss of teeth and during making plan of treatment. By itself, a complete loss of teeth almost always leaves a mark on the patient's psyche. The complete loss of the teeth even from accidental causes, such as trauma, creates a sense of physical inferiority in the young people. It is more heightened in the women than in men. It is known that after a complete loss of teeth the chewing of food is broken, clarity of speech is impaired and appearance of the patient is changed. This undoubtedly reflects on the general condition of the patient, his mood, behavior and imposes

definite imprint on the patient's psyche. Such patients limit themselves in contact, attend meetings, theater etc. The loss of teeth can be seen as a disaster for the patient, teachers, performers, announcers, lecturers. The loss of teeth means the parting with favorite business, and sometimes it means the need for retirement, which can also cause severe patient feelings. A person who entirely gives themselves to a work which is the purpose of their life feels a lack of activity. This violates not only the patient's social connections, but affects his/her composure.

Psychological features of ophthalmological patients

Psychological features of ophthalmological patients can be viewed as an example of blind patients.

Defects of various sense organs, including the vision, create some difficulties in the work of doctors and medical staff.

It is believed that the blind patients have the modified thresholds analyzers of hearing, touch, smell. The studies show that thresholds of other analyzers in blind patients not at lower but at higher stage of differentiation.

Psychological features of blind children depend on age. Early development usually flows without disabilities, but desire of parents to protect children from hardship become visible very soon. There are some neurotic symptoms in 3-5 years, sometimes in the form of night terrors, enuresis, and appetite disorders. Children are aware of their physical disability at age 6 or 7 years. Adults only underscore the helplessness of the child by showing excessive care and thus often worsen patient's condition. The neurotic reactions could be deeper at this period and more expressive fears can occur.

Some blind children become timid, indecisive, and whiny, they prone to daydreaming in the following years, and they keep the distance from children and teachers, the other patients may have irritability, moodiness, stubbornness, resentment, irritability.

The beginning of schooling is associated with difficulties for the children. Adaptation to a boarding school is always difficult for the blind children: the

separation from loved ones, with the usual situation, on the one hand, and the challenges of the new environment on the other hand, often contribute to appearance of neurotic symptoms and sleep disturbances, appetite, fatigue, daytime sleepiness in class dominate in the clinical picture. Alertness and increased vulnerability can occur. Children become whiny, gloomy, slow and very helpless. They often have a severe reaction to the helplessness such the protest reaction.

Pedantry, the desire to perform daily routine, sometimes hypochondriac fixation, suspicion and alertness can occur in some blind children in puberty. We can see excessive reaction of the patients to their defect at this age and uncertainty in their abilities, fear for their fate may occur. Children especially badly feel in the company of those who see. They follow to the formal rules of order, behave arrogantly, are intolerant to the comments and overrate their own possibilities. The most common psychological feature is «idée fixe» of inferiority due to loss of vision. This is more clearly seen in persons with acquired blindness than with innate. Usually, there is no intellectual failure in blind patients, if it is not connected to the simultaneous destruction of the brain. They are characterized by a high level of understanding of morality, principle and justice. Persons that are experiencing a painful defect always feel bad among those who see.

We often can see a sleep disorder in blind patients, that is why they resort to sleeping pills. Sleep is surface and sensitive with a lot of bad content. They feel defeated and powerless in the morning.

There are various options for personality changes due to blindness. In some patients asthenia and obsessive disorders prevail. Such persons cannot tolerate life difficulties, the physically and mentally tired rather quickly. They turn to the clinic complaining of malaise, fatigue, anxiety and they are concerned for their health and the health of their loved ones. The qualities of people with asthenic (neurotic) type eventually are formed in them. They reduce to the minimum their contacts, limit themselves, try not to work the full-time, create a weakened regime and strictly follow to the instructions of doctors. They show enough persistence in their own interests, in some cases, terrorizing the family. People are relatively adapted to the

work. These patients often may have hysterical reactions, when the conflicts arise, that's why they must to turn to the psychiatrist.

Eventually, hypochondriac symptoms become less clear and give way to a chronic affective disorder with the changing nature. This hypochondriac dynamics is not unique to the blind, but to the sighted - hypochondriac personality development goes through the same stages. Sometimes, behavioral disorder, which occurs during prolonged examination of patients in hospital are regarded as a reaction to physical pain, but it is not the full explanation of the clinical picture of disturbances.

It is worth to pay attention to the some mental characteristics that appear after successfully undergone of surgery in individuals which were borne blind or were blinded at an early age. The holistic perception of objects and phenomena arise not once in them, but after a long accumulation of reserve of visual representations, which played a decisive role in the perception of the world. The patient has a period of time after operation when it cannot see as those who were sighted from childhood. They often have a reaction of despair because of their point of view and the outside world should be represented differently and that their hopes in this respect are not justified in this case. However, the development of such conditions is not always caused by psychogenic factors only, although they can be significant, especially if with patient has not been conducted appropriate therapeutic work. The inclusion of the visual analyzer changes the whole function of the brain. Excessive overload on the visual analyzer lead to the development of asthenic symptoms, discomfort and mood in most cases. The patient must be aware before the operation that he or she can't see normally immediately, but only after a certain stage accumulation of representations, lasting several months. The patients must to know that the stock of spatial representation accumulates slowly and it will be necessary for the determining of distances. The patients need the rational therapy and prescribing of tranquilizers to mitigate asthenic symptoms after the operation.

Psychological features of patients in the oncology

Cancer is a life-threatening, severe disease. The term «cancer patients» includes not only patients with malignant tumors and precancerous diseases, but also people who recovered from cancer. In clinical oncology distinguish *4 groups of cancer patients:*

1. the patients with precancerous diseases;
2. the patients with malignant tumors that subject to the radical treatment;
3. the patients who had cured cancer;
4. the patients with advanced forms of cancer that subject to the symptomatic treatment.

It has long been observed that some of the psychological characteristics of the individual can be the evidence of predisposition to cancer. Over the past 50 years, doctors and psychologists think about the qualities and traits of personality, by which can be recognized a particular risk of cancer. In the literature, this type is known as a C-type personality.

C-type of personality includes:

- the tendency to suppress negative emotions and hidden dependence on others;
- increased anxiety;
- anger, hostility (especially deliberately muted);
- autoaggression;
- emotional excitability;
- pessimistic attitude to the life situations;
- insularity;
- expressed kindness and excessive sincerity, excessive willingness to help;
- susceptibility to depressive reactions;
- religiousness;
- low social activity, etc.

The features of psychological reactions in cancer patients during the different stages of the disease.

A special study, conducted by Bazhin E.F., Gnezdilov A.V. (1983) showed that psychogenic reactions that vary the degree of their severity, clinical manifestations and psychological content, were observed in all cancer patients at all stages of treatment.

The degree of reaction usually ranges from mild to severe: wherein in the first case it mean a complex of mild expressed disorders that are approaching to the neurotic level and in severe case, the degree of emotions reaches considerable intensity, reaching almost psychotic level. The medium degree of severity corresponds to the neurotic level. Leading disorders in these reactions include anxiety, sometimes reaching the level of fear or even horror, depressed mood (from sad to a deep longing), apathy, sometimes dysphoria (sad, angry mood).

The degree of reaction and symptoms associated with a particular stage of the treatment process and premorbid features of patient's personality. There are such major phases: diagnostic, starting with the first contact of the cancer patient with cancer service, stage that include admission to hospital, covering the first 7-9 days of hospital stay, preoperative phase, then the postoperative period, preparation for discharge and discharge from the hospital, and finally, follow-up phase, which covers the patient's stay at home during outpatient treatment and observation.

Accounting of premorbid personality traits also is necessary to understanding of the features of mental reactions of cancer patients. The following groups can be differentiated in accordance with the classification: «synthon», «cycloid» and «schizoid» that characterized by restraint, asociality and some estrangement. The impulsivity, temper, irritability, combined with pedantry, viscosity and slowness is inherent for a group of «excitable». «Hysteroid» persons characterized by ostentation, theatricality, exaggerated emotions. «Anxiety suspicious» persons those are prone to severe anxiety for any occasion complete this description.

The knowledge of treatment stages, the ability to determine the severity of mental reaction and premorbid personality traits of patients is necessary for the

understanding and forecasting of the behavioral characteristics of patients, for the choosing of forms and methods of psychocorrection of the patient himself, and for the working with patient's microsocial ambience.

General tasks of medical and psychological work with cancer patients

In modern social psychology emphasizes that the system of value orientation plays the significant role in the person's reaction to the different life circumstances. Last connected with correlative necessity of life goals and means to achieve them, the degree of involvement in activities - career, family and home, etc., they are based on past experience and person's life position.

Meeting with cancer for each patient is definitely conflict, and this conflict is purely psychological, primarily because of it is related with the immediate threat to life, that have the vital nature. When the patient falls into a similar situation it feels anxiety and fear of the danger that often leads to fixation of mental disorders and disorganization of behavior. The threat for the life leads to the increasing emotional stress and significant violations of interpersonal relationships.

The mechanisms of psychological defense which are known in modern psychology as a special regulatory system which aims to eliminate or significantly reduce anxiety related with the presence of conscious conflict begins to form, turn around and act in this situation. Psychological defense designed to detach of the patient's mind from those experiences that injure the psyche by its content. Psychological defense at its origin and in the further development has a number of specific mechanisms, forms and types, in specific situations (in medicine in general, and particular in oncology): «denial», «suppression», «projection», «identification ««regression», «isolation», «rationalization», «conversion» and others. It is important to emphasize that the psychological defense can be both successful and unsuccessful. The choice of compensatory mechanisms of cancer patients usually is at the level of the unconscious and bound with certain premorbid personality characteristics.

So, some patients refuse the presence of cancer. Very often these methods of compensation observed in individuals for which hysteroid features are characterized

in the premorbid period. Another group of patients choose another method of psychological defense such a unspecified installation according to a diagnosis. Commonly, patients say directly that they would not get any information about his condition. Such answers like: «I do not know» is particularly characterize them, which can be interpreted as an expression of «humility with fate» and total dependence on the doctor. This attitude is often express in some patients as significant passivity that sometimes comes to the point of apathy. Disturbing thoughts is usually dominated in patients of this group in premorbid period; these patients were generally prone to rapid depletion.

There is a third type of response – when patients partially recognized, but not fully, the presence of a malignant tumor in them, and they answered to the questions like «maybe it is a tumor». There is a specific phenomenon in this case: patients see themselves as from outside. This characteristic allows considering this type of personal reaction as the definition of the distancing of the person from the current conflict situation which means the alternative definition like «health-disease», «life-death». This unique type of psychological defense is observed mainly in those patients that had schizoid features in premorbid period.

The last, the fourth group of patients was characterized by realistic, adequate acceptance of the existence of cancer. Expressive installation in any, even the most traumatic type of treatment and expressed desire as soon as possible receive special medical care occur after a relatively short period of anxiety and confusion. The mobilization of all psychological resources of the individual occurs in this period. Some patients directly stated that they know everything about the nature of their illness, but they believe in the possibility of doctors, medical advances, etc Patients which premorbid period was characterized by syntonic features and partly cycloid features, were included in this group. Conscious setting of treatment, recovery and optimism were common for them.

Mental disorders of varying degrees of severity (from psychological pre nosological reactions at the diagnosis prognosis of the disease to acute psychosis)

are frequent thing that is observed by oncologists, surgeons, gynecologists and psychiatrists and psychologists during the cancer.

There are five phases of response to the malignant tumors and cancer:

Phase 1 (anosognostic): appears after the first assumption of the presence of the malignant tumor in patient. It is characterized by the presence of the negation of oncological diseases, decrease the significance of patient's condition, anosognosia and the conviction that the diagnosis is wrong;

Phase 2 (dysphoria), arises after the confirmation of the diagnosis, it expressed by violent protests, dysphoria, a tendency to do acts of aggression against others or yourself (such as suicide);

Phase 3 (autoaggressive): is characterized by acceptance of the presence of the malignancy and the necessity of long-term treatment in combination with the necessity to avoid the pain;

Phase 4 (depressive) arises after a long period of therapy and expressed by gradual loss of hope for recovery, the emergence of pessimism, depression and passivity;

Phase 5 (apathetic) arises in the final stages of the disease, expressed by «reconciliation» of patient with the fate, acceptance of any outcome which accompanied by indifference regarding internal and external processes.

The number of cancer patient's suicide attempts is much higher than similar indicator in other somatic diseases. This fact indicates that, firstly, there are some distinctive features of mental feelings in oncology, and secondly, none of the existing disease does not pose such a powerful stress load as a malignant tumor.

The frequency and severity of mental reactions to the cancer pathology depend largely on the location and nature of the disease process, the presence of metastases and some other factors (A.V. Gnezdilov). Not only the nature and localization of cancer affect the frequency of mental disorders. An important role is played by factors such as the features of the cancer patient's character, the presence in the premorbide accented character traits (E.F. Bazhin, A.V. Gnezdilov).

Collision with the diagnosis of «cancer» often has a lot of stress for any person and activates different psychological reactions. The process of experiencing of the disease has a few obligate stages, each of which dictates the necessity of interaction with the patient according to his personality, that's why the understanding of the *phases of feelings* is an important tool for making contact in the «doctor - patient «system.

There are several phases:

1. Prediagnostic phase
2. Diagnostic phase
3. Treatment phase
4. Postoperative care (rehabilitation)
5. Progressive phase

Mental emotions and behavior of cancer patients are individual and very different during each phase of treatment, and depend on various factors (personal characteristics, previous experience, vulnerability of patient, age, sex, social status, treatment and flowing of disease, prognosis, etc.).

Prediagnostic phase.

During this phase the doctor must to answer the following questions: how people come to the conclusion that they have cancer? How they explain the symptoms that feel? What did affect the patient to ask for the medical help? The lack of clear symptoms and fear of catastrophic diagnosis often does not allow the patient to go to the doctor and detect the disease at an early stage of its development. Suspected cancer can occur during diagnostic process of any manifestations of diseases and during the routine inspection. The physician should ask the patient about the occasion and the time of his desire to get clinical examination («Why now?») during the taking a history. The patient, in turn, should as soon as possible to talk a doctor about their fears and misgivings. There are aggravation and suicide in this period.

Diagnostic phase. Uncertainty arises from the fear of the expectations of diagnosis, giving reason to suspect the presence of cancer. The change of mood from

panic to hope is became during the waiting of examination results. If suspected cancer diagnosis is confirmed by laboratory and X - ray studies than it is necessary the further examination and the doctor begins the process of clarification. Getting information about the disease and about the possibilities of the treatment is important for the patient and people close to him. Fear is the most common reaction to the news of cancer. The fear of cancer occurs at patients in varying degrees of intensity and may increase depending on the progression of the disease and its treatment method. Fear can be the cause of adaptation disturbances, which in turn has a negative impact on quality of patient's life, its social, emotional and functional ability. These reactions require correction as the general pathological fears (phobia, panic), which in most cases appear as early premonition of danger and they can be activated as a result of cancer. Clinical observations suggest that affective symptoms of patient behavior occur more often and express more strongly in the phase of diagnosis in patients with progressive disease than in patients in the phase of post-operative care. Fear and anxiety reach the highest point during the diagnostic, and then they gradually regress, giving the place for a sense of helplessness.

Phase of treatment.

Hope for the complete elimination of cancer in the patient is arising on stage of medical interventions. But fear for the future may develop during the treatment: fear of loneliness, loss of social environment and the profession, fear of isolation, pain, loss of identity (such as fear of distortion own body) loss of self-control and fear of treatment-related side effects. The reaction of apathy, the desire to avoid intrusive thoughts, terrible dreams or any thoughts about the disease can occur in patients during the treatment. Constant dialogue with doctor and involvement in a joint decision about the choice of treatment strategy are very important for the patient during this period.

Phase of postoperative care.

A carrying out of control checking awakens old fears in patients. If patient receives a lot of good news during the phase of post-operative care, then faster and more confident it get better, and the fears gradually recede.

Treatment in rehab - is the period of psychological and moral changes of many patients. Rehabilitation allows leaving the clinic and the debilitating treatment and gives new strength. The favorable course of the disease makes it possible to reconstruct the mental personality, accompanied by a strong desire to forget and often rethink life priorities which are resulting in improved quality of life compared with the period before the illness.

Progressive phase

There are disease recurrences, metastasis (re-treatment, palliative treatment), the final phase and the phase of dying during the cancer. Recurrence is associated with such psychological reactions as a re-shocking reaction during the diagnosis and as feelings of helplessness and hopelessness. The symptoms of depression are more expressed. The final phase is characterized by the patient's efforts to give a meaning to that is happening and to accept change as inevitable and unavoidable.

The complex of treatment, including psychotherapy effects must be provided at all stages until the last moment of life. It is important to remember that feeling of doom and fear of death looming contains a huge risk of suicide. There are brilliant descriptions of cancer psychology in modern literature: A.I. Solzhenicyn's novel «Cancer Ward» and N.P. Bobrov's story «Sashen'ka», which tells about lung cancer in author's five year daughter. The last tale is strongly recommended for a reading to pediatricians.

The main principles of work are: the installation to an active, full, rich emotional life, to the awareness of the possible existence of a higher content in life even in the limited time frame, to the necessity of it personal searching, to the spiritual self-improvement, to the opening a creativity, to the discovery for a new levels of existence, to the mutual assistance among patients and to the desire of living every moment of the remaining time by more dignified and with a sense of gratitude. The name of autobiographical notes of one of hospice patients - «I die happy» that deserves to become required for reading of every doomed patient indicates that it can happens.

Psychological effect of the congenital and acquired physical defects

The psychology of congenital defects

This is the psychology and personality features of persons which belong to the so-called «cripples» from their childhood. Physical defects of such children and adolescents are often caused by disorders of the muscular-skeletal system due to such diseases as coxitis, gonitis, spondylosis, traumatic injury of muscular-skeletal system. Physical defects of childhood include such diseases of the nervous system as encephalitis, poliomyelitis, birth injuries etc, during which are developing mono- or parahemiplegia and paralysis. Individuals with congenital subluxation and rudimentary limbs belong to this category too. Psychology of these patients has a number of common features and patterns despite the various causes and looks of the physical defects.

The common features are the features of the character in the formation of which following factors play an important role:

a) the environment (family, children's group, school);

b) self-consciousness-self-assessment of their defect by comparing the physical health of others.

The main role in shaping of the child's psyche belongs to the first factor. Such children, especially teenagers, are very emotional, vulnerable, fragile, sensitive, even if the surround people express the favorable and friendly attitude. They perceive even small hurt difficulty in the form of reactions such as anger or even aggression and alienation. Teenagers are very sensitive for the talks about the looks, they are fixed on the loss of it; they overrate their defects and talk about very tragic perspective. There are such features of the child and adolescent personality as: suspicion or neglect of his/her defect, also called bravado, as a kind of compensatory reaction.

The behavior of these individuals express in 2 types:

a) active type of the behavior which is manifest in the form of free, sometimes cheeky behavior as compensatory psychological reactions of the individual;

b) passive, in which the behavior has isolated character, with a tendency to loneliness.

Both types of behavior always contain elements of introvert. The degree of traits depends on the type and severity of the defect, the attitude of parents, family, doctor, teacher, educator that create psychological atmosphere of goodwill and are interested in terms of the interests and needs of the child, adolescent.

Relationships within the family and contacts with society are plagued by having a child with developmental disabilities. Causes of disorders are related with psychological features of the sick child, and with considerable emotional stress which is occur in members of its family in connection with long-term stress. The qualitative changes in these families are expressed at the *following levels*: psychological, social and somatic.

The psychological level

The birth of a child with developmental disabilities is perceived by her parents as a tragedy. The fact of the birth of the child which «is not such as all «is the cause of severe stress, which is experienced by both of parents, especially the mother. Prolonged stress causes significant distortion of parent's psyche and the sharp change of family life style. There are such changes in family areas as:

- the style of internal family relationships;
- the system of relationships of the members of family with surrounding society;
- the features of the outlook and values each parent of a sick child.

