HEALTH MINISTRY OF REPUBLIC OF MOLDOVA

THE UNIVERSITY OF MEDICINE AND PHARMACY
NICOLAE TESTEMIŢANU

Mariana CERNIŢANU, Constantin EŢCO

MEDICAL PSYCHOLOGY

(courses for medical students)

CHIŞINAU
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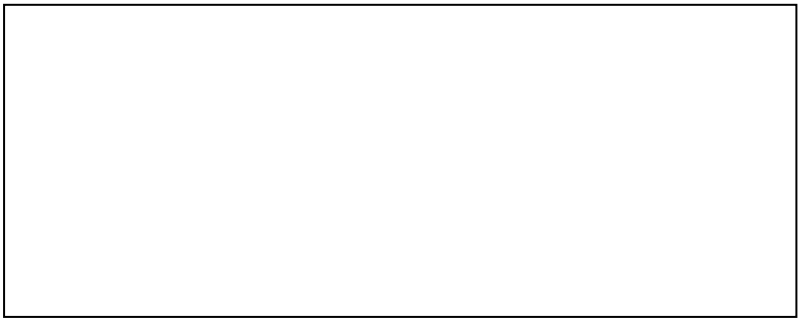
The course Medical Psychology is proposed to the students from medical institutions. The main goal of this course is to provide actual knowledge about the Doctor – Patient relationship