Social level

The family closes from others after birth of the child with development problems, because of the numerous emerging problems. It narrows the circle of friends and even relatives according to the features of the child condition and development, and because of the personal settings of the parents (fear, shame).

This overload also causes distortion of the relationship between the parents of the sick child. These families often break. The birth of a sick child and its health in

the future is the objective stressor that causes frustration in the family. According to the literature, incomplete families with children with developmental disabilities, are ranging from 30 to 40 %. The disintegration of the family with a sick child has a negative effect on the formation of the child with developmental disabilities.

Some families refuse birth of other children because of the presence of genetic disorders (fear of parents before the birth of another sick child is legitimate) and because of the mothers with children with developmental disabilities are alone. The disabled child is the only one in such families.

Somatic level of reaction

Stress that arose as a result of irreversible complex of mental disorders in a child can cause various diseases in the mother. There is pathological chain: disease of the child causes psychogenic stress in the mother, which provokes physical or mental illness.

Somatic diseases in parents of ill children have certain characteristics. The mothers have insomnia, frequent and severe headaches, menstrual cycle disorders and early menopause; frequent colds and allergies; cardiovascular and endocrine diseases; problems with the gastrointestinal tract.

Psychological features of persons with mental retardation

Specificity of mental health disorders in mentally retarded children is characterized primarily by total underdevelopment of higher cortical functions, inertia of mental processes, total underdevelopment of cognitive activity, expressed persistent deficit of abstract thinking, processes of generalization and distraction.

Features of cognitive function of retarded children are characterized by undifferentiated processes of perception and attention, unformed mental operations, narrow amount of mechanical memory and undifferentiated mnemic images.

Disadvantages of speech development of mentally retarded children have complex and systematic nature and are characterized by totally unformed speech activity and expressed difficulties with formation of verbal expression. The disorders

of emotional and volitional are characterized by a lack ability to control their trains, the presence of unmotivated fears, low criticality, inability to analyze their own behavior and, most importantly, very low socio-adaptive capabilities.

Intellectual defect of the mentally retarded children, which is leading causes particularly destabilizing effect on the psyche of their parents. The leading defect is stressful factors for the parents and relatives of mentally retarded children because of this anomaly, despite the existing potential of the development of positive dynamics, eliminates the possibility of full recovery of the child, successful social and labor adaptation and self-fulfilling life in society.

The position of mothers of mentally retarded children is contradicted. On the one hand, mothers show compassion to the children. The failure of mentally retarded children forces their mothers take care and control. On the other hand, the mothers of mentally retarded children have the weariness, irritation, desire to punish the child, ignore the interests of the child because of their primitiveness. Mother's emotional state characterized by depression, guilt, grief, shame and suffering. It should be noted that among parents of children with mental retardation is the high percentage of persons with intellectual disturbances. It greatly reduces the possibility of family to make the rehabilitation which ensures optimal development of mentally retarded child.

Features of formation of personality and emotional and volitional in children with infantile cerebral palsy can be caused by two factors:

biological features associated with the nature of the disease;

social conditions – the impact on family and child educators.

In other words, there are two factors, which affect the child's development: on the one hand, the special position related with limitation of the moves and speech which significantly affect the development and formation of the child, on the other hand - the relationship of family to the disease of the child and the atmosphere of the upbringing. That's why you must always remember that the personal features of children with infantile cerebral palsy are the result of close interaction between these two factors.

The disorders in the case of infantile cerebral palsy (ICP) are characterized by a combination of the triad: motor disorders, mental disorders and speech disorders, with accompanying of visual impairment, hearing disorders and sensory. motor sensitivity.

Movement disorders are the main clinical syndrome of infantile cerebral palsy and include paralysis, paresis, loss of coordination and violent movements, forming of bone deformities and multiple contractures. Pathology of the skeletal system is one of the most important factors that slow down and distort mental development in children with ICP.

The level of intellectual disorders is different in children with ICP. Some of the children with disorders of movement are close to the healthy children according to the development of intelligence. The majority of children with ICP has mental retardation which is also called as the psychic infantilism. Mental infantilism is the immaturity of child's emotionally volitional sphere. It can be explained by slow formation of higher brain structures (frontal parts of the brain) associated with volitional activity. Intellect of the child can respond to the age norms but the emotional sphere remains unformed. Emotional and volitional disorders can manifest itself in different ways. In some cases, it can be irritability. These kids are restless, fussy, irritable, and prone to unmotivated aggression. They are characterized by acute change of the mood: from extreme joy to irritability and explosion of aggression.

Another category differs by passivity, lack of initiative, excessive shyness. The possibility of choice puts them at a standstill. Their actions are characterized by weakness, slowness. Such children are very difficult to adapt to new conditions, it is difficult to go to the contact with strangers. They are characterized by various kinds of fears (heights, darkness, etc.). These features of the personality and behavior are much more common in children with cerebral palsy. The considerable disorders of intellect are expressed in some children.

The third group of disorders during the ICP consists of the speech disorder, dysarthria, rarely alalia and disorders of writing – dyslexia, dysgraphia.

The children that suffer from disorders of the muscular - skeletal system commonly have:

- Sleep disorders (nightmares, disturbing sleep, difficulty with falling asleep);
- Increased vulnerability;
- Increased fatigue.

The volitional activity is the serious problem which can be faced by parents at another area. Any activity that requires discipline, organization and focus, causes the difficulties in a sick child.

Overprotection is the preferred style of education in families with children and adolescents with cerebral palsy. It is known that such model of education leads to psychopathic development of the sick child's personality, it creates a self-centered settings and it has the negative effect to the formation of the senses of responsibility and duty. Typically, parents who show such style of the upbringing, reduce the labor and social activity. All this leads to the fact that the child grows inert, unsure of their abilities and capabilities timid. The child accepts the disease and not seeking independence. Such child expects that others will do all instead it. Then, the child gets used to this state of affairs, it is convenient for its. Among families with children with motor disorders, there are those in which there is emotional rejection of the sick child, manifested in the violent behavior of parents. And the model of family care often depends on psychological characteristics of the parents themselves, their value attitude to the child and their cultural level.

The personal attitude of the child to the own disease cannot be ignored. Obviously, that the situation in the family has the significant affects to it. The studies show that awareness of the defect express to 7-8 years old in children with ICP and it is related with the feelings of the hostile attitudes of others and with the lack of communication.

Thus, the features of the personality and emotional and volitional sphere during the cerebral palsy largely depend not only on the specific of the disease, but primarily on the attitude of the child's parents and family. That's why the thought

that the cause of failures and difficulties of education is related with child's disease cannot be assumed.

Psychological features of the children with sensory disorders

*Deafness i*s a serious mental disorder. It is caused by to the originality of the auditory analyzer – it has the crucial role for the development of language, especially as a means of communication. If deafness occurred before the age of 2 years, then comes the deaf – children cannot master the language, because of it cannot be heard. The second signaling system does not work in children from early childhood because of the speech cannot develop without special training methods.

Mental retardation is expressed in children before the period of special education, which eventually can be compensated. The emotional and volitional infantility, mental infantilism, retardation in the valuation of the interpersonal relationships are marked in the deaf children and adolescents. The tendency to avoid surrounding people without such defects and introvert features can be observed in such patients. Auditory and social deprivations are the causes of the displacement of character. Sensitive, nonsense-like idea of relationship can easily occur in the patients in society: they think that others judge and laugh from them. Actions of others are interpreted in the personal address. Patients hesitate of their defect, trying to hide it; they often are characterized by a lack of self - control and impulsiveness. The deaf child is forced to resort to gestures and significant facial expressions which are the necessary for the contact with loved ones, that's why rich facial expressions early develop in them. The general level of orientation in space and labor adaptation is higher compared to the blind. The doctor must carefully to talk about limited opportunities of the intellectual or social development of patients with disorders of the senses. The doctor should always remember and inspire the patients to believe that covert potential of psychophysiological functions is infinitely more.

Parents that have children with hearing disorders can be divided into two significant obstacle to the establishment of the social contact and interpersonal groups. The first - parents with normal hearing. Hearing impairment in a child is a

relationships for these parents. This in turn leads to a distortion of the interpersonal relationships and parental position in the family that provokes the negative attitude of deaf children to relatives and performs distortion of the personality development of deaf children. Another group of parents consist of those who also suffer from auditory disorders. According to the research of N.V. Mazurova (1997) they do not feel special experiences related with child's disease because they have such disease too.

Surdopsychology (lat. Surdo - deaf) is a branch of Psychology that studies the patterns of mental activity in the deaf patients.

The subject of Surdopsychology is the study of mental features and possibilities and ways of compensation of the varying disorders in the deaf patients.

The tasks of the Surdopsychology are: to identify general and specific patterns of mental development of people with hearing disorders compared to the people with normal hearing; to study the features of certain types of cognitive activity of people with impaired hearing; to study patterns of the personality with hearing impairment; to develop methods for diagnosis and psychological correction of the mental development of children with hearing impairment; to give the psychological description of the most effective ways and methods of the pedagogical effects to the people with impaired hearing; to study the psychological problems of integration of the deaf people into society, in particular the problem of integrated education.

There are no doubts that the exclusion of such important sources of information as the *vision* from the learning process can affect to the features of mental development of children. Awareness of their physical defect can occur in the child with *visual* impairment in about 7 years old. Adults only worse child's condition by the showing excessive care. There is indecision, timidity, tearfulness, separation from the children and teachers' irritability, moodiness, stubbornness, resentment, irritability in some blind children.

Constant readiness to the uncertain fears is observed in children with severe visual impairments. With age, the fears became more specific and more related to the vision's defect: patients fear to fall or to get lost or to confront with something.

Often there is a fear of loneliness and feeling of someone presence. There are such deviations before the early school age as: the separation from the others, passivity, depressed mood and autistic tendency.

The pathological fantasy on the theme of heard stories and read books are the common phenomenon in blind children. Imaginary figures are projected to the outside. Imaginary «living in a fairy tale» is the alternative to the invisible world. There is synesthesia which is also called the color hearing in some people with the early loss of sight. Sounds, words, melodies can cause the imagination of some colors.

Typhlopsychology (from the Greek. Tveloç - blind) is the part of the special psychology that studies the mental development of blind and visually impaired people, ways and methods of their correction. As a science, Typhlopsychology initially includes only psychology of blind. Currently Typhlopsychology also is studying the features of people with profound visual impairment and with amblyopia and strabismus. The subject of it is the psyche of people with profound visual impairment. The tasks of Typhlopsychology are to study the mechanisms of blindness compensation; to detect the potential possibilities of people with visual impairments; to develop the psychological basement of correctional and educational work with people with visual impairments; to develop the psychological basement of integration of the people with visual impairments.

Psychological features of the patients with acquired defects

If birth defects occur in children, then the acquired defects occur in adolescents and adults which are physically and mentally normal. Psychology of persons with acquired defects is described in the literature on example of the wounded in World War II which was very traumatic. There are such reasons for disability in peacetime as: a) injuries of the skull, eye (or both eyes); b) injuries of the limb with partial or a total amputation; c) the burns; d) the impact of radical surgery during maxillofacial pathology.

It is known that the individual psycho emotional reaction to a particular type of blemish begins to manifest after the acute period and will become heavier in the future depending on the type and degree of the defects, age, sex, temperament and character features, social status, prognosis of working capacity, possibilities of the prosthesis.

Persons with amputation of hands react more emotionally than the persons with leg amputation. Those who lost legs and eyes are the most oppressed. Acute changes in mental and emotional state arising in a case of deformation of the face due to injuries, burns, consequences of maxillofacial operations.

The experience of the patient assumes the character of a psychological disaster because of not only the defect and it significance are experienced by the patient, but the patient's perception of others is changed - the patient is convinced that his defect is unpleasant to them, so patient avoid the contacts, and vulnerability is appear. The emotional state became depressed even in strong personality.

Acquired physical defect of the face is profoundly change the psychological readiness of the patient to the social and labor adaptation, which often leads to the attempts of suicide.

There are deliberate demonstration of the defect, anger, conflict and aggravation of disturbed functions for the purpose of the benefits (disability group) in some patients with disabilities.

Reactions of patients with facial injuries

The patients more difficultly perceive the facial injuries than the loss of the other part of the body. The human face plays a role not only in making of the impression on others, but also in the creation of the impression of itself. The face is associated with the emotional sphere, and destruction of this communication leads to severe changes of the emotions and consciousness. Often there is disgust to itself in people with injuries of the face (burns). They are sensitive to the statements of others, became suspicious and excessive abusive. There are constant mood disorders - depression, frequent suicide attempts. The constant change in the character by the type of pathological (anxiety, hysteria, suspicion that transit in the paranoia) are

frequently observed. It is necessary to remember that the patient should be specially prepared to the first glance in the mirror.

The different versions of the psychotherapy based on the personal characteristics of the patient must be provided at all stages of rehabilitation .

Thematic plan for self-control

1. Psychological changes at diseases of the cardiovascular system.
2. Psychological changes at diseases of the bronchi and lungs.
3. Psychological changes at diseases of the digestive tract.
4. Psychological changes at patients with infectious diseases.
5. Psychological characteristics of the patients in endocrinology.
6. Psychological changes in female patients in gynecological hospital, during pregnancy and childbirth.
7. Psychological specifies of sick children and elderly people.
8. Psychological specifies of patients in the surgical hospital.
9. Psychological specifies of patients in dentistry, ophthalmology. oncology.
10. Psychological effect of the congenital and acquired physical defects.

Section VIII. Psychological aspects of dependent, suicidal behavior, thanatology and euthanasia

Psychological aspects of psychoactive substance addiction

Nowadays, there is a dangerous tendency of growth of drug addiction, for example, according to some statistical studies, every sixth boy or every twenty girl had some drug experience. The high urbanization level comes across a great proportion of teenagers, who behaves like that.

The modern Ukrainian youth is growing up in terms of transformation processes in the Ukrainian state. The formation of market relations, free flow of minor Western film and video production, a breakthrough in the information field – these and other aspects define a much calmer, compared to the previous generations, attitude of the modern young people to alcohol, tobacco, drug and toxic substance abuse.

The experience of drug use is growing rapidly with aging: 9 % at the age of 13 – 14 took drugs, 18 % – up to 17 years old, 6 % of minors, aged 13 – 17, use drugs regularly (including 3.4 % did that within last 30 days, and 2.6 % – from 3 times per month, or daily).

The most common drug among teenagers is cannabis. 17 % of the questioned boys and 6 % of the girls stated that they had used that particular drug for the first time.

As a rule, the first drug experience happens with friends. That is confirmed by the results of the study. Among those, who have drug experience – 39 % took them with friends, 23 % – received the drug from an older friend (a girlfriend), 17 % – from peers or the younger friends. Thus, it can be concluded that drugs are something common and non-awful in the imagination of the youth.

Modern science considers a drug as substance, officially recognized to be narcotic, because of its ability, even in case of a single use, to cause a specific euphoric condition, and in case of a regular use – mental or physical dependence.

Psychoactive drug (PAD) – any chemical substance that is similar to the narcotic effect on the body, but it is not officially classified as drugs.

Substance abuse is a diseased condition that is presented through the regular use of drugs (psychoactive substance), accompanied by the phenomena of psychic and physical dependence.

The causes of the substance abuse are complex and different. Social and cultural factors are of great importance. The following personal deviations lead to the drug development: infantilism, increased suggestibility, a propensity for demonstrative behavior, a desire to be in the center of attention, combined with low positive social attitudes. Among the socially constructed reasons for the drug abuse, there is a social disorder, unemployment, a low labor qualification, a condition of chronic stress. Moreover, in recent years the risk of the abuse has been growing among adolescents, who:

- were subjected to violence;
- are the victims of ill
- treatment in families, in different everyday situations;
- experienced a psychological trauma that had occurred as a result of parents' death, loss of close people;
- experienced a difficult divorce of the parents;
- tried a suicide attempt, and now are intending to commit suicide;
- are shy adolescents;
- had an abortion and other serious medical interventions;
- are gifted children, who have problems with adaptation to the environment;
- were in a crisis situation that led to the disorder of social adaptation.

Almost all drug addicts say that their slip in a remission period was associated with a variety of stresses, with which they could not cope with. This is negatively colored emotional distress (break-up with a close friend, family scandals) and eustress (holidays, meeting with old friends), accompanied by positive emotions.

During the regular use of *opiate*, appearance and condition of the patients are changed, they look much older: the skin is pale, dry, with a yellow tinge, with numerous wrinkles on the face. There is also a tooth destruction and loss. There is early alopecia, hair loses its shine and becomes brittle. The body weight is reduced. Drug addicts often have a lot of traces of non-drug injections on their superficial veins of the limbs, there is often some sclerogenic induration on the veins. The patients become dishonest, secretive, indifferent, and do not have a positive attitude to anyone.

Regular *marijuana* smoking (hashish, cannabis) is usually associated with some family troubles, poor progress in studies, early sexual activity, use of other drugs (including alcohol, psychostimulants, hallucinogens and sedatives). Other factors that cause the use of marijuana include: self-treatment in cases of anxiety conditions, depression, dissatisfaction with a life, a protest against social norms of behavior.

People, who use marijuana, are distinguished by strongly marked schizothymia characteristics, and those, who stopped its use, are suffering from severe depressions. During the psychological examination of the patients, who had been using marijuana for a long time, there were found some significant violations of cognitive processes, including understanding and assimilation of new information, weakening of creative abilities, language functions, a reduced ability of active attention, formation of short-time and image memory, violation of analytical and synthetic abilities.

There are the following mental problems: hallucinations, delirium, anxiety, depression, panic attacks, personality decline, memory and thinking impairment - all the said usually lead to dementia and suicide attempts.

Cocaine is another type of the dangerous drugs. It has a stimulating effect on the CNS that is similar to amphetamine. There is some emotion disturbance as euphoria, ineffective activity, insomnia, in case of overdose – irritability, aggressiveness, impulsive sexual behavior, as well as frequent hallucinations. Clinical scores are the following: a pale face, dilated pupils, tachycardia, increased

blood pressure, runny nose and cough. A euphoric effect is short: after 40 – 60 minutes, a good mood disappears, depression comes that sometimes causes suicide. The psychic drug addiction is extremely expressed, and it is often developed after a single dose. Regular use of cocaine leads to increase of tolerance, sometimes to death, because of the overdose.

It should be remembered that the people, who are directly in close relationship with those, who are substance addicts (relatives, family members, wives and husbands) have a condition that is similar to the psychological characteristics of the drug addiction. They have to hide the facts of the drug addiction of their loved ones from others, to transform their lives, combining a formal good external behavior with internal discomfort, leading to inadequate emotional "I".

Overvalued hobbies (gambling, Internet addiction), dependence of eating behavior

Gambling, ludomania - (pathological addiction to gambling) lies in frequent repeated episodes of gambling participation that dominates in the life of the subject, and leads to a decrease in social, occupational, material and family values.

A lot of researchers consider gambling to be a serious social problem that poses a threat to the population. The problem is complicated by the fact that in the game process, in some cases, there is some relaxation, relief of emotional stress, distraction from unpleasant problems, and the game is seen as a pastime. Based on this mechanism, there is a development of involvement and dependence.

C.P. Korolenko and T.A. Donskih (1990) identify a number of features.

These include:

1. Permanent involvement, much time in situation of the game.

2. Changing range of interests, displacement of the former motivations for playing, constant thoughts about the game, predominance in imagination the situations, involving game combinations.

3. «Loss of control», presenting in the inability to stop the game after a big win, and after permanent losses.

4. The state of psychological discomfort, irritation, anxiety, which are developed, because of the relatively short periods of time after the regular participation in the game, with a desire, which is difficult to overcome, to start the game again. Such states, for a variety of features, resemble the state of abstinence that the drug addicts have, they are accompanied by headaches, sleep disorders, anxiety, a bad mood and impaired concentration.

5. A gradual increase of the frequent participation in the game, the desire for increased high risk.

6. A periodic state of tension, accompanied by a playing «drive», the desire to find a way to participate in gambling.

7. Fast - growing reduced ability to resist temptation. This is reflected in the fact that, having decided once and for all to «give up» in case of provocation (meeting old friends, talk on the theme of the game, the presence of the gambling house and so on), and gambling returns.

Speaking about the psychological characteristics of the problem gamblers, most researchers underline the loss of control over their own behavior, and this applies to all versions of gambling – from betting to slot machines (O'Connor, Dickerson, 2003).

According to such Australian researchers as A. Blascinski and L. Nauer (Blaszczynski, Nower, 1997), there are three subgroups of the problem gamblers:

1. with behavioral problems;

2. emotionally unstable;

3. antisocial gamblers, who are prone to impulsive actions.

Although the gambling addiction is more common among men, this also concerns women. Women more often become addictive, and they are difficult to respond to psychotherapy. Unlike men, women come under the gambling dependence in adulthood for different reasons. The most common is private problems, which they try to solve by playing. Most often it occurs between the ages of 21 to 55, and in 1 – 4 % of cases the passion takes such forms, in which a psychiatrist's help is required. Every third pathological player is a woman. For

example, a recent comparative study of 70 problem men gamblers and 70 women gamblers showed a progressive development of the addiction among women in the stages: social gambling; intense gambling; problem gambling. The gender differences between men and women lie in the fact that gambling among women is often accompanied with a depressive disorder, and among men – with alcoholism.

It should be noted that those involved in the game often drink to excess and use another PADs, that is, they are involved in the combined forms of the addictive behavior. The gamblers often have difficulties of interpersonal relationships, frequent divorces, violation of labor discipline, frequent changes of workplaces.

There are some *factors that lead to gambling* (Korolenko C. P., Dmitrieva N.V., 2000):

- improper upbringing in the family;
- parents', friends' participation in the games;
- the desire to play from childhood (dominoes, cards, monopoly and so on);
- reassessment of material values;
- fixed attention on financial values;
- the envy of wealthy relatives and friends;
- the belief that all problems can be solved with the help of money.

An American researcher A. Pasternak (Pasternak, 1997), in his turn, identifies the following risk factors:

- belonging to a national minority;
- the absense of a family status;
- depression, as well as different variants of chemical addiction.

Stages of gambling development

R. Kaster (Custer, 1984) distinguished three stages of the gambling development:

- stage wins;
- stage losses;

- stage of frustration.

Stage wins represented by the following features: random play, frequent wins, imagination precedes and accompanies the game, the more frequent the game, increasing the size of bets, fantasy game, a very big win, irrational optimism.

For stage losses are typical: the game alone, boasting wins, thinking only about the game that can span episodes of losses, the inability to stop playing, lying and hiding from his friends problems, reducing worries about the family or the spouse, the reduction of working time in favor of the game, failure to pay debts, personality changes – irritability, fatigue, unsociable, severe emotional situation at home, borrowing money on the game, a very large debts by both legal and illegal means, the inability to pay debts, desperate attempt to stop playing.

Signs of frustration stage are loss of professional and personal reputation, a significant increase in time spend on playing, and the rates, removal from family and friends, remorse, repentance, hatred of others, panic, illegal activities, hopelessness, suicidal thoughts and attempts, arrest, divorce, alcohol abuse, emotional disturbances, withdrawal.

V.V. Zajcev and A.F. Shajdulina (2003) give special attention to the so-called *«thinking errors»* that form the gamblers' irrational orientations. The thinking errors can be strategic, causing a general positive attitude towards the addiction, and tactical ones that trigger and maintain the mechanism of «playing trance».

There are the following inner convictions of the strategic thinking errors:

- Money talks, including the problem of emotions and relationships with people.

- Lack of confidence in it and the expectation of success as a result of the winning, imagination of the possibility to solve all problems with the help of the successful game.

- Replacement of fantasies about the control over own destiny with fantasies about the winning.

The tactical thinking errors include:

- Hope of winning - a lucky day.

- Mindset that there will be a turning point in the game.

- Ideas about the possibility to return the debts only with the help of the playing.

- Emotional connection only with the last episode of the game and promising oneself not to play ever.

- Belief that it will be possible to play only for a part of money.

- Perception money, as playing, as chips or numbers on the display.

Imagine the bets as transaction. Internet addiction is defined as a non-chemical dependency' on the Internet use, accompanied by social maladjustment and psychological symptoms.

Internet addiction is a mental disorder, the obsessive desire to connect the Internet and the unhealthy inability disconnect it.

Evaluation criteria of the Internet addiction

Some researchers suggest various criteria, on which you can define the Internet addiction.

For example, Kimberli Jang stands out *four characteristics*:

1. A constant desire to check an e-mail.

2. A constant desire to go online.

3. Complaints of others that the person spends too much time on the Internet.

4. Complaints of others that the person spends too much money on the Internet.

Ivan Goldberg offers a more comprehensive system of *the criteria*. According to him, the Internet addiction can be confirmed by the presence of 3 *following points*:

1. The amount of time, which is required to spend on the Internet, in order to get some satisfaction (sometimes, the satisfaction of communication in the network borders on euphoria) is significantly increased.

2. If the person does not increase the amount of time he or she spends online, the effect is reduced markedly.

The first and second items reflect the occurrence of such a phenomenon as tolerance. Smokers, alcohol and drug addicts have the same characteristics, when it

is necessary to increase the dosage to get some pleasure. In this case, the «dosage» is the amount of time spent on staying in the virtual world.

3. The user attempts to abandon the Internet, or at least spend less time on it.

4. To stop and reduce the time spent on the Internet. That leads to unwellness, which is developed from over a few days to a month, and expressed by two or more factors:

- Emotional and move arousal.
- Anxiety
- Obsessive thoughts about what happens on the Internet
- Fantasies and dreams of Internet
- Conscious and unconscious movements of the fingers that resemble typing on the keyboard.

These emotional changes, which happen to the person, who tries to refuse from or reduce the time spent online, pointing to his psychological Internet addiction, and in a language of psychiatry, it is called «a denial syndrome» or «a withdrawal syndrome». In this case, it is very different from the «withdrawal syndrome» of smokers, drug addicts, alcoholics and people, who overeat, as they have not only psychological, but also a physical addiction to harmful substances, and it is difficult to cope with the withdrawal from drugs. The advantage of the Internet addiction is the absence of physiological component. The withdrawal syndrome causes the reduce or violation of social, professional or other activities.

5. Using the Internet allows avoiding «the withdrawal syndrome».

6. The Internet is often used for a long period of time or more than it was intended.

7. The significant social, professional activity, time off work are stopped or reduced, due to the use of the Internet.

8. Using the Internet is continued, despite knowing about the existence of permanent physical, psychological, social and professional problems that are caused by using the Internet (lack of sleep, family (marital) problems, being late for the meeting scheduled for the morning, neglect of professional duties).

Compulsive overeating (or food addiction), which is in the need of frequent meals, and the cause of it is not associated with hunger. This is the most socially acceptable form of passion, although getting rid of it is a long and complicated process.

Why is there food addiction? The answer is simple: like all other addictions, the food one is an attempt to escape from problems, not with their solutions, but by «emotional eating' («emotional drinking», «flirting», «emotional smoking», etc. in the correspond dependencies).

Overeating may be permanent or paroxysmal, aggravating in adverse situations. Often, the need for food is increased in a situation of stress or, conversely, in its absence, in an atmosphere of boredom.

Are there any analogues of overeating?

There are no complete analogues, because, besides sucking and chewing reflexes, a deeper one is involved – a food instinct. There are some elements of extinguishing the «anxiety lips» by loading them up with some work. This is nail biting, biting of skin holes around nails, biting of the tip of a pencil, of seeds, chewing gums, of mucosa of the inner surface of the lips.

Thus, the anxiety has a lot of external manifestations. This is a tense posture, stiffness of facial muscles, shoulder girdle, sharp head turns, involuntar movements of the fingers, legs shaking, body rocking and so on. The more severe anxiety can be manifested in the need to move, absorb food.

The symptoms of the «disturbing feet» and «disturbing lips» are similar, because there is an inversion of the passive anxiety to an active movement. Over time, there is the food addiction, food tolerance is increased – the body is not satisfied with the number of eaten in the past and requires more. This is contributed by a physiological factor – the increase in the stomach, and, hence, the area of absorption. Thus, a vicious circle is formed.

Methods of treatment:

a) An encoding method is applied to block the food center by a psychotherapy ban, but the engagement of a more primitive process is not considered

– the act of chewing. The psychological state of the patient, explicit or subtle emotional disturbances are not taken into account.

b) Rational therapy offers the ways of independent ridding of this passion, finding out the causes of disinhibition of the food addiction.

Codependency

A codependent person is the one, who is totally involved in control of another person's behavior, and does not care about the satisfaction of their own vital needs.

The codependent people are:

1) people, who are married or have intimate relationships with a patient with substance abuse;

2) people, who have one or both parents, suffering from substance abuse;

3) a person, who was brought up in emotionally repressive families.

The codependent people come from the families, in which there was the substance abuse, or ill treatment (physical, sexual or emotional aggression), a natural expression of feelings was forbidden («do not cry», «you are too merry, be careful, you may cry» «boys cannot cry»). These are called a dysfunctional family.

Symptoms of the dysfunctional families:

1. Denial of problems and support of illusions.
2. Vacuum intimacy
3. Freeze of rules and roles
4. Conflict in relationships
5. Non-differentiation of «I» of each member («If mom gets angry, then all get angry»)
6. The boundaries of a person are mixed or separated tightly with an invisible wall
7. All hide the family secret and support the face of pseudo happiness.
8. Tendency to the polarity of feelings and judgments
9. The closed system
10. Absolutize the will, the control.

The main characteristics of the codependency

1. Low self-esteem is the main characteristic of the codependent people, upon which all others are based. Herefrom, there is such a feature of the codependent as an outward orientation. The codependent people are completely dependent on external assessments, relationships with others, although they imagine poorly how others should treat them. Due to the low self-esteem, the codependent people can constantly criticize themselves, but cannot stand, when they are criticized by others, in this case, they become arrogant, angry, and aggressive.

2. A compulsive desire to control the lives of others. The codependent wives, mothers, sisters of the addictive patients are controlling relatives. They believe that they are able to control everything.

3. The desire to care and to save others. The more there is a chaotic situation at home, the more effort they make to control it. They think that others see their family the same they represent it. The following phrase is common for the wives of the substance abuse patients: «I want to save my husband». The codependent people love to take care of others, often choosing the profession of a doctor, a nurse, a teacher, a psychologist. This behavior is a consequence of their conviction that they are responsible for feelings, thoughts and actions of others, for their choice, desire and need, their happiness and unhappiness, and even for their destiny.

By «rescuing» the substance abuse patient, the codependent people inevitably obey the laws, known as «Karpman drama triangle». There are the following three roles of Karpman triangle: Rescuer – Persecutor – Victim.

If the codependent person does not learn to recognize the moments, when they have to be a Rescuer, they will always allow others to put them in the position of the Victim. In fact, the codependent people are involved in the process of their own victimization.

Shifting the roles in the triangle is accompanied by changes of emotions, and, quite intensive. The time spent by the codependent person in one role can last from several seconds to several years, it is possible to have a lot of roles – as the Rescuer – the Persecutor – the Victim.

The aim of psychotherapy is to teach the codependent people to recognize their roles and consciously abandon the role of the Rescuer. The prevention of the role as the Victim lies in a conscious rejection of the role as the Rescuer.

Suicidal behavior, prevention and early detection of suicidal tendencies. Suicide, motives and aims. Variety of suicidal behavior. Timely detection of suicidal thoughts and intentions. The role of social services, trust services

Suicide has been known to the mankind since ancient times, but at different stages of history, the attitude towards it was different. Almost all peoples had the acts of sacrification for the sake of social or religious interests. For example, it was as a way of survival in the starving times, or the suicide of «old believers», who did not want to be baptized. The women also committed suicide, when their husband died, demonstrating their loyalty (the Indian people have a positive attitude to a ritual of women's self-immolation after their husbands' death). There is an «honor code» among military commanders, when, in case of defeat, the shame disappeared after the suicide.

Suicide often occurred during the periods of the so-called society recessions (1908, 1923, 1933). This dependence is due to not only social or economic conditions. Both the rich and the poor find a reason to commit suicide (a Russian millionaire Sava Morozov committed suicide, as well as a 38-year-old daughter of a multi-millionaire Onasis). The problem of suicide is the most serious in the industrialized countries (most of all, in Sweden), the level of the completed suicides is higher among men than among women, although the latter ones commit suicide attempts more often. Perhaps, this is due to the fact that men tend to use more traumatic means such as guns, hanging, or they jump at a height, but men seldom poisoned themselves, as women do.

Over the period of two decades, a suicide risk among young people has been increased. Thus, suicide attempts among children and young teens are quite rare, but starting with the age of 14 – 15, the suicidal activity begins to rise sharply (30 % of

children of this age have the suicidal thoughts). Suicide attempts are made by 6 % of boys and 10 % of girls.

In general, the increased suicidal activity among the post-Soviet population is caused by the change of ideological priorities of valor and compassion for acquiring wealth and achieving the fullness of life experience. The absence of only one of these components among modern humans can cause the feeling of inferiority.

Suicide is an intentional life deprivation. Most suicides are committed by mentally healthy people in a state of social and psychological maladjustment in terms of micro social conflict.

Often, suicides occur, when a person has some symptoms of depression, which can be noted among healthy individuals and related to some traumatic situation, or among the mentally ill people on the background of thinking disorders.

The psychological state, in which a decision on suicide is made, is characterized as a crisis, associated with interpersonal or intrapersonal, conflict.

In a state of the *suicidal* crisis, a person feels anxiety, depression, dive into their experiences, and there are no important things in life for them. A personal pessimistic commitment to the prospects for overcoming the crisis and a negative self - attitude reach its extreme forms and defines a *suicidal behavior* – first thoughts and intentions of suicide, and then, the preparation and implementation of an act of suicide.

The duration of the *pre-suicidal period* until the completed suicide is different – from several minutes to several days, weeks or months.

The suicidal behavior has several varieties:

1) «Protest»or «protest – revenge»;
2) «Call»; - «Avoidance»;
3) «Self - punishment»;
4) «Failure».

The protest forms of *behavior* occur as an attempt at an objective link of conflict that is aggressive towards the person. The «revenge» is a specific protest, in order to harm the enemy (from the point of view of the suicider) environment. The

behavioral reaction of this type is considered to be the transition of the impossible hetero - aggressive behavior into a variant of the autoagressive actions.

The suicidal behavior of the type «call» is intended to draw the attention of the people around, in order to change the current situation. Statistically, each five acts of suicide – four, in one or another form, tried to find a way to get out of the crisis.

The behavior of the type «avoidance» occurs in cases that threaten the biological existence of the person, or significantly reduce their self-esteem, provided rather high initial level. The person, to some degree, removes themselves from the crisis.

The motivation of the type «self-punishment» occurs, when there is a kind of self-introjection simultaneously with a role as a «judge» and «defendant», accompanied by active self-blames and attempts to destroy a «self-enemy».

In case of *«failure»,* there is a kind of ' fusion ' of the purpose and the reason, resulting in the suicidal behavior as a manifestation of the surrender to the circumstances.

A choice of the suicide method depends on social, cultural, historical, and individual psychological religious, aesthetic, situational moments characteristics of the person. It also determines by a sincere intention to commit suicide, or a desire to demonstrate this intention. The absence of an objective of the intentional desire to commit suicide, allows distinguishing the true form of suicide from various forms of the *parasuicidal behavior*.

Different individuals may have various suicidally dangerous individual and psychological reactions. However, the characteristics of the suicidal behavior are largely determined by a personal content provided by a person of the decision to commit suicide: objecting to an offender, calling for compassion, avoiding sufferings, self-punishment, conscious rejection of life.

The period after *suicide attempt* is defined as a *post-suicidal state,* which also has some certain dynamics. Its duration and prognosis in terms of other attempts of suicides are defined with urgency of the conflict (whether it was initiated or not).

The presence or the absence of a critical attitude to the actions, as well as to similar suicidal reactions in the past.

There are several signs of high risk of suicide:

1. A suicidal attempt in the anamnesis. The second attempt is often committed within three months after the first one;

2. Psychiatric disorders: depression, psychosis, alcohol abuse, drug addiction;

3. Employment type: unemployed and unskilled workers make suicidal attempts more often than qualified people. The suicidal behavior is more common among actors, doctors, musicians, poets, writers, employees of law enforcement, physicians (especially psychiatrists, ophthalmologists, dentists and anesthesiologists), insurance agents, lawyers;

4. Marital status and social circle. The highest risk of suicide is among unmarried, divorced, widow and widower, those, who are married but childless, singles, people, who lost their loved ones;

5. Gender. Men commit suicide three times more often than women, but women are 2-3 times more likely to attempt suicide;

6. Age. The suicide rise is possible among the young people, aged 15 – 19, men at the age of 50 – 70, women over 50 years old (often, at the age of 55-65);

7. Family anamnesis and religious affiliation. Suicide is often committed by those, who had the similar cases in their families. The individuals from Catholic and Muslim families rarely commit suicide;

8. Health status. The suicide risk is increased after some operations, when a person has some regular pains, among people with chronic and incurable diseases, patients infected with HIV (30 – 40 times more than among healthy people), cancer patients (2 – 4 times more).

The suicide risk assessment is very important. Each approach to this assessment has to be individual. It is always possible to influence the decision of the person to die. In case of psychosis, it is often enough to use some basic treatment, in case of some affective disorders – a doctor can prescribe some antidepressants, other people just need some moral support. If there are statements regarding the intention of

suicide, it should be considered seriously, because in the future, there can be the real suicide attempts. It is also advisable to know the following concepts:

1. *Pre-suicidal syndrome* – a type of the suicidal dynamics that can last from a week to several months;

2. *Suicidal tendencies* – thoughts and suicide attempts as perversion of protective instinct. They also include the actions that were taken in the heart of a moment, due to immaturity of the idea of life and death;

3. *Suicidomania* – constant efforts to end the life with the help of suicide (often, in cases of depression, schizophrenia, psychopathy);

4. *Para-suicide* – incomplete suicidal acts that result the suicidal threats, or a type of suicidal behavior, which precedes the completed suicide;

5. *Suicidal threats* – threats to commit suicide, which should be considered as a way of impact of the individual on a difficult situation. However, in case of these «demonstrations», there is always the danger that this attempt could be realized.

The organizational forms of providing some medical and psychological care during the suicidal crisis are: «Helpline», social and psychological care offices in clinics, crisis centres, where the person can not only obtain various types of psychological care, but medication.

E. Shnejdman describes common *features of suicide*:

1. The overall objective of suicide is to find a solution. Every suicide is intended to find the solution to the problems, which the person has, and causes intense sufferings. To understand the cause of suicide, it is necessary to know what problems it was supposed to solve.

2. The overall objective of suicide is cessation of consciousness.

3. The common stimulus of suicide is an unendurable psychological pain. There is a rule in Clinical Suicidology: reduce the degree of sufferings and the person chooses the life.

4. A common stressor of suicide is frustrated psychological needs. First of all, suicide is committed through unrealized or unmet needs. Satisfy the frustrated needs and suicide will not arise.

5. The overall suicide emotion is helpless – hopeless.

6. A common internal attitude to suicide is ambivalence.

7. A common state of mind is cognitive constriction. The synonym for the narrowing is «tunelizing», that is, a sharp limit of behavior choices, which are available to the consciousness of the individual.

8. The general action in cases of suicide is aggression (escape).

9. A joint communicative action in cases of suicide is a statement of intention. Their recognition is an indispensable condition for the suicide prevention.

10. The general pattern of suicide is the general compliance of the suicidal behavior with the general lifestyle. The personality of the suiciders has some originality – this is impulsivity, psychological immaturity or, in other words, infantilism, emotional instability, uncompromising, limited thinking, when choosing solutions to the problem that has arisen.

To prevent suicide, it is necessary to recognize the development of the crisis timely, and create the conditions for adequate emotional and intellectual reaction and mental processing of a psycho-traumatic event.

Since depression precedes most suicides, early recognition of the depression symptoms with its treatment, with the help of medication and psychotherapy is an important factor in the prevention of suicide. Usually, suicidology researches are aimed to identify people with a high risk of suicide, then, to help such people, preventing the suicidal attempts.

Hotline is a service that provides some emergent psychological assistance by telephone. In general, the Hotline, in cases of the help by psychologists, who do not have clinical and medical acquirements, is used not for the organization of traditional psychotherapy, but mainly in order a person, who has some difficulties, could find a companion, get rid of emotional stress, share experiences, get support to change their hard, unbearable emotional state. Talking to a consultant allows a lot of people not to stay alone with their feelings. In this sense, the Hotline is extremely useful and can be defined as a psycho-preventive emergency aid, which is aimed at the case of urgency. It provides the individuals, who are in critical situations, immediate

communication by telephone from an anonymous sympathetic listener, who knows a special technique to work on the phone.

Some features of suicidal behavior of somatic patients

The features of suicidal behavior of AIDS sufferers

Suicidal behavior among HIV - infected and AIDS patients occurs 30 – 40 times more than among the healthy people. This is, primarily, due to a hard perspective of the imminent death, lack of current effective medicine. Therefore, this condition needs a special attention from doctors.

Suicidal thoughts are typical for people, who are in a risk group (especially those, who have a seropositive reaction) on the background of the self-blame ideas, although suicide attempts are rare to happen. Most often, suicidal attempts are common in cases of a symptomatic period of the illness, in which depression is typical, especially among the patients, who have witnessed the death, because of AIDS, and among psychopathic individuals.

The features of suicidal behavior in Oncology

There are four main periods in the dynamics of the mental state of cancer patients: pre-medical, ambulatory, stationary and terminal. The stationary period has the highest risk in terms of suicide. During this period, the anxiety is increased with the neoplastic progression and metastasis, suspiciousness appears with some doubts in the fidelity and appropriateness of the treatment, the patients often find that they are treated improperly, and hopeless experiments are carried out. The symptoms of asthenia with fatigue, lethargy, heightened sensitivity are predominated, general background of the mood is reduced, and there is sub depressive or depressive condition.

The features of suicidal behavior in cases of congenital and acquired physical defects

The behavior of the people with congenital defects is caused by some typical characterological changes, in formation of which both the environment (attitude to the defects from the environment and people around) and self-informing are important, based on their own assessment of their defects, when compared with healthy people. Even in cases of a friendly attitude and other favorable conditions, the emotional reactions are of a high sensitivity and vulnerability. The active and passive type of the adapted behavior to the condition always has the elements of introversion. Teenagers are very sensitive to talk about their appearance, they focus on their losses, the existing flaws are important, they paint their own tragic perspective. Such a condition is the most threatening, concerning suicidal behavior.

The emotional reaction of the people with disabilities is most obvious after an acute period, and it is increased gradually, depending on the type and extent of the defects, age, sex, temperament and character features, social status, forecast of working capacity, opportunity of prosthetics, etc. Most emotional reaction occurs in cases of loss of lower limbs, eyes, face, hands. The person experiences not only the fact of the loss, but also the subjective value of its consequences from the perspective of their own hierarchy of values. This mental state may cause suicidal intention and various tendencies of different sustainability.

The features of suicidal behavior in cases of a state of dependence

The states of substance dependence (alcoholism, drug addiction, substance abuse) can also be accompanied by suicidal behavior in cases of various manifestations of the disease, especially in cases of the pathology of perception (hallucinosis), or thought disorders (delusions on the background of the fear affectus), expressed withdrawal syndrome.

Psychological aspects of dying and death. Euthanasia

Death is an irreversible cessation of all vital functions. It has a personal and cultural value, concerns not only a dying person, but also alive people. According to the psychoanalytic theories, it is normal for people to be afraid of death, although a number of studies show that far fewer people feel the fear of death that reach old age. They are not afraid of the death itself, but the possibility of prolonged and painful dying.

The issue of importance of the death in our lives and description of experiences, when a person dies, define a plenty of problems. There is often a fundamental idea of a person in its basis about lifetime or consciousness after the physical death of the body.

Natural unconscious psychological protective mechanism in the form of «denial», helps the process of the conscious processing of life stress, such as illness and dying, but can also prevent a person to struggle against these difficulties.

Kjubler-Ross highlighted *five phases* of adaptation to the thoughts of death:

I. «objection»;
II. «protest»;
III. «auction»;
IV. «depression»;
V. «acceptance of death».

The critics of this common to all people scheme of the reactions to the approach of death, indicate that each person is a unique one and cope with the thought of death in their own way.

Psychology of death also has a complex structure.

Peterson (1977) highlighted *four kinds of death*:

Social death – a person needs to isolate himself/herself from others;

Psychological death – human awareness of the inevitable end, accompanied by a reduction of extroverted consciousness, increase of introversion with an analysis of the past;

Cerebral death – a complete cessation of the brain with the control loss over providing life functions.

Physiological death – fading of the functions of the body that ensure the activities of their vital organs;

There were a lot of scientific concepts for the notion of «mechanics» of interpersonal experiences and altered states of consciousness that occur among some people at the time of the death approach, especially sudden. It is believed that all the observations of the altered states of consciousness are explained by some common, genetically determined patterns and brain hypoxia.

Some experts note the possibility of changing the mental state of a person even during the last stages of dying. Sometimes it can be seen the paradoxical behavior when a person says that he or she is happy, that there is the higher meaning of life in front of them. This position is the conceived fetus of awareness of the existential drama of a human life.

Close people of the dying person have to adapt themselves to the process of the dying and the death. Their psychological reactions in such situations, according to Kjubler-Ross, correspond approximately with the same that ill people have. There is evidence that the psychological reactions of the loss, the nature of the loss in case of the death of a beloved person, and the time required to recover from the heavy loss, are caused by cultural traditions.

The problem of euthanasia

Euthanasia (from Greek «ευ»- «good» + from Greek «θανασία» - «death») is the practice of ending (or reduce) a person's life that is made by a doctor, who is suffering from an incurable disease, experiencing unbearable suffering, to meet the request of the patient to relieve pain and suffering.

The term «euthanasia» was first used by F. Bekon in the 17th century to refer to «an easy death». The issue of the human right to manage own death and regarding the euthanasia is being under debate nowadays.

There are *two* types of it: active and passive euthanasia.

Active euthanasia is the deliberate killing «out of pity», at or without the request of the patient. In the legal aspect, these actions are treated as a murder – in countries, where euthanasia is illegal. Active euthanasia is also called «a method of a filled syringe».

Passive euthanasia entails the withholding of especially complex medical methods for supporting a patient's life, which, in spite the fact that they continue his existence, but cannot save him. It is about reducing of the disthanasia period, i.e. «bad dying». Passive euthanasia is also called «a method of deferred syringe».

In countries, where euthanasia is legally recognized (by 2009, some forms of voluntary euthanasia had been officially allowed in Belgium, Luxembourg, the Netherlands, Switzerland and some US states), for its implementation, nearly forty demands must be kept up with, including the affirmation of the absence of any other modern medical methods of life preservation.

The dominant views of society are the ones that prohibit the use of medical experience of a doctor's knowledge with the aim of introducing «an easy death», even at the patient's request. An unresolved problem regarding the concept of «clear consciousness» of a person, who is in the state of illness, as far as he or she realizes this request, contributes to this. The objections to the attempts of the fact that euthanasia has to be formally recognized are also in the practice of medicine, because there are some cases, when even people with the «doomed» diagnoses were cured. It is completely impossible to ignore such facts. Moreover, practice shows the person's ability to adapt to life, in spite of complete disability. Acceptance of euthanasia as a form of medical care will certainly preclude from the development of medical science that is stimulated with the medicine struggle with death.

The concept of hospice stands against the views that life sustaining of the death-sick people with the help of medical equipment only and medicines, is allegedly ignoring the human needs of autonomy and expressing their feelings in common for them environment. This concept lies in the fact that death is as natural as birth, but sometimes it is «heavy work» that requires alleviation of suffering and help of specialists. Hospices, providing palliative care, given the opportunity to the

terminally ill patients to live the rest of their lives as rich as possible, painlessly and independently

Thematic plan for self-control

1. Psychological aspects of psychoactive substance addiction
2. Overvalued hobbies (gambling, Internet addiction), dependence of eating behavior
3. Notion of codependency, family and social relations of dependent persons
4. Suicide: variety, motives and aims.
5. Prevention and timely detection of suicidal thoughts and intentions.
6. The features of suicidal behavior of AIDS sufferers, oncological patients
7. Features of suicidal behavior of the patients.
8. The features of suicidal behavior in cases of a state of dependence
9. Psychological aspects of dying and death.
10. Notion of euthanasia, pro et contra.

Section IX. Mental rehabilitation hygiene, psychological prophylaxis and rehabilitation

Mental hygiene is the science of security, preservation and support of the human's mental health, which studies the factors and environmental conditions, which affect the mental development and mental condition of the person and develops recommendations in order to preserve and promote the mental health. It is a part of more general medical science of the human's health, which is hygieology. The specific feature of mental hygiene is the following: it has strong connection with clinical (medical) psychology, which is considered as a scientific basis for mental hygiene by Mjasishhev V.N. (1969). In the system of psychological sciences, which was proposed by Platonov K.K. (1972), mental hygiene is included into medical psychology.

In the USA in 1909 National Committee on Mental Hygiene was founded, it was engaged in the prevention of neuropsychic diseases of the healthy individuals, creating of the most favorable conditions of life for the individuals, who are prone to diseases as well as the organization of treatment for already diseased individuals. In a few years the mental hygiene society began to extend. So in 1917 it was founded in Canada and in 1918 – in France. In Paris in 1922 the representative International Congress of Mental Hygiene took place. And in the thirties of the twentieth century, the term «mental hygiene «was replaced by the term «mental health». Founded in the United States Committee on Mental Hygiene was renamed as National Association of Mental Health. Section of Mental Health at the World Health Organization was formed after the Second World War. The concept of mental health is characterized by emotional well - being, freedom from anxiety as well as ability to establish constructive relations and respond to the daily demands of life.

Since 1970's Center of psychohygienic activities moved into the local communities, so-called support groups, which are considered as an alternative form of the government centralized services.

Today the idea of self-friendly, possession of the own psyche, on which the modern idea of mental health is based, becomes the humanistic value. Currently, the aim of mental hygiene and psychoprophylaxis is to provide specialized help to the practically healthy people in order to prevent neuropsychic and psychosomatic illnesses and self-neural facilitation of the acute psycho-traumatic reactions.

There is various systematization of mental hygiene sections, which usually distinguish the personal (individual) and the public (social) mental hygiene. In the system of mental hygiene knowledge the *age-related mental hygiene* is separated independently with the following sections: mental hygiene of childhood, youth, adulthood, old people. In addition, it is separated *the mental hygiene of intellectual and physical labour, the mental hygiene of life and family relationships.* There are also several special sections of the labour mental hygiene - the mental hygiene of engineering, sports, military, etc. All kinds of mental hygiene directions are closely related to each other. So, the age-related mental hygiene is the integral with the mental hygiene of training and education, labour and life.

Mental hygiene of education

V.M. Behterev (1905) noted that the temperament deviations begin at an early age often because of the certain conditions of education, which could be easily removed in time. This point of view received the further development in the studies of domestic neuropsychiatrists. Specifically, Mjasishhev V.N. noted that an inadequate education, particularly in the style of praise, contributes to the formation of hysterical temperament, and excessive demands promote the creation of the psychasthenic features of the personality. False education can often promote the formation of child's psychopathic traits. Kerbikov O.V. and V.Ja. Gindikin (1962) on the basis of their researches were pointing out that hyperprotection and neglect in childhood are typical for the excitable psychopaths. Education according to the type of «Cinderella», i.e. without affection and attention, at constant humiliation, often leads to sleep disorders and the development of neuroses, because sleep is the

main condition for the rest and recuperation. Thus, the compliance with the mental hygiene norms in the process of education is at the same time the psychoprophylaxis.

Mental hygiene of training

The proper training system ensures the harmonious development of the personality. Defects of the training can also contribute to the formation of the abnormal traits of children.

The first school year is a crucial moment for the child. Here the child for the first time faces with new requirements, unusual regime and responsibilities. It is easier to adapt to school for the children, who attended preparatory group in kindergarten, compared to so-called «home children». Properly prepare the child for the school is not an easy task. Great assistance for the parents in this case can by provided by children's doctors and clinical (medical) psychologists of children's clinics. Knowing the individual characteristics of children, they can provide parents with the appropriate recommendations.

Mental hygiene of labour and life

Labour, activities are an integral human need and under favorable conditions they are an important factor for maintaining and strengthening of the health. A number of studies have shown that deprivation of employment, unemployment are accompanied by the deteriorating of mental health and increasing of somatic diseases. Labour can not only enhance mental health, develop capacities at healthy people, but also to treat patients. Occupational therapy is widely used in psychiatric hospitals, where, like any therapeutic effect, strictly dosed according to the weight of neuropsychiatric disorders.

The distinction between intellectual and physical labour in modern society tends to the abrasion. However, differences between mental and physical labour objectively exist, which allows to talk about the relevant sections of mental hygiene. Lebedinskij M.S. believes that it is necessary to consider as the intellectual labour «such mental work, which is being done in a certain direction, according to the

defined plan in order to solve certain tasks with the purpose to obtain the certain result, which has a particular public importance».

Mental hygiene of family and sexual relations

Family represents the small group, characterized by a number of specific features. These features are caused by the formed traditions, relationships between the older and younger generations, the unity of habitation, life and other factors. Family can contribute to the disclosure of the creative human capabilities, encourage person to the useful activity or hamper the initiative, undermine moral. Marriage becomes a happy one in such cases, when the spiritual and physical proximity constitute harmonious unity. In the developing of family mental hygiene problems the specialists created the concept, according to which the diversity of relationships between people can be represented in the form of five marital factors interactions: *physical factor, financial, cultural, sexual and psychological*. According to the defined formula the so - called marriage potential is calculated. If there is the main focus of the marriage factors on the family strengthening, the marriage potential expressed by a positive factor, otherwise the value is negative. In case of negative marital potential, which is actually the true sexual disharmonies (discords), the family relationships and sexual relationships are broken. In primary personal inconsistencies always collapses the sexual life, and family disintegration occurs faster than it takes place in the case of the primary sexual mismatch. The adequate level of personal development, maturity of judgment and emotional relationships is required for a higher level of family adaptation, family relationships harmonious development.

The most effective way to prevent the family conflicts is the careful preparation for the marriage. To this way includes the following: taking care of the health of pregnant women, combating of the childbirth disorders, providing of the proper mental and physical development and education of children, special training of persons, who are entering into marriage, diagnostic and therapeutic work in cases of family sexual disharmony.

Psychoprophylaxis

Psychoprophylaxis is a branch of medicine, which deals with the development of measures, which prevent the emergence of mental illness or their transfer into the chronicity.

Methods of mental hygiene and psychoprophylaxis include the psychocorrective work within the counseling centers, «hot lines» and other organizations focused on psychological care for the healthy people; massive survey in order to identify so-called risk groups and prevention work with them; informing of the population and so on. Medical workers and psychologists join forces with the purpose to conduct interviews and advice relating to the problems of marriage and family, fight against bad habits, formation of the healthy lifestyle in the younger generation. The way in which people perceive themselves, their lives, other persons-positive or negative-may indirectly affect the condition of the person's body. Subjective vision of the situation in which the person is located, leads to the development of certain relationships with other people. Percept images, relationships with other persons generate appropriate emotions. In their turn, emotions are manifested not only in the experiences at the behavioral level, but also on somatic one. For example, a number of «toxic» emotions: anger, fear, anxiety launch or support a number of the person's psychosomatic diseases. So in a state of anger the ability of the heart to pump blood is reduced by 5-7 %, leading to the increase of the repeat heart attack probability. Emotions launch into the course the certain mechanisms, which influence the immune system.

Mental hygiene as a scientific field of health, studies state of nervous and mental health, its dynamics in the connection to the impact on humans of the different environmental factors (natural, industrial, social and social conditions) and develops on the basis of these studies the scientific substantiated measures of the active impact on the environment and function of the human body with purpose to create the most favorable conditions for maintaining and strengthening of the human's health. If until recently the duty of hygiene as a science was mainly to study the influence of external factors on somatic health, nowadays the subject of its main

concerns is the analysis of the environment impact on the neuropsychological status of the population, and especially the younger generation.

In the complex of psychoprophylactic measures it should be considered both as environmental factors and etiologic and pathogenic factors associated with the person caused by person's constitution and premorbid personality characteristics. Here the following factors we should be kept in mind: a) personal; b) the nature of interpersonal interaction; c) situational - in their relationship. During the psychological prophylaxis conducting both the own body defenses, stored components of the psyche and distinctive features of the disease and its consequences should used.

Specific objectives of mental hygiene and psychological prophylaxis are to help people in crisis situations of the family, educational or industrial nature, working with «young families» and those families which are breaking down and so on. Considering the fact that nowadays the psychogenic origin of many mental disorders as well as diseases of cardiovascular, immune and endocrine systems, gastrointestinal tract can be considered as the proven one, it is important to perform measures for the protection of human health against the negative impact of psychogenia. In this case the main importance has the following: early detection, diagnosis and comprehensive treatment of neuropsychiatric disorders, prevention of relapses and transfer of disease progression into a protracted or chronic form.

The major tasks of mental hygiene and psychological prophylaxis are the organization and education of the healthy lifestyle of persons, improve of their life and production conditions of labour, overcoming of psycho - traumatic situations, refusal of acute and chronic alcoholic and narcological intoxications.

Using the data of mental hygiene, psychological prophylaxis is developing the system of measures, which are leading to reduction of neuro-psychological morbidity as well as contribute to the implementation of these measures into the health care practice. Methods of psychological prophylaxis include the study of the dynamics of neuro-psychological condition of the person both in the process of labour activity and in everyday life conditions. It is accepted to subdivide

psychological prophylaxis into the individual and the social ones, in addition into the primary, secondary and tertiary ones.

Primary prophylaxis includes the sum of measures focused on the preventing the actual fact of the disease occurrence. This includes the extensive system of legislative measures, which provide the protection of public health.

Secondary prophylaxis is a maximum detection of the initial manifestations of mental illness and their active treatment, in other words this is such kind of prevention that results in more favorable progression of the disease as well as quick recovery.

Tertiary prophylaxis consists of the prevention of relapses, which is achieved by the performance of activities, which are focused on the removing of factors. obstructed the employment of patient.

In the complex of psychological prophylaxis measures it should be considered both as environmental factors and etiologic and pathogenic factors associated with the person caused by person's constitution and premorbid personality characteristics. The modern rehabilitation concept dates back to the development of its principles and practical applications in England and in the United States during the Second World War.

Rehabilitation

The modern concept of rehabilitation dates back to the development of its principles and practical applications in England and in the USA during the Second World War. Rehabilitation is a system of government, social and economic, medical, professional, educational, psychological and other measures, designed to prevent the development of pathological processes, which lead to temporary or permanent disability, the effective and early return of diseased and disabled people (adults and children) into the society and socially useful work. Rehabilitation represents a complex process in the result of which the active attitude to the violation of patient's own health is formed by the patient as well as a positive perception of life, family and society is restored.

Rehabilitation includes prevention, treatment, adaptation to the life and labour activity after the illness, but first of all - the personal approach to the disabled person. Currently, it is used to distinguish the medical, the professional and the social rehabilitation.

At mental illness the rehabilitation has its own distinctive features, which are associated first of all with the fact that the serious violations of the individual, its social connections and relationships take place at their occurrence. Rehabilitation of the mentally diseased persons is understood as their re-socialization, restoration or preservation of individual and social values of the patients as well as their personal and social status. The basic principles of rehabilitation include partnership, diversity and graduation of efforts, unity of psychosocial and biological methods. Its stages are the following: the replacement therapy, readaptation, rehabilitation in the proper sense of the word. Rehabilitation is at the same time the goal (restoration or conservation of the individual status) and the process, which has neurophysiological and psychological mechanisms, methods of approach to the patient.

Basic principles of rehabilitation:

- person, partnership is a constant appeal to the individual of diseased concerted efforts of the doctor and patient in setting goals and choosing the ways of their solution;
- diversity of influences - points to the need to use the different measures of influences, starting from biological treatment up to different types of psychotherapy and social therapy, involving the family of the diseased person as well as his/her entourage into the restoration process;
- the unity of psychosocial and biological methods of influence - emphasizes the unity of the disease treatment, the impact on the body and the personality of the diseased person;
- gradation of the influences includes a gradual transition from one to the other rehabilitation measures (for example, at the early stages of the disease the biological methods of the disease treatment may take

place, and at the stages of restoration to health and strength the psychological and social therapeutic).

There are three stages in the process of rehabilitation:

1. *stage of reducing treatment* (recovery of the biomedical status) - treatment in hospital, the active biological therapy with the inclusion of psychotherapy and social therapy, the gradual transfer from the protecting activating mode (according to WHO experts in 87 % of the diseased persons the rehabilitation ends at the first stage, when the diseased persons in the result of recovery or full compensation of the disturbed functions return to normal activity);

2. stage of *socialization or re-socialization* (recovery of the individual and personal status) - begins in the hospital and continues at the community acquired conditions. This adaptation to the family and micro social environment with the development, formation or restoration, compensation of the social skills and functions, conventional kinds of activities of daily living as well social and role sets of the individual;

3. stage of *social integration or reintegration* (recovery of the social status) - focuses on providing of support and creating the conditions for inclusion or return to the normal living conditions together and at the same level with other members of society (sustainable employment, normalization of living conditions, active social life).

Each of the stages of rehabilitation has its specific purpose and objectives, they are different according to their measures, means and methods of the rehabilitation influence.

Adaptation

Adaptation (from the Latin adaptare - adapt) - in the wide sense – it is the adaptation to the changing of internal and external conditions. Adaptation – is a person's ability to have the conscientious relation to the body as well as the ability to adjust person's own mental processes (to control own thoughts, feelings, desires). There is a limit of the individual adaptation, the adapted person can live in his/her

usual geological and social conditions. Adaptation of the person has two aspects: the biological and the psychological ones. The biological aspect of adaptation is common to humans and animals – includes adaptation of the organism (of the biological being) to the resistant and changing environmental conditions: temperature, atmospheric pressure, humidity, light and other physical conditions, as well as to any changes in the body such as: disease, loss of any internal organ or limiting of its functions.

To manifestations of biological adaptation are included a number of physiological processes, for example: the light adaptation. Adaptation of animals to these conditions take place only within the boundaries of national measures and capabilities of the regulation of body functions, and human uses a variety of the additional measures, which are products of human's activities (housing, clothing, vehicles, optical and acoustic equipment and so on). At the same time a human shows the abilities to arbitrary mental regulation of certain biological processes and states, which expands human's adaptive capacities. The study of the physiological regulatory mechanisms of adaptation is essential for the purpose to solve applied problems of psychophysiology, clinical psychology, ergonomics and other similar sciences.

There is the particular interest of these sciences to the adaptive reactions of the organism to adverse effects of the significant intensity (extreme conditions), which often occur in different types of professional activities, and sometimes in the daily lives of people; a set of such reactions is called the adaptive syndrome. The author of the adaptation syndrome is G. Sel'e, who understood under this term the concrete non - specific set of reactions of the organism to any load. During many experimental studies on animals Sel'e found out that at the same time as the different factors cause specific reactions in the organism (for example: cold causes vasoconstriction, etc.), the same factors cause some stereotypical, general, non-specific reaction unrelated to the nature of the particular factor, but it serves as a response to the requirement, which is caused by factor according to the organism's ability to adapt to the external conditions. This general, non - specific signal to the inclusion of the adaptive

capacity of the organism is actually, according to Sel'e, the stress essence (this term itself belongs to him). In such a case, it even does not matter whether the factor or situation affecting the organism, pleasant or unpleasant, it is essential only the actual fact that they put demands to the adaptive capacity of the organism.

The psychological aspect of adaptation - adaptation of human as individual to the existence in the society according to the requirements of the society and own needs, motives and interests. The process of active adaptation of the individual to the social environment conditions is called social adaptation. Social adaptation is performed by the way of mastering the ideas about norms and values of this society (both as in wide meaning and in relation to the immediate social environment – the social group, the working group, the family). The main manifestations of *social adaptation* are interactions (including communication) of the person with other surrounding persons and person's active work. The most important means of the achieving of successful social adaptation are the general education and training as well as labour and training activity. There are particular difficulties of the social adaptation of the persons with mental and physical defects (defects in hearing, vision, speech abnormality and so on). In these cases to perform the adaptation helps the usage of various special measures of the correction of distressed function and compensation of the missing ones during the process of education and in everyday life. Spectrum of studied adaptation process in psychology is quite wide. In addition to the mentioned above: sensory adaptation, social adaptation, adaptation to the extreme conditions of life and activities, the processes of adaptation, which were called perceptual or sensory-motor adaptation, have been studied in psychology. Denomination «sensory - motor adaptation» reflects that importance, which have the physical activity of the subject for the restore of adequate perception in these conditions. It is believed that in the last decades in Psychology was created a new and independent branch, which is called «Extreme Psychology» and explores the psychological aspects of human adaptation in the case of supernormal conditions of existence (underwater, underground, in the Arctic and Antarctic, in deserts, high mountains and, of course, in the space) (E.V. Filippova, V.I. Lubovs'kij).

The concept of stress is especially noteworthy in relation with the concept of adaptation, which was received a variety of interpretations, particularly in the psychohygienic context. In such a case, it is often left out of account the fact that, according to Sel'e, stress means normal, natural reaction to the constantly changing external conditions. Thus, proposed by many popular publications, the idea to fight against stress is absurd on its own. The full exemption from stress is death only. The central problem of the most psychological theories is human interaction with the world, and in some cases it is considered as the adjustment, adaptation of the person to the world. However, in different theories the concept of adaptation has received a variety of interpretations. The psychological aspect of the adaptation processes of living beings is, above all, the adaptation interpretation of behavior and psyche. From an evolutionary point of view the origin of psychic activity became a qualitatively new stage in the development of biological mechanisms and modes of adaptation. Without this mechanism, the evolution of life would represent a very different picture in comparison with that one, which is studied by biology. Deep thoughts on the mental factors of evolution and adaptation to changing environmental conditions were expressed by the biologist A.N. Severcov (1866-1936) in his small-scale study «Evolution and psyche» (1922). This line was picked up by the theorists of the behavioral ecology (for example: Krebs and Devis, 1981), who directly formed the problem of the exact study of the behavior meaning for the survival in an evolutionary perspective. There is no doubt that the behavioral adaptations play an important role in the structure of lifestyle. A point of view at the behavior and its mental regulation as at the active forms of adaptation was developed by many psychologists of so-called functionalist orientation. U. Dzhejms was at the root of functionalism in psychology, but early functionalism was unable even to put forward the program of ecological-behavioural and ecopsychological researches. However, as a matter of principle, functionalism has given the correct theoretical idea, in the frames of which the different evolutionary forms of behavior and mental processes can be compared. On the basis of this representation Zh. Piazhe developed the concept of intellectual development. Piazhe himself stated his commitment to

the ideas of E. Klapared about the fact that intelligence plays the role of adaptation to new (for the individual and the biological species) situation, whereas the skills and instinct serves for the adaptation to the recurring circumstances. In such a case, the instinct is particularly similar to intelligence, since its first usage is also the adaptation to a new for individual (but not for species) situation. But only with the real development of animal psychology and ethology the understanding and substantiation of the requirement to study the psyche and behavior within the structure (context) of that whole, which is called lifestyle, had come. This idea does not lose its justice at the transition to the area of human psychology. Successful adaptation promotes the normal development of human, supporting person's mental health. However, as Frejd thought, if «I» is weak, helpless before the unconscious impulses of «It», then at the contact with the outside world the person may feel the danger. At this case «I» begins to perceive the danger, which is coming out from the unconscious impulses, as the external one, and after unsuccessful efforts, similar to the earlier relative to the internal motives, trying to escape from this danger by the way of «getaway». In this case «I» makes the displacement of the unconscious impulses. But as the internal is replaced by the external, in spite of the fact that similar protection from danger leads to a partial success, this success revolves the harmful effects on the person. Repressed unconscious turns to «I» as «forbidden zone», in which the mental substitution in the form of neurotic symptoms is formed. Thus, «escape in the disease» becomes such a form of person's adaptation to the world, which is performed by the inadequately way and demonstrates the weakness, immaturity of «I». Based on this understanding of the adaptation, the goal of psychoanalytic therapy is to perform the «restoration of I», its liberation from the restrictions caused by the displacement and weakening of its influence on «It» in order to more acceptable manner than the «escape in the disease,» to solve the internal conflict, which is connected to adjusting to demands of the surrounding world.

Further development of relevant ideas about adaptation is reflected in the studies of a number of psychoanalysts, including H. Gartman and E. Fromm. Thus,

in study of Gartman «Psychology of «I» and the problem of adaptation» this subject was considered not only in terms of changes, which are made by the person in his/her own mental system or in the surrounding environment, but also in the terms of search and selection by the person of a new psychosocial reality, in which the adaptation of individual is carried out by both external and internal changes. In Fromm's book «Escape from the Freedom» the division into *static and dynamic* adaptation is performed. Static adaptation is a king of adjustment in which «person's temper remains the constant and unchanged and only the appearance of any new habits is possible». Dynamic adaptation is an adjustment to the external environment, which encourages «the process of changing of person's temper, which manifests new aspirations, new warnings». As the illustrations of static adaptation, according to Fromm, the transition from the Chinese way of eating by using chopsticks to the European way of possession of a fork and knife can serve. When the Chinese, arrived in America, conforms to the standard way of eating, such adaptation does not serve as the cause of changes in his personality. As the example of dynamic adaptation may be considered the case when the child is afraid of the father, submits to him, becomes obedient, but during the adaptation to the inevitable situation in child's personality undergoes substantial changes, associated with the development of hatred for the father-tyrant, which, being depressed, become the dynamic factor in a child's temper. According to the point of Fromm's view «any neurosis is nothing else as an example of dynamic adaptation to the conditions, which are irrational for the individual (especially in the early childhood) and, undoubtedly, are unfavorable to mental and physical development of the child». Social-psychological phenomena, in particular, the presence of express destructive or sadistic impulses, also, according to Fromm, demonstrates the dynamic adaptation to specific social conditions.

Compensation (lat. compensare counterbalance, compensate). In general medical sense is the restoration of the full or partial amount of the loss of the disturbed functions activities of the certain internal organs, tissues or body systems due to the compensatory mechanisms.

According to Frejd - it is a reaction of the organism and psyche, which counteracts the traumatic violation by the way of extracting of the active energy in all mental systems and creating of the corresponding energy filling around the injured cells. According to the definition of A. Adler, compensation – is increased development of physical, mental and personal components, which compensate some disadvantage, real or supposed. Excessive compensation transfers into supercompensation. Both of them play role of mechanisms and means of neutralizing and overcoming of the inferiority complex.

Psychotherapy

The most adequate to the rehabilitation goals (as also psychoprophylaxis) serves psychotherapy. Softening of the manifestations and course of the mental diseases and empower of the modern psychopharmacological treatment boosted the role and efficiency of the psychotherapeutic influence. At the same time «point of application» of psychotherapy, as opposed to the biological treatment methods, is not the actual disease process (though its dependence on emotional factors and human activities is undeniable), and the identity of the patient and the system his/her relationship to the reality.

Psychotherapy - is a system of complex verbal and nonverbal therapeutic effect on emotions, judgments, self - consciousness of the person at various diseases (mental, nervous, psychosomatic), effect on the entire organism and behavior of the patient).

The main task of psychotherapy is considered as the elimination of psychopathology symptomatology, due to which the achievement of internal and external harmonization of the personality is happening.

It is accepted to distinguish the concept of therapy in the narrow medical sense as a method of treatment (like physiotherapy, therapeutic physical training) and in a wider sense, which includes the organization of labour and life, prevention of stressful factors and so on. In this case, psychotherapy is closely related to such concepts as mental hygiene and psychoprophylaxis.

Psychotherapy is a specific method of treatment, because the therapeutic effect is achieved not by the physical or pharmacological properties of the medicinal factor, but by these information and emotional charge that it carries in itself.

Psychotherapy can be used both alone and in combination with other treatments. Talented clinicians always used techniques of psychotherapy in the treatment of the systemic diseases, because the same medical drugs, miraculous in their hands, lost their healing properties in the hands of other doctors.

Psychotherapy can be performed at the direct contact of the doctor with the patient or indirectly, by means of recording, radio, telephone, television, film, written word, music, paintings, etc.

The most effective psychotherapeutic influence has a living word at the direct communication of the doctor with the patient (compliance).

Domestic psychotherapy began to develop in the middle of the 80-ies of the XIX century, which coincided with the scientific understanding of the phenomenon of hypnosis and its usage as a method of the therapeutic effects. In the first decades of the last century the worldwide interest in psychotherapy directions and formed within them the psychological concepts of personality was growing continuously. The clinical and psychological base for the development of personality-oriented psychotherapy started to form. Among the prominent physicians the enormous contribution to the development of psychotherapy was made by V.M. Behterev (1857-1927) – a prominent neurologist, psychiatrist, physiologist. His most famous studies are the following: «Objective Psychology», «Neuroinduction and its role in the social life», «Hypnosis, neuroinduction and psychotherapy and their therapeutic importance». Among other members of the Soviet direction of psychotherapy are widely known the following scientists: A.M. Svjadoshh, V.E. Rozhnov, E.G. Jejdemiller, B.D. Karvasars'kij, I.Z. Vel'vovs'kij, A.T. Filatov, N.K. Lipgart and others. In domestic psychotherapy in the recent years the following main areas are dominated: suggestive (neuroinduction in hypnosis, etc.), reconstructive (personality - oriented) and conditioned reflex.

From the all variety of methods of psychotherapy the following are the most common for us nowadays: 1) suggestive therapy (suggestion in the waking state, in the state of natural sleep, hypnosis, emotional stress psychotherapy, narcotherapy), 2) self-hypnosis (autogenous training, Kue method, the method of Dzhekobson) 3) rational psychotherapy; 4) group psychotherapy; 5) behavioral psychotherapy; 6) family therapy.

In such a case, the most widely used became three psychotherapeutic areas: 1) psychoanalytic; 2) behavioral; 3) existential-humanistic (non-legislative psychotherapy, Gestalt therapy, etc.).

How efficient the psychotherapeutic treatment is depends on therapist - patient relationship (compliance). The main thing in the psychotherapist's job is the desire to reveal the patient his own hidden abilities. Psychotherapy should turn on the knowledge of clinics of disease, taking into account the patient's personal characteristics and psychotherapist professional skills.

The basic modern concepts and principles of psychotherapy

Psychotherapy is an independent health-oriented clinical discipline with its own genealogy, history, sphere of pathonosological competence and therapeutic arsenal;

The competence of psychotherapy includes the development and study of theory and practice of the clinics, psychotechnical arsenal, the theory of healthy and pathological psyche, theories of personality and autodisciplinary - identity theory;

The subject of psychotherapy is the following: psychotherapeutic phenomenology; clinical therapeutic effect of psycho-syndromes and ways to achieve them (total therapy); pathonosological forms and pathology of psyche sphere, which is subject to psychological adjustment (clinical psychotherapy); secondary nososyndrome-based psychopathological forms at non-psychic diseases (therapy in the clinic) and social and social supplement (special and social psychotherapy);

Psychotherapy is closely related to psychiatry, neuropsychiatry and medical psychology;

Diagnosis of psychotherapy, based on the concept of clinical effect syndrome, is different by its specific and requires the formulation of special psychotherapeutic diagnosis.

Three targeted strategies of psychotherapy

- reconstruction of the inner world of the patient's individual – is correction of inadequate, selr- frustrational stereotypes of experience and behavior, as well as the development of new, more mature and constructive ways of perception, experience and behavior;
- reconstruction of the patient's connections with immediate social environment, the solution of actual life conflict, improvement of interpersonal functioning;
- direct effect on symptoms of the disease by using suggestion and training.

If the first strategy requires a long, deep and hard psychological work, which however gives principal and stable results, then the third one can be accomplished in a short time and very efficiently, but it often leads to temporary and unstable results. At psychotherapeutic contract the patient should have the right to decide how to spend own time, effort and money to fight against the disease, select with the assist of psychotherapist the appropriate strategy of psychotherapy.

Types of psychotherapy

At the current moment the conventional classification of psychotherapy methods does not exist. It is necessary to distinguish the methods and forms (techniques) of psychotherapy.

Under the term method the general principle of treatment, arising from the concept of the nature of the disease, is understood. For example, the concept of neurosis as the error of the mind, false thinking has created the rational method of

psychotherapy (Dubois P., 1912). The concept of neurosis as a disorder, caused by jams in the field of unconscious affect, experienced in the past, gave rise to the method of catharsis, and understanding of neurosis as a manifestation of the repressed infantile - generated sexual desire into the unconscious generated psychoanalysis (Freud).

The way of usage of one or another method of psychotherapy is called a form of psychotherapeutic treatment. For example, the method of rational therapy can be applied in the form of individual conversations with the patient, in the form of a conversation with the group or in the form of lectures. The method of suggestion can be applied in a dream or hypnosis. Psychoanalysis is applied in the form of surveillance of free association stream, associations studying, analysis of dreams, in the form of associative experiment and so on.

The same form of psychotherapeutic effects may serve for the different methodical instructions. Thus, hypnosis can be used for the purpose of suggestion as well as for catharsis.

The complex of different methods of psychotherapy, united by a common principled approach to treatment, forms a system, or the direction of psychotherapy. It is accepted to speak about the separate directions of psychotherapy, within their frames to allocate separate methods, and then inside each method to point out different techniques and methods.

There are several types of psychotherapy:

- *General* – is a complex of psychological factors action on the patient of any profile in order to increase patient's forces in the fight against the disease.
- *Private (special):*

- rational (individual);
- autogenic training (AT) (individual and group forms of performance);
- hypnosis (individual, group);

The psychotherapy is systematized by nature of its impact (direct or indirect); by etiopathogenetic principle (causal or symptomatic); by purpose of impact

(sedative, activating, amnesic); by patient's participation in it (catalytic-willed, passive); by type of doctor's influence (authoritarian, tutorial and etc.); by source of influence (heterogeneous, autogenic); by direction regarding pathogenic interpretation (emotionally synergistic, antagonistic, discussion); by doctor's tactics doctor (selective, combined or complex); by number of individuals with whom the physician works (individual, group), etc.

There is a classification of principles for the psychotherapy method to be chosen depending on the disease: 1) under acute hysterical symptoms there's better suggestion, 2) under vegetative disorders there's autogenic training; 3) under the life difficulties there's «rational» therapy; 4) under phobias there's behavioral therapy; 5) under characterological disorders there's Gestalt therapy, psychodrama, 6) under disorders associated with family problems there's family therapy; 7) under complex disorders there are deep psychological methods.

Pathogenetic psychotherapy

Pathogenetic psychotherapy allows most fully realize the causal approach to understanding and elimination of the causes and mechanisms of disease. It is most significant in cases when the personal and psychological mechanisms are leading to the emergence and preservation of painful disorders such as neurosis, psychosomatic disorders.

Symptomatic methods of psychotherapy

Symptomatic methods of psychotherapy (logical persuasion, suggestion, relaxation and etc.) are focused on eliminating or weakening of some, although, key symptoms, controlling of physiological functions of the organism, optimizing of the behavior.

To symptomatic psychotherapy, which involves the activation of cognitive component of the personality, belongs *rational psychotherapy or convincing*. It aims to the logical convincing of the patient, patient's education for reason thinking (Dubois P., 1912) and provides various options for the explanatory psychotherapy.

Convincing (persuasion) - is the process of replacement (changing, restructuring, and transformation) of the previously formed conviction under the influence of additional or explanatory information, which was obtained from various sources and in different circumstances. Treatment by conviction – is a treatment by information, which comes into the contact and interaction with representations of the patient and exposes them for evaluation. On these basis new views on things, a new estimation of the mentality traumatic events, new institutions for the future may occur. Now the new institutions for the future specify the importance for the patient of certain signals, and hence the response to certain stimulants. At the treatment according to this method, there will occur or fix new ideas, which are healthy for the patient, or inhibited the old ones. Outwardly, it appears in a way that the changes related to the patient's circumstances, which gave rise to the disease, morbid excitement are losing their importance, urgency. One of the main tasks of the physician at the treatment by conviction is to help the patient to choose the right course of action for the future.

Swiss neurologist Dubois supported the treatment by conviction, he developed this method in details and gave it the name of rational psychotherapy (from lat. ratio mind). The terms «treatment by conviction» and «rational therapy» are synonymous. Technology of treatment is reduced to the conversations with the patients, during which the doctor explains to the patient the cause of the disease and reversible disorders that the patient has, encourages the patient to change his/her attitude to the events, which concern, stop to fix his/her attention on the pathological symptoms.

Rational psychotherapy

Persuasion is an integral part not only of any form of psychotherapy, but also each contact of the doctor and the patient in each clinic. The psychotherapist deliberately or inadvertently teaches the patient to the constructive way of life, convinces the patient to take personal responsibility for his/her own actions and active role in managing of his/her life, and as a result appropriates to the patient the philosophy of mature, independent and responsible person. Rational psychotherapy

as one of the elements is included into all types of psychotherapy, without it the beginning of each is difficult. There are no complications and contraindications.

The term rational psychotherapy is used by most authors to describe a method of psychotherapy associated with the name of Djubua.

Rational psychotherapy is a method that uses the patient's logical ability to make comparisons, conclusions, to prove their validity. In this respect rational psychotherapy is opposed to the suggestion introducing the information and new attitudes bypassing human's criticality. The main target for rational therapy to influence is «an internal picture of disease» which creates an additional source of emotional experiences for the patient. To remove uncertainty, to correct contradictions, inconsistencies in the patient's perceptions that are especially related to his illness represent the main elements of rational psychotherapy influence.

The patient's wrong perceptions changed by logical reasoning can be noticed in all the versions of rational psychotherapy and distinguishes it from other methods of psychotherapy.

Various options for rational therapy are distinguished depending on the degree how direct the psychotherapist is. Applying ones one patient is led to a programmed result as a result the psychotherapist shows high activity in the argument defeating the patient's wrong arguments and encouraging him to formulate the necessary conclusions. The Socratic method of a dialogue can be of a significant importance in this situation under which the questions are asked in such a way so that to cause only positive answers, on which basis the patient makes conclusions himself. Djubua himself was a bright representative of direct rational psychotherapy. Other representatives of rational psychotherapy referring to the patient's logical reasoning also give a significant importance to the reaction, behavioral tuition. The main forms and to some extent stages of rational psychotherapy are: to explain and clarify a disease, its root causes taking into as a rule previously ignored by the account possible psychosomatic relations patient and not built-in into the «inner aspect of disease»; this stage results in achieving a clearer aspect of the disease, which takes away additional sources of anxiety and opens the patient a possibility to monitor his

disease more actively; to be convinced isn't only a correction of a cognitive but also an emotional component of attitude to the disease, promotes transition to the patient's personal settings to be modified; to refocus is to achieve more stable changes in patient's attitudes, first of all in his attitude to the disease associated with changes in the system of values and its output beyond his disease; psychogogy is a broader refocusing that creates a positive perspectives for the patient after the disease. Rational psychotherapy can be carried out in the form of both individual and group psychotherapy. In the latter case special methods increasing patients' activity and their motivation to be treated can be applied.

Rational therapy has not lost its significance even nowadays. As one of the elements it's actually included into all types of psychotherapy. The success of rational therapy depends on the consideration of patient's individual attitudes and his opportunities caused by consistent, systematic work with him.

Stages of rational psychotherapy:

Explanations, which include the interpretation of the materiality of the disease and reasons of its appearance, with the consideration of the possible psychosomatic connections, which, as a rule, were ignored by the diseased person and did not belong to the «internal picture of disease». As a result of this stage more defined picture of the disease is reached, which allows the patient by his/her own to control the disease actively;

Persuasion – is the correction of cognitive and emotional component;

Reorientation is the achievement of more sustainable changes in the patient's prescriptions in his/her relation to the disease;

Psyhogogics – is the reorientation of the broader plan, which creates a positive outlook for the patient out of the disease.

To the symptomatic therapy, centered on the emotional and volitional sphere of personality, belongs a various options of *catharsystic psychotherapy and neuroinduction (suggestion).*

Suggestion

The term neuroinduction or *suggestion* means information influences, which cause sensation, imagination, emotional states and volitional impulses, as well as affect the autonomic functions outside the active participation of the individual, without critical and logical processing perceived.

Suggestibility – is a kind of quality of the human psyche, which allows human to perceive the information without its critical evaluation.

Basic requirements for therapist are the following: authoritarianism (directivity).

Within suggestive psychotherapy attaches great importance to the diagnosis of *suggestibility* as the most important instrument of phenomenon «from the side of the patient».

The main instrument of suggestibility is the word, *speech* of the therapist - suggestor. Non-verbal factors (gestures, facial expressions, actions) usually perform additional potential forming or laxative effect.

In drawing up the suggestibility formula it is necessary to consider the distinctive features of the soma and physical state, age and sex of the patient, the extent of suggestibility and personality characteristics. The effect of suggestion is stronger in dependence of the higher s authority of the doctor, who performs suggestion, according to the patient's opinion; the extent of the realization of suggestion is defined as well by the personal characteristics of the patient.

As for clinical usage, it should be noted that suggestive psychotherapy is used for all types of somatic and psychosomatic diseases.

Contraindications to the usage of suggestive methods are psychosis, although suggestive elements are included in all manifestations of everyday therapeutic process in psychiatry. Today iatrogeny is recognized as the main complication of suggestive psychotherapy.

Hypnotherapy or hypnosuggestive psychotherapy

It was formed historically, that hypnosis is very popular in the treatment of patients. But in the recent decades hypnosis is successfully displaced by various methods of group psychotherapy. But till nowadays there is no unified theory, which would explain the nature of hypnosis. There are some separate concepts, to some extent justified systems of opinion on the mechanism of this phenomenon. Let us examine some of them.

According to the neurodynamic theory of I.P. Pavlov, hypnosis – is a partial sleep. It represents an intermediate, transitional state between wakefulness and sleep, in which based on the braked with the varying degrees of intensity of the brain areas there is a vigilant, «observation» item in the cerebral cortex, which enables the ability of «rapport» between the hypnotist and that person, who is being hypnotized.

Way back, V.M. Behterev singled out such concepts as suggestion, suggestibility and hypnosis. Currently there is pointed out the therapy of suggestion without hypnosis, the therapy with expansion of hypnosis state and the therapy of suggestion in the state of hypnosis. Even Breer and Frejd used hypnosis to achieve the emotional discharge (hypnocatharsis), Erikson and Linder used it in order to overcome the resistance in psychoanalysis (hypnoanalysis), Zhane, K.I. Platonov, V.E. Rozhnov used the prolonged hypnosis as a meaning, which calms and strengthens the nervous system.

The method of suggestion in hypnosis became the most widespread. On the basis of this method is the fact that in the state of hypnosis verification of incoming information is significantly reduced, and as a result suggestibility is increased.

The process of treatment with the help of suggestion in hypnosis can be divided into several periods: preparatory, hypnotizing, therapeutic suggestion in the state of hypnosis, dehypnotization with the posthypnotic suggestion.

According to the opinions of the prominent contemporary psychotherapists Kondrashenko V.T. and D.I. Dons'koj, the greater part of the domestic hypnologists even today in the understanding the nature of hypnosis follow the physiological positions of I.P. Pavlov.

In 1921 Zigmund Frejd outlined his opinions about hypnosis in his book «Mass psychology and personality analysis». According to Frejd, hypnosis - is a transfer in the sphere of unconscious on the hypnotist's personality of the innate memories about the tribal leaders, displaced attitudes of children towards their parents (for example, son t towards his father). This phenomenon of transfer creates actually, according to Frejd, the insurmountable power of the hypnotist relative to the patient, who is being hypnotized. Hypnotic relationships, according to Frejd, have the erotic basis. «Hypnotic relationships, - Frejd wrote, - consist of unlimited amorous self-sacrifice, except for sexual satisfaction». A follower of Frejd, Ferenci (1975) sees in hypnosis the revival of Jedip complex with his love and fear. Hence, it follows, that there are two types of hypnosis: «maternal», which is based on love, and «parental», which is based on fear. Shil'der (Schilder, 1938) also in the base of hypnosis sees the phenomenon of transfer. According to Shil'der, the patient, attributing omnipotence to the doctor, in such way is realizing his/her own sexual-infantile fantasies. An important contribution to the psychoanalytic theory of hypnosis was made by Shtevart (Stewart, 1969). He argues that the hypnotic state contains not only the reward of instinctual needs but also the complex balancing and protective tendencies, in which distrust and hostility play a significant role. In other words, Shtevart suggests that the patient in the state of hypnosis is in the state of ambivalent towards the hypnotist, whom he loves and hates at the same time. According to Shtevart, hypnotic state is based on the following fiction: hypnotist, if he/she wants to achieve the hypnotic trance, should pretend that he/she is omnipotent. But the «unconscious» of the patient «knows» that the hypnotist pretends and compensates this situation by the feeling that the patient by his/her own makes hypnotist to this fiction and by his/her own controls the hypnotic situation. In physiological theory of 1.P. Pavlov and psychoanalytic theory of Frejd, which are, in fact, opposites, there are many concepts, which attempt to explain the nature of hypnosis. Berngejm thought that hypnosis is a form of suggestion expression and, in fact, identified both of these concepts.

Charcot identified hypnosis with hysterical neurosis, considering both as a painful confusion. Vol'pe (1959) believes that hypnosis is a product of artificially created experimental situation, which affects not only the patient, but also on the experimenter. Hypnosis, according to Vol'pe, in many ways can be considered as «folie a'deux» (madness for two): each involved in the hypnotic relationship plays the exact role, which is expected from him by another. The patient behaves such as if he/she is notable to resist the suggestion of the hypnotist, and the hypnotist plays the role of all-powerful individual. V.M. Behterev considered hypnosis as artificially induced combined reflex of inhibitory nature with the inhibition of active concentration. Shertok (Chertok, 1982) considers hypnosis as some kind of trance. According to his opinion, «hypnosis is a special state of consciousness, which provides some change of psychophysiological reactivity of the organism». Shertok defines hypnosis as «the fourth state of the organism» (along with the state of wakefulness, sleep and dream activity).

A.M. Svjadoshh (1982) believes that hypnotic sleep - is a state of constricted consciousness, caused by the action of the hypnotist and it is characterized by increased suggestibility. V.E. Rozhnov (1985) understands hypnosis as a special psychological condition, which occurs under the influence of directed psychological impact, and it is different from both sleep and wakefulness. According to his opinion, hypnosis – is a psycho-physiological phenomenon at which the permanent available synergy of conscious and unconscious acquires a certain transformation in the sense that their combined activity dissociates and at the same time is able to act as both the conscious and non - conscious mental products, Numerical strength and variety of the theoretical approaches to the nature of hypnosis are actually evidences of the complexity of the problem, which is far from being solved.

Hypnotherapy or hypnosuggestive psychotherapy represents the method of psychotherapy, which uses the hypnotic state for the medicinal purposes.

Term *hypnotizability* means the quality of the central nervous system, which allows achieving of a modified state of consciousness in response to directed psychological impact.

Hypnotic trance is the special state of consciousness, which occurs under the influence of directed psychological impact. It is different from both sleep and wakefulness; it is accompanied by increased perception to specifically directed psychological factors at reducing of the sensitivity to other effects of the environmental factors. Term *rapport* (fr. Rapport – communication, report) in psychotherapy means the verbal contact of the person, who hypnotizes, with the person, who is in the hypnotic state.

During the process of hypnotherapy the basic diagnostic techniques, which confirm the feasibility of its implementation, reduced to the identification of hypnotizability. At low hypnotizability the usage of hypnotherapy has certain difficulties. Also before the beginning of hypnotherapy session it is necessary to perform the correctional talk with the patient about patient's relationship to this method.

Methodology for hypnosuggestive psychotherapy performance:

The main methods of immersing in hypnosis are the following: *fascionation, fixed gaze, passes, rhythmic stimulant, and verbal formulas.*

There are three stages of hypnotic trance in psychotherapy practice:

drowsiness – is accompanied by sleepiness and relaxation;

hypotoxy (catalepsy) – non-motility, mutism, waxy flexibility are observable;

somnambulism – is the complete detachment from the reality, hypnobatia and induced images.

In any stage of hypnotic state it is required to maintain *rapport.*

Hypnosuggestive therapy can be performed individually and in groups. Individual performance allows giving of the specific prescriptions, created for the patient, which increase the effectiveness of psychotherapy. Group hypnosis is used primarily within the sanatorium-and-spa services.

Indications and contraindications for hypnosuggestive therapy performance.

The indications for hypnosis may be some symptoms, such as headache, which is not relieved with analgesics, pain in trigeminal neuralgia, phantom pains. There are positive results during the treatment by hypnosis of atypical forms of bronchial

asthma, angina attack, arterial hypertension of the I-st and II-nd stages. neurosis, some forms of skin diseases. Hypnosis has been used successfully in the treatment of alcoholism, drug addiction, in obstetric and dental practice.

As contraindications to hypnotherapy should be considered: thrombosis, stroke, the III-d stage of arterial hypertension, hypertensive crisis.

Material - mediated indirect therapy (placebo - therapy)

Within the placebo-treatment (lat. placebo - to seem, to imagine) the therapeutic effect is regarded as the *indirect suggestion*. Suggestion is realized in case when the therapeutic options are given to the real object or phenomena, which do not have inherent possibilities. Substance placebo is understood as pharmacologically indifferent substance, which imitates the medical drug.

In medicine psychotherapy is considered as a general medical discipline, its methods are used to treat and prevent not only neuropsychiatric, but also many systemic diseases.

There is no conventional classification of psychotherapy methods, however, similar to medicine in general, it is accepted conventionally to subdivide these methods of treatment onto the symptomatic and the pathogenetic.

Autogenic training

Autogenic training (from the Greek autos – by oneself, genos - origin) – is an active method of psychotherapy, psychological prophylaxis and mental hygiene, aimed at restoring of the dynamic equilibrium of the system of the human organism's self-regulating homeostatic mechanisms, which was affected by the stress exposure. The main elements of the methodology are the training of muscle relaxation, self-suggestion and self-improvement (autodidactics). Activity of the autogenic training confronts some negative sides of hypnotherapy in its classical models - passive relation to the patient's treatment process, depending on the doctor.

Methodology for autogenic training performance

There are two stages of autogenic training performance (by Shul'c):

1) the lower stage – is learning to relaxation through exercises, designed to induce a feeling of weight and heat, to possess cardiac rhythm and breathing;

2) the higher stage (autogenic meditation) - is the creation of trance states of the various levels.

The lower stage of autogenic training consists of six standard exercises, which are performed by the patients in one of three postures:

1) position «coachman posture» - sitting on a chair with the head being slightly bowed forward, hands and forearms are lying freely on the front of the thighs, legs are spaced loosely;

2) supine position, the head is on a low pillow, arms are being slightly bent at the elbows lying freely along the trunk palms down;

3) reclining position – the person, who performs the training, is sitting freely in an arm-chair, leaning back, hands on the front of the thighs or on the arms of the arm-chair, legs are spaced loosely. In all three positions the complete relaxation is achieved, eyes are closed for better concentration.

Exercises are performed through the mental repetition (5 - 6 times) of the formulas of self-suggestion, which are said by the supervisor of the training. Each of the standard exercises follows the formula-purpose: «I am quite calm».

The first exercise. Recall of the feeling of weight in the hands and feet, accompanied by the relaxation of striated muscles. Formula: «The right hand is quite heavy», then «the left hand is quite heavy» and «Both hands are quite heavy». The same formula is for the feet. The final formula: «Hands and feet are quite heavy».

The second exercise. Recall of the feeling of warmth in the hands and feet in order to master the regulation of vascular tone of limbs. Formula: «The right (left) hand is quite warm», then «The hands are quite warm», the same formula for the feet. The final formula: «Hands and feet are quite heavy and warm».

The third exercise. Regulation of the heart rate. Formula: «My heart beats strongly and smoothly».

The fourth exercise. Normalization and regulation of the respiratory rhythm. Formula: «I breathe quite calmly».

The fifth exercise. Recall of the feeling of warmth in the abdomen. Formula: «My solar plexus radiates heat».

The sixth exercise. Recall of the feeling of coolness in the forehead in order to prevent and make weaker the headaches of vascular origin. Formula: «My forehead is pleasantly cool».

The indicator of the next exercise mastering is the generalization of feelings. For example, exercise for recall of the heat in the limbs is considered to be learned when heat begins to flood through the body. It takes two weeks to master each exercise. The whole course of autogenic training lasts about three months. Usually the trainings are performed in groups 1-2 times per week under the guidance of a therapist; duration of the training is 15-20 minutes. Great attention is paid to the self-dependent trainings of the patients, which take place twice in a day (in the morning before to get up and at night before bedtime), and in such a case, as a rule, the patients fill diaries, in which they describe sensations, incurred by them during class.

Application. Autogenic training (AT) is the most effective in the treatment of neurosis and somatoform disorders, adjustment disorders and psychosomatic illnesses.

The best results are observed in the treatment of those diseases, which are associated with manifestations of emotional stress, smooth muscle spasm, while «sympathetic» effect is greater than the «parasympathetic».

The good results are noted at bronchial asthma, in the initial period of hypertension and obliterative arteritis, at dyspnea, esophagospasm, cardiac angina, spastic pains in the gastrointestinal tract, peptic ulcer disease.

AT is included into the comprehensive treatment of alcoholism and drug addiction, to eliminate withdrawal symptoms and formation of anti-intoxicative prescription.

The successful removal of the emotional stress and anxiety by using AT justify its inclusion into the method of psychological prophylaxis of pain during childbirth.

Contraindications for AT are the following: states of unclear consciousness and delirium, especially the attitude and persecution delusions. AT is not recommended during acute somatic attacks and autonomic crises.

Psychoanalysis

Psychoanalysis as a psychotechnics can be applied as a treatment for a wide range of pathologies requiring psychotherapeutic treatment. Psychoanalysis is traditionally thought to be indicated for treatment of patients with neuroses, personality disorders, sexual disorders.

Z. Frejd (1856-1939) is a prominent psychologist, the founder of psychoanalysis, dreamt of devoting himself to theoretical research, but was forced to get engaged in private practice. Being influenced by medical care Frejd became interested in of mental disorders of functional nature. To treat the latter Frejd invented a unique theory that meant to create means of entering into forgotten experienced feelings being the basis of functional states (neuroses). To overcome patients' unconscious resistance Frejd found the ways to the pathogenic affects when interpreting dreams, free associations, small and large psychopathological manifestations, extremely high and low sensitivity, movement disorders, reservations, forgetfulness. In the first period of Frejd's scientific activity psychoanalysis was mainly the method to treat neuroses. In the second period Freud's concept turned into a general psychological study of personality and its development. Within the third period Frejd's theory called «Frejdism» changed significantly and developed into its philosophical completion. The psychoanalytic theory became fundamental for understanding culture, religion and civilization. The instinctivism was complemented with ideas about attraction to death, destruction. Such Frejd's works as «The Interpretation of Dreams», «The Psychopathology of Everyday Life», «Three Essays on the Theory of Sexuality», «Introduction to Psychoanalysis: 5 lectures», «The Ego and the Id» are widely known. Al'fred Adler (1870-1937) was one of Frejd's students. The illness that severely attacked Adler in

his childhood influenced him to choose the profession of a doctor and then to get interested in the ideas to compensate organic inferiority.

Group psychoanalysis or analytic group psychotherapy is an option of psychoanalysis. Adler was among the first ones to carry out *psychoanalytically oriented group psychotherapy*. He used a type of group discussion and group discourse of patients', children's and parents' problems. Adler had quickly his followers Wender P.H. and Schilder P. They widely used group activities when working with patients because in their opinion only they allowed to combine psychoanalysis and a personal touch that contributed to individual reorganization and greater socialization of patients.

Being free from studies in psychology and psychiatry, Adler studied pedagogy, organization of counseling centers in schools where parents could get advice on education and relationship in the family. Adler is the founder of individual psychology. He claimed that the objectives and expectations had more influence on human behavior than the past experience and the basic human motivation is the desire to achieve superiority in the medium.

K.G. Jung (1875-1961) is the Swiss psychiatrist, the founder of analytical psychology, actively collaborated with Frejd from 1907 to 1913, being Frejd's most diligent follower. Since 1913 he and Frejd had a cooldown due to the publication of his book «Metamorphosis and Symbols of the Libido» where he denied Frejd's interpretation of sexual libido. «Psychological Types» is a very famous K. Jung's work. Jung is a creator of psychological experiment, the concept of intra- and extraversion. An outstanding place in Jung's analytical psychology is given to the regulations on the collective unconscious which reflected past human experience in the form of archetypes. He considered the analytical psychology as «the western human yoga».

G. Ajzenk is a prominent psychologist and psychotherapist. He believed one of his most important tasks was to separate clinical psychology as a separate discipline. His main research was to study the theory of personality, intelligence research, behavioral genetics and behavioral psycotherapy. Ajzenk's questionnaire is widely

known to determine personality characteristics. In the field of psychotherapy Ajzenk is one of the founders of behavioral therapy. According to him the theoretical basis and the practical foundation of behavioral psychotherapy which is aimed at positive change human emotions are modern educational theories.

The founder of *transactional* psychoanalysis is an American psychiatrist Jerik Bern (Berne E.). According to his conception a human is programmed with earlier decisions when relating to the life position. The human lives his life under the «scenario» written by his relatives, takes decisions based on stereotypes once necessary for psychological «survival» but now turned out to be useless. The main goal of transactional analysis is to reconstruct the personality on the grounds of revising life attitudes, getting aware of unproductive behavioral stereotypes, building a new system of values.

Franc Aleksander (1891-1964) is a German psychoanalyst, psychiatrist, researcher of psychosomatic diseases. He developed ideas of short-term psychoanalysis through periodic treatment interruption. According to Aleksander, psychosomatic diseases occur as a result of emotional overload which is a manifestation of inner personal conflict with different degrees of its suppression. Aleksander's notion about the depth with which an emotional conflict is suppressed being various in terms of emotional stress at different neurotic and psychosomatic diseases made the foundation for his concept of specific emotional conflict. The Swiss scientist L. Binsvanger (1881-1966) made a great contribution to the development of psychotherapy. He was the founder of the school of *existential psychoanalysis* called the design analysis which subject matter is to describe human existence or being in the world.

Cognitive psychotherapy

Cognitive psychotherapy (Eng. Cognitive therapy) is a method based on the provisions giving crucial importance to cognitive processes (and first of all thinking) causing various kinds of psychological problems and mental disorders (e.g. depression). The System was created by Aaron Bek, a specialist in cognitive therapy

of depression and other affective disorders. The system developed in the confrontation with the directions in psychoanalytic psychotherapy, although nowadays there are trends towards convergence.

In the preface to the famous monograph «Cognitive Therapy and the Emotional Disorders» Bek has claimed his approach as a fundamentally new, different from leading schools devoting themselves to study and treat emotional disorders – traditional psychiatry, psychoanalysis and behavioral therapy. Despite substantial differences with each other the above stated schools share a common fundamental hypothesis: the patient is plagued by hidden forces over which he has no power. These three leading schools state that the patient's source of disorders is *beyond his consciousness*. They pay little attention to conscious concepts specific t*houghts and fantasies namely cognitions*. The new approach namely the cognitive therapy believes that the emotional disorders can be treated in a completely different way: the key to understanding and solving psychological problems is in the patients' *consciousness*.

There are five goals of cognitive therapy: 1) to reduce and/or complete eliminate the symptoms of a disorder; 2) to reduce the chance of a recurrence after being treated; 3) to improve the efficiency of pharmacotherapy; 4) to solve psychosocial problems (which can either be the result of a mental disorder or precede it); 5) to eliminate the reasons contributing to the development of psychopathology: to change maladaptive beliefs (charts), to correct cognitive mistakes, to change dysfunctional behavior. To achieve the stated goals the cognitive psychotherapist helps the patient to solve the following tasks: 1) to realize the impact of thoughts on emotions and behavior; 2) to learn to identify negative automatic thoughts and to observe them; 3) to examine negative automatic thoughts and arguments supporting and defeat them («for» and «against «), 4) to replace false cognitions by more rational thoughts; 5) to identify and change maladaptive beliefs that form a fertile ground for cognitive errors to be made. Nowadays the cognitive therapy is at the interface of behaviorism and psychoanalysis.

Basic theoretical principles of cognitive therapy:

1. The method of situations structured by an individual determines his behavior and feelings. As a result the external events interpreted by an individual are at the core, they occur as follows: external events (incentives) cognitive system → interpretation (thoughts) → affect (or behavior). If the interpretation and external events are greatly diverged, it causes mental disorders.

2. Affective pathology is a strong exaggeration of normal emotion caused by misinterpretation under the influence of many factors. The central reason is the «private ownership (personal domain) » (personal domain), which center is the «Ego»: emotional disorders depend on the person's perception of the events as enriching, debilitating or as threatening or as encroaching on its ownership.

3. Examples: the sorrow may be caused by the loss of something valuable, i.e. getting rid of private ownership.

1. Euphoria is feeling or looking forward to acquisition.
2. Anxiety is a threat to physiological or psychological well-being.
3. Anger is caused by feeling the direct attack (intentional or unintentional), or violation of law, moral norms or standards of the individual.

4. Individual differences depend on the past traumatic experiences (i.e. the situation of staying in a confined space for a long time) and biological predispositions (constitutional reason).

The conditions of cognitive therapy:

1. the patient and the therapist have to come to an agreement on the problem to be worked at;

2. the therapist should be very empathic, natural, congruent (the principles are taken from the humanistic psychotherapy).

3. there should be no direction.

The Cognitive Therapy in Bek's version represents a structured study, experiment, training in mental and behavioral ways designed to help the patient learn the following operations.

1. The psychotherapist should teach the patient to:
2. Identify his negative automatic thoughts;

3. Find the link between knowledge, emotions and behavior;
4. Find the facts «for» and «against «of such automatic thoughts;
5. Search for more realistic interpretation of them;

Learn to identify and modify disruptive convictions causing distortion of skills and experience.

Specific methods of automatic thoughts to be detected:

1. The empirical verification (to find arguments «for» and «against»; to build an experiment to verify the statement; the therapist turns to his experience, to artistic and academic literature, statistics; the therapist reveals: indicates logical errors inconsistencies in patient's judgments). E.g .: the patient thinks when he leaves the house, a stray dog bites him. The therapist asks his patient to leave the house in his and presence. As a result when the therapist experimentally tests his thoughts, of course it is not confirmed. The hypothesis should be empirically tested.

2. Method of revaluation. To check the chances of alternative causes in action of this or that event.

3. Decentration. When having social phobia the patients feel in the public eye and are affected by it. It also requires empirical testing of these automatic thoughts.

4. Self-expression. Depressed, anxious and other patients often think that their sickness is controlled higher levels of consciousness, always observing themselves, they understand that the symptoms do not depend on anything, and the attacks have their beginning and end. Conscious introspection.

5. Decatastrophy. When having anxiety disorders. The therapist makes questions: «Let's see what would happen if ...», «How long will you have such negative feelings ?», «What will happen alter? Will you die? Will the world will be ruined? Will it ruin your career? Will your relatives abandon you ?» and so on. The patient realizes that everything has a time frame and an automatic thought «this horror which will never end «disappears.

6. Purposeful repetition. To train a desired behavior, to practice various positive instructions multiple times leads to increased self-efficacy.

7. To use imagination. Anxious patients don't have so much «automatic thoughts» as dominant as «haunting images», i.e. this is rather the thinking that will cause maladjustment than the imagination (fantasy). The stop method should be applied: a loud command «stop». In such a way this negative image of imagination is destroyed. The repetition methods: to mentalize a fantasy image namely it's enriched by realistic views and more probable contents. Metaphors, parables, poems should be used. The methods modifying the imagination: the patient actively and gradually changes the image from the negative to more neutral and even positive, thereby realizing the possibilities of his consciousness and conscious control. Positive imagination: a positive image replaces a negative one and gives a relaxing effect. Constructive imagination (desensitization): the patient ranks an expected event causing the forecast to be deprived of its globality.

The humanistic approach in psychotherapy is quite homogeneous. It includes: existential therapy, design-analysis, speech therapy, client-centered psychotherapy, Gestalt therapy and others. The representatives of this approach are aim at maximum integration of human mind, body and soul. The pathology is understood as the lack of opportunities for self-expression. The client-centered psychotherapy by Rodzhers (Rogers C.R.), as a form of this approach, contains a positive belief that each body has an innate tendency to develop its optimum abilities. Psychotherapeutic meetings effect through the fact of their novelty. Under such conditions the psychotherapist is the catalyst thanks to whom the patient realizes his own abilities to self-development. The task of the psychotherapist is to teach the patients to sincerely communicate with each other. Psychotherapists use some psychotherapeutic agents to penetrate the inner world of the patient.

Art therapy

The art-therapy means the application of (means) art as a therapeutic factor. The therapy by creative self-expression can be used both in the hospital and outpatient in a clinic and dispensary, in the rooms of esthetic therapy (in spas), when working with groups at risk (those who suffer from alcoholism). Moreover, this

method can take an important place in the system of rehabilitation of the mentally ill.

The creative therapy is contraindicated to individuals with severe depression and suicidal thoughts because the atmosphere of inspired creativity may deepen the dreary feeling of hopelessness, distance from people.

Gestalt – therapy

Gestalt - therapy is used more and more, it's a method created by American psychologist Perls (Perls F.S.) influenced by Gestalt psychology, existentialism, psychoanalysis and others. Perls believed that a human-being should be in a balanced state with itself and with the world around him. To preserve harmony it is just necessary to trust the body wisdom, listen to the body needs and not to interfere with their implementation. When creating Gestalt therapy the existential philosophy helped Perls to leave the psychoanalytic approach under which the main attention is given to the patient's story of development. Instead of searching for the problem roots in his patients ' past, Perls began to look closely at present and in how they adapt and live in his world. Using such an approach the therapy stops being a system to obtain information from the memory. Perls believed that the information necessary for a therapeutic change was contained in the patient's direct behavior, including the way of his interaction with the therapist and manifestation of himself in this interaction. Perls propagated the principles Gestalt theory as for the study of personality, using the concepts of figure and background. The most important and significant events for a human-being take a central place in the consciousness of the patient, and less significant stay back, taking the background. In the following example: the figure and the background can be interchanged and something that a human-being has previously paid no attention to, for example health used to be only background, begins to take a central place in his mind and becomes the background, but the thing that took a central place, for example, plans for the future, turns only into the background. This is called Gestalt construction and finish. When being mentally healthy the Gestalt construction is self-regulated. The aim of Gestalt

therapist is to help the patient in realizing his needs (to form Gestalt), its finish, that will help a person to get out of dead-end.

Gestalt-therapy is applied in individual therapy, in the couple therapy, in the family, group therapy; in the institutions (schools, hospitals, factories). This approach is applied to those who have difficulties when facing problems (conflicts, interruptions of relationships, loneliness, mourning, unemployment). Nowadays this method is greatly known by business consulting. Perls called this method «a normal person therapy».

Neuro - Linguistic Programming

Neuro-linguistic programming (NLP) was developed jointly by three individuals: Richard Bendler, Dzhon Grinder, Frenk P'juselik in the 1960s and 1970s. This system was developed in an attempt to answer the question why some therapists happen to so effectively interact with their patients. Instead of exploring the issue as a matter of psychotherapeutic theory and practice, Bendler and Grinder turned to analyze what successful therapists did by visual examination their work, and worked out certain categories as general patterns of interpersonal influence. NLP is trying to teach the people to observe, to make suggestions and react to people as well as efficient therapists. Based on speech patterns and body signals collected by expert methods while observing the psychotherapists practicing neuro-linguistic programming it's believed that our subjective reality determines beliefs, perceptions and behavior, and thus it's possible to change behavior, transform beliefs and treat mental injuries. The main goal of NLP is a profound knowledge of own behavior in addition to its improvement. NLP also develops a system of special techniques aimed at improving these or those human traits necessary to successfully execute the set tasks from different areas of human activity and different significance.

NLP is the science of the word impact on the human-being allowing a person to program himself using words, and then to change these programs. Every person bears hidden mental resources and the psychotherapist's aim is to provide the patient to get access to these resources, to get out of the subconscious, to bring to awareness

and to train how to use these resources. B.D. Karvasars'kij formulates the basic principles of NLP as follows:

The human brain is a set of «programs»; in addition to genetic programming there's observed the formation of «behavioral programs-stereotypes», which is often caused by important people.

Most programs are not realized and reflected in an ordinary speech but only in deep linguistic structures. The therapist can read important information, focusing on non-verbal response manifestations.

All behavioral stereotypes had adaptive functions in the past, but it's possible to reprogram a human-being to new more adaptive stereotypes based on the suggestions that are more often held in trance states.

NLP focuses on efficient technologies in the form of adjustment to the patient.

NLP uses several terms to adjust the patients, namely «modality» (visual, auditory and kinesthetic), «adjustment» (the ability to quickly recognize modality and find the clues to access), «anchor» (associated with bright feelings), «reframing» namely reforming and rethinking the perception and thinking in order to reject unacceptable patterns.

Since the creation of NLP multiple empirical research have been carried out regarding the study of its effectiveness, the efficiency of NLP methods has been experimentally tested in vitro effectiveness of NLP and validity of its concepts. The obtained results are contradictory. In general, the undoubted merit in terms of NLP attempting to associate neuro-linguistic methods and psychotherapy, NLP can't be recommended for widespread application in the clinical practice. In psychiatry the method can only be used in the clinics of neurotic disorders.

Group psychotherapy

This method of the use of psychotherapy was described by A. Adler. It deals with the feelings of personality deficiency divorced from the collective team and contributes to get back to the collective tea.

The group psychotherapy includes:

therapeutic groups where patients are given lectures, and then there's a discussion;

1. groups of so called «interview» type where the patients discuss their problems freely, express deep personal information about themselves;
2. work groups mean communication at work;
3. «Alcoholics Anonymous» Society represent meetings, discussions;
4. group therapy with relatives;
5. individual psychological aid.

Psychodrama - method of the group psychotherapy that is represented by a role play where the necessary conditions are created for spontaneous expression of feelings associated with the most important problems for the patients. The psychodrama as a psychotherapeutic method of treatment was created and developed by Moreno J.L. based on the experience of his theatrical experiment, which initial purpose was not associated with the psychotherapy and meant to realize the creative potential of a human-being. Moreno relied on the fact that a person has the innate ability to play and when playing different parts he has an opportunity to experiment both with real life parts and those ones created by his imagination that allows him to work creatively at his problems and conflicts. Over playing a situation the person reaches the catharsis (purification of reaction) and the insight (enlightenment, sudden understanding, which results in a meaningful solution to the problem).

The family psychotherapy is traditionally understood as a complex of psychotherapeutic techniques and methods aimed at treating the patients inside the family and through the family, as well as at optimizing family relationships. The family as a living system communicates with the environment. Throughout its existence, the family goes through natural «development crisis»: marriage, child birth, etc. It is at this point the family is not able to solve new problems using old means and it calls for complicating the adaptive responses. The family performs its functions with family roles. Their structure determines which of the family members has to do what and how, interacting with each other. There are «standards of interaction». In normal families the structure of family roles is a holistic and bears

an alternative character. Strictly fixed family roles that are pathologizing, or even the lack of family system causing a psychotraumatic effect on family members can be there.

Method of group training got name of Balint Group (BG) after its creator Balint M. The BG classical study subject is the doctor - patient relationship. The patient puts emotional and behavioral stereotypes on the doctor similar to those emotions caused by significant people of the inner circle. The analysis of these relationships enables to understand the patient better. At the same time the doctor is often confronted with the patient's reactions strange for him because the doctor requires processing of the stated phenomena in the circle of colleagues headed by a qualified professional that will help the doctor to clarify his attitude to the patient and the way he perceives the patient.

Psychotherapy in work of General Practitioner

Nowadays psychotherapy is integrating more and more in the somatic medicine. Different diseases, especially the so-called somatic disorders become the object of psychotherapeutic effects. However, as noted by one of the prominent representatives of somatic medicine Stokvis, «the success of psychotherapy in psychosomatics doesn't make such an iridescent impression. There is no reason to dress them up: in many cases, the results are scarce and quite often equal to zero». Foreign scientists emphasize that somatic patients are unpromising for psychotherapeutic effects, especially for psychoanalysis (P. Sifneos). Trying to explain the difficulties in the use of psychotherapy when treating somatic patients and considering that the basic dificulty is the complex nature of somatic diseases. Karasu specifies some of these difficulties. He rates them as follows: the role of the actual physical (biological) mechanisms and their manifestation; personal characteristics, imagination and patient's protective mechanisms that are directly related to motivation at treatment and behavior at treatment (e.g., patient resistance, his denial of the role of psychological mechanisms of disease and etc.), negative value of countertransference reactions in most internists and psychotherapists. All

this causes that it is difficult to implement an effective therapy of such patients, if not an impossible task.

We should also take into account the general attitude to somatic problems in medicine. Psychosomatics is rather developed and is developing at a theoretical level, it hasn't acquired popularity in the health care so far and is slowly introduced into practice, patients ' care practice. It's only a brief episode for an ordinary internist to meet Psychosomatics that has no effect on his ongoing work: he isn't good at it and does not understand the benefits associated with it; Psychosomatics fails to gain prestige and due to the fact that it seems that this authority has already been acquired (Flanneri).

However, psychotherapy turns out to be certainly useful in various somatic disorders if realistic goals are put to it. It's focused on restoring those elements of patient relations systems that determine participation in the etiopathogenesis of mental stress disease, or the neurotic «strata» development, the psychotherapy tends to reduce clinical manifestations of disease, to improve social activation of patients, their adaptation to family and society as well as increases the efficiency of treatment effects of biological nature. In this regard it should be noted as the most common model nowadays is the medical one of disease, according to which the treatment is carried out primarily by means of medicines and procedures providing great opportunities when using psychotherapeutic mediation and effect potentiation of biological nature (medical, dietary, physical, etc.).

Various methods of psychotherapy, hypnotherapy, autogenic training, self-hypnosis, rational therapy and others are widely used when treating somatic diseases. There is evidence of positive results of behavioral therapy when applied to patients with somatic diseases. In this case the main aim is to overcome the recorded anxiety reactions. Using the mentioned methods, it's possible to influence the psychopathological disorders such as fear, fatigue, depression, hypochondria, as well as neurovegetative and neurosomatic functional and dynamic disorders (in the cardiovascular, respiratory, gastrointestinal and other systems).

A major incentive to long-lasting attempts to have an efficient application of psychotherapy in somatic clinic the development of various forms of personality-oriented, including group, psychotherapy occured. This can be found not only in foreign literature, being oriented in psychodynamics and existentialism but also in the work of authors who reject psychogenesis of these diseases, but at the same time recognize an important role in the origin of psychosocial factors. In this case the object of group psychotherapy as psychotherapy influences as a whole, is represented by psychological factors of disease pathogenesis (intrapsychic conflict, psychological defense mechanisms, «an internal image illness», including the individual's pathological reaction to the disease; the patient's system of significant relations, including the patient's broken social relations caused by disease). Nowadays the attempts of using group psychotherapy in actual somatic diseases represent the greatest interest, as well as the matter of its correlation with various types of symptomatic therapy.

A lot of literature is devoted to the psychotherapy for hypertension. When treating such patients using hypnotherapy as well as reducing neurosis and neurotic disorders, the blood pressure got reduced or even normalized. A long-term treatment should be applied. As a result, Bul' recommends after massive hypnotherapy course (25-30 sessions held every other day) to gradually lengthen 5 days, in 7 the intervals between sessions, at first having them in 2-3 days, then days, and then in 10 days. According to the author if the effectiveness of hypnotherapy on patients with hypertension depended on its duration, turned out to be quite clear, in such a way the depth and duration of hypnotic sleep were relatively less important. In addition, the autogenic training is used at treating hypertension, the frequency of its use in which the spa treatment of patients can be explained in such a way that a rapid parasympathetic effect can be achieved with this method applied. The method of biofeedback is widely used in the treatment of hypertension in addition to other methods of relaxation and psychological effect Studying the goals and tasks of psychotherapy for hypertension, one of the famous experts in this field Katzenshtein notes that in this regard the psychotherapy shouldn't be limited only to the

development of methods of relaxation that it should also be directed to change the wrong positions in the patient's attitudes to various areas of life using different forms of group psychotherapy, namely the psychotherapeutic work with patients should mean psychotherapeutic effects focused on symptoms, personality and socializing.

Psychotherapy turns into an essential component of treatment at all stages of regenerative therapy of patients with coronary heart disease, including post-infarction patients. If a disease occurred suddenly being psychologically unprepared to it, it makes the patient panic. Each diagnostic or therapeutic act in the cardiology department should have a psychotherapeutic mediation. The information how difficult the case is should be taken into account the patient's personal characteristics and if possible to be exhaustive to prevent a sick person from its wrong or incompetent interpretation (possible iatrogenic effects). If having ischemic heart disease with strokes, the hypnotherapy is prescribed. The course of treatment consists of 10-20 sessions held every other day for 40 minutes. The statements are given not only in an imperative way, but also in the form of explanation and persuasion. A large number of works is devoted to the use of autogenic training when having ischemic heart disease, including post-infarction period. Jurdanov, Zajcev created its most appropriate option for patients with myocardial infarction. However, the traditional methods of autogenic training had such techniques excluded as «weight», «heart», «breath», and such conditions of its implementation as the position of «locks», the prone position accompanied by undesirable phenomena. At the same time new exercises were introduced («body flexibility», «warmth and will in the chest» and others) and new elements (e.g. «opened eyes»), the mastering sequence of autogenic training techniques was changed. Autogenic training appears to be also useful in the sanatorium stage with regenerative treatment of patients having ischemic heart disease. The self-regulation of heart rate is applied to get rid of the cardiac arrhythmias (often in the form of paroxysmal tachycardia being the most frequent complication in the post - infarction period) using biofeedback techniques. The group psychotherapy is prescribed to the patients with coronary heart disease including the patients with myocardial infarction on the later stages of

regenerative treatment. The classes are held in groups (with 12-14 patients), the age and formation are taken into account at their compilation (if possible the groups are homogeneous). Discussions and other forms of psychotherapy are used.

Psychological aid given at crisis and psychological characteristics of medical care to be given in emergency situations

One of the most significant issues of clinical psychology is to provide psychological assistance to the clients with a variety of life problems that are in crisis in addition to the patients having somatic and psychiatric diseases with neurotic, psychosomatic disorders, deviations and personality anomalies.

Psychological aid is understood as the information given to a human-being abouthis mental state, causes and mechanisms of psychological phenomena, psychopathological symptoms or syndromes to develop, as well as the active purposeful psychological influence on the individual in order to harmonize his life, to adapt to the social environment, to stop psychopathologic symptoms and to reconstruct the personality to form frustration tolerance, and stress and neurosis resistance.

Psychological aid is a practical implementation of theoretical research of a clinical psychologist based on the scientific analysis of mental state and individual psychological characteristics of a person, the types of his responses to various frustrating events, first of all, diseases and conflicts.

There are three types of psychological aid:

1. Psychological counseling;
2. Psychocorrection;
3. Psychotherapy.

Psychological counseling means to analyze the patient's mental state using various methods of psychological diagnostics (interview, experiment and etc.) giving him objective data and scientific interpretations in addition to teach the skills of psychological protection and the means for his emotional state to get harmonized.

Psychocorrection is based on the counseling and admits a purposeful active psychological effect on the patient to bring him to normal mental state when being diagnosed any personality abnormalities as well as the process for any activity to be developed by him.

Psychocorrection represents expert's actions to correct those personality traits that are not optimized for him. Psychotherapy is a kind of active psychological effect on the patient who has psychopathological symptoms and syndromes and has crisis, frustration and stress.

The clinical psychologist must be aware of different types of psychological aid and effect on the patient moreover he should be not only knowledgeable how to develop an examination plan, to make a professional conclusion, but also to choose the most appropriate and effective ways of psychological aid provision.

Thematic plan for self-control

1. Conceptual definition of Mental hygiene
2. Core units of Mental hygiene, their content and sphere of application
3. Psychoprophylaxis, main tasks
4. Primary, secondary and tertiary psychoprophylaxis
5. Rehabilitation, its basic principles. Stages of rehabilitation
6. Adaptation and compensation
7. Psychotherapy as a branch of Medicine and Medical Psychology.
8. The basic modern methods and principles of psychotherapy
9. Psychotherapy in work of General Practitioner
10. Psychological aid given at crisis and psychological characteristics of medical care to be given in emergency situations

References

1. Spirina I.D., Pylyagina G.Ya., Chugunova V.V., Fauzi E.S., Zhivilova Y.S., Shevchenko Yu.M. Medical psychology: a textbook edited by Spirina I.D. Dnipro: LIRA, 2022. 300 p
2. Luban - plozza B, Zaporozhan VN, Pryaev NP. Therapy union between doctor and patient Kiev: ADEF - Ukaina; 2001.
3. Pshuk NG, Markova MV, Kondratiuk AI, Stukan LV. Medical psychology. Vinnitsa; 2010.
4. Spirina ID, Vitenko IS, editors. General and medical psychology. Dnipropetrovsk: ART PRESS; 2002
5. Vitenko IS, Chaban AA, Buslo AA. General medicine. Psychology aspects of diagnosis, prophylactic and treatment. Ternopil: Ukrmedkniga; 2002.
6. Vitenko IS. Medical psychology. Kiev: Zdorovie; 2008.

TEST TASKS

To section I

Subject, tasks and methods of psychological examination of state of human being. The concept of mental health

1. The subject of study of Medical Psychology is the following:

A - psychological methods of influence on the psyche of a person in medical and prophylactic aims

B - various and deep disorders of mentally ill people psychic activity

C- the personality of a sick man in the wide sense of this word, a medical officer, interrelations of a patient and medical officers on the stages of medical and diagnostic process

D - principles and methods of psychological research in the clinic E - psychological aspects of medical environment organization

2. This scientist considered clinical psychology to be the component part of medical psychology:

A – Gippokrat

B - B. D. Karvasarskij

C - Z. Frejd

D - 1. P. Pavlov

E - K. K. Platonov

3. Home scientists attribute this discipline to the basic units of medical psychology:

A - general psychology

B- clinical psychology

C - psychological correction

D - medical ethics and deontology

E - all the answers are true

4. According to K.K. Platonov, the following principles are of great importance for medical psychology:

A - of determinism, reflectory one, of unity of consciousness and activity

B - of historical method, of development, of structural properties, of personality approach

C - of materialism

D - answers A and B are true

E - all the answers are true

5. In psychological research the subjects of observation can be all 5. mentioned below, except:

A - the properties of psyche

B - non - verbal behavior

C - moving of people

D- the distance among people

E - physical influences

To section II

Personality and disease. The internal picture of disease

1. **The complex of different aspects of a person's psyche that reflects the realized unity of the self that is saved at all the changeability of temporal and spatial correlations is the following:**

A - homo sapiens

B- personality

C – individual

D – individuality

E - all the answers are true

2. **This scientist is considered to be the founder of the studies about temperament:**

A - Ch. Darvin

B - R. Dekart

C - I. P. Pavlov

D - Je. Krechmer

E – Gippokrat

3. **K. Leongard distinguished:**

A - 12 types of accentuations of a personality

B - 6 types of accentuations of a character

C - 3 types of the hidden accentuation

D - 3 types of the explicit accentuation

E - all the answers are true

4. Intellect is as following:

A - the complex of personality features, vital aims, plans and vital values

B- the features of self - perception, perception of time and environmental reality

C the level of ability to use the operations of thinking inherent in everybody

D- the available stock of knowledge, level of education

E- the individual standard of a person's mental condition

5. **The exaggeration of symptoms, heaviness of the state by the patient is called:**

A – simulation

B – aggravation

C – dissimulation

D – hospitalism

E – hypochondria

To section III

State of mental functions and disease. General characteristics of cognitive processes

1. Reflection of surrounding reality in its external connections and relations is:

A – sensation

B – perception

C - volitional attention

D - non - volitional attention

E - thinking 1.

2. These are related to the intensity degrees of intellectual underdevelopment at oligophrenia:

A – moronity

B – imbecility

C – idiocy

D - psychical infantilism

E- all the answers are true, except D

3. This state is named as dysphoria:

A - instability of mood, change of mood under influence of insignificant events

B - elated, merry, glad mood, that is accompanied by the wave of cheerfulness, good physical feeling, overvalue of own possibilities

C passive, good - natured, carefree mood, experiencing of complete satisfaction of own state

D- the lowered mood, experiencing of depression, sadness and despair

E vicious and depressed mood with experiencing of dissatisfaction by oneself and surrounding, often accompanied by aggression

4. All enumerated below is related to pathology of volitional behavior, except:

A – hyperbulia

B – hypobulia

C – parabulia

D – cryptomnesia

E - passive subjugate

5. The deepest stage of consciousness that is turned off is:

A – obnubilation

B – somnolentia

C – coma

D - sopor

E – stupor

To section IV

Psychology of health care workers

1. The following stage is not attributed to the stages of professional becoming of a doctor:

A - the stage of basic professional education

B- the stage of professional activity

C- the stage of professional intentions forming

D - the stage of professional readaptation

E - the stage of professional deformation

2. The following kinds of errors are considered as tactical medical errors:

A - wrong determination of indications for operation

B - wrong determination of contraindications to surgery

C- the erroneous choice of time of operation realization

D - volume of operation determined in the wrong way

E - all the answers are true

3. The following type does not belong to the psychological types of 1. doctors:

A - empathic one

B - emotionally neutral non – directive

C - emotionally- neutral directive

D - sympathetic directive

E - sympathetic non – directive

4. Doctor's professiogram includes such necessary possibilities as:

A - concrete - imaginative thinking

B - communicative competence

C – introversion

D - psychoemotional instability

E - emotional memory

5. Personality features which increase predisposition to syndrome of burnout appearance:

A - low level of anxiety

B - communicative competence

C - not high level of self – control

D - suppression of negative emotions and rationalization of own behavior

E - low sensitivity to the problems of other people

To section V

Psychology of treatment and diagnostic process

1. These are attributed to the constituents of communicative competence:

A - awareness in different communicative situations, based on knowledge and vital experience of individual

B adequate orientation of a person in himself his own psychological potential, in his partner's potential, in a situation

C - knowledge, abilities and skills of structural communication

D - readiness and ability to build contacts with people

E - all the answers are true

2. This principle is not attributed to the basic principles of medical ethics:

A - principle of not causing damage

B - principle of benefaction

C - principle of justice

D - principle of the state

E - principles of autonomy

3. Choose the signs of destructive conflict:

A - expansion of conflict

B - independence of conflict from the reason of its origin, even if the reasons of the conflict are removed, then the conflict continues

C - increase of expenses and losses the participants of the conflict suffer

D - increase of aggressive actions of the conflict participants

E - all the answers are true

4. Delete from the enumerated strategies of behaviour in conflict situations one that does not exist:

A - strategy of defence

B - strategy of leaving

C - strategy of adaptation

D - strategy of collaboration

E - strategy of competition

5. The conflict with no reason for, that, however, arises up in the consciousness of conflicting parties because of the false understanding of the situation is called:

A - latent conflict

B - wrong conflict

C - displocated conflict

D - real conflict

E - casual conflict

To section VI

Psychosomatic disorders

1. Poor vital imagination and insufficiency of the emotional plugging in the objective situation, inability to empathy, incapacity to describe the thin nuances of feelings and often inability to find words for self expression is called as:

A – empathy

B - alexithymia

C – apathy

D- euphoria

E - dysthymia

2. Mechanism of psychological defense at that experiencing shows up in the form of appearance or intensifying of somatic disease that distracts a person from the thoughts about the existing problem is called:

A – repression

B – sublimation

C – projection

D – denial

E – rationalization

3. The mechanism of psychological defense by means of that the actual behavior is given the grounds which justifies and masks its veritable motivation, that is why the behavior appears and is understood so that it looks fully reasonable and justified is called:

A – sublimation

B – repression

C – projection

D – denial

E – rationalization

4. All the diseases enumerated below are attributed to the classic psychosomatic diseases which are grouped into the «large seven «(according to F. Aleksander), except for:

A - bronchial asthma

B – neurodermitis

C – atherosclerosis

D - essential hypertension

E - rheumatoid arthritis

5. All the diseases enumerated below are attributed to the classic psychosomatic diseases which are grouped into the «large seven «(according to F. Aleksander), except for:

A - diabetes mellitus

B – rheumatism

C- ulcer of stomach and duodenal ulcer

D- ulcerative colitis

E – neurodermitis

To section VII

Psychological characteristics of patients with various diseases

1. How many stages of premenstrual syndrome development are distinguished according to the classification?

A – 2

B – 4

C – 3

D – 5

E - 1

2. These forms of climacteric syndrome display occur most often:

A – depressed

B – paranoiac

C – phobic

D – hysterical

E – asthenic

3. These features are attributed to the general psychological features of children:

A - predominance of emotional level in general structure of the illness inward picture

B - insufficiency of identification and ability to express one's own feelings

C - high suggestibility

D - absence of independence and dependence on parents

E - all the answers are true

4. A person is subordinate to anyone, does not have too high vital claims and due to that willingly leaves the professional environment, as his/her home environment gives the feeling of safety to him/her. What type of personality adaptation to old age is it talked about?

A - constructive attitude

B - attitude of hostility of a person towards himself

C - attitude of dependence

D - attitude of hostility towards surroundings

E - defensive attitude

5. How many phases of disease experiencing are distinguished for oncological patients?

A – 5

B – 3

C – 4

D – 2

E – 6

To section VIII

Psychological aspects of dependent, suicidal behavior, thanatology and euthanasia

1. About which stage of gambling development is it talked about: loss of professional and personal reputation, increase of game time and rates size, moving away from family and friends, repentance, hatred for the others, panic, illegal actions, suicidal thoughts and attempts, divorce, alcohol abuse, emotional violations, withdrawal?

A - the stage of winnings

B - the stage of disappointments

C - the stage of losses

D - all the answers are false

E - all the answers are true

2. How many signs of internet - dependence were distinguished by K. Jang?

A – 4

B – 1

C – 3

D – 5

E – 6

3. Which type of suicidal behavior in the case when a person tries to attract attention to himself/herself, for the sake of change of the actual situation, the method of getting out of the crisis?

A – protest

B – appeal

C – avoidance

D – refusal

E - self – punishment

4. Determine the type of behavior: the uncompleted suicidal actions which are the result of suicidal blackmail, or the type of suicidal behavior that precedes to the completed suicide:

A - suicidal mania

B - presuicidal syndrome

C - suicidal blackmail

D – parasuicide

E – suicide

5. Peterson distinguishes four types of death, choose the odd variant:

A - physiological

B – cerebral

C – clinical

D – psychological

E – social

To section IX

Mental hygiene, psychological prophylaxis and rehabilitation

1. The complex of measures directed to warning of the fact of mental disorder emergence is determined as:

A - primary psychological prophylaxis

B - second psychological prophylaxis

C - tertiary psychological prophylaxis

D - all the answers are true

E - all the answers are false

2. These principles are attributed to the basic principles of rehabilitation:

A – partnership

B - influence versatility

C - unity of psychosocial and biological methods of influence

D - gradation of influence

E - all the answers are true

3. The system of complex medical verbal and non - verbal influence on emotions, opinions, consciousness of a person at different diseases (psychical, nervous, psychosomatic), influence on the whole organism and behaviour of a patient is called:

A - dynamic adaptation

B - static adaptation

C - psychological adaptation

D – psychotherapy

E - the true answer is not given

4. The special state of consciousness that arises up under the influence of the directed psychological effect is called:

A – rapport

B – hypnotizability

C – suggestion

D - hypnotic trance

E – fascination

5. Analysis of the client's mental condition with the use of different methods of psychodiagnostics (interview, experiment and others) with granting objective data and scientific interpretations to him/her, and also the process of learning skills of psychological defence and means of normalization of the emotional state is called:

A - psychological counseling

B - psychological correction

C – psychotherapy

D - all the answers are true

E - true answer is not given Standards of answers

Standards of answers

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№ of question	**The true answer**
1.	**C**
2.	**E**
3.	**E**
4.	**D**
5.	**A**
To Section II **Personality and disease. The internal picture of disease**	
№ of question	**The true answer**
1.	**B**
2.	**E**
3.	**A**
4.	**C**
5.	**B**
To Section III **State of mental functions and disease. General characteristics of cognitive processes**	
№ of question	**The true answer**
1.	**B**
2.	**E**
3.	**E**
4.	**D**
5.	**C**
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№ of question	The true answer
1.	E
2.	E
3.	A
4.	B
5.	D
To Section V **Psychology of treatment and diagnostic process**	
№ of question	The true answer
	E
	D
	E
	A
	B
To Section VI **Psychosomatic disorders**	
№ of question	The true answer
	B
	C
	E
	C
	B
To Section VII **Psychological characteristics of patients with various diseases**	
№ of question	The true answer
	C
	D
	E
	C

	A
To Section VIII **Psychological aspects of dependent, suicidal behavior, thanatology and euthanasia**	
№ of question	**The true answer**
	B
	A
	B
	D
	C
To Section IX **Mental hygiene, psychological prophylaxis and rehabilitation**	
№ of question	**The true answer**
	A
	E
	D
	D
	A

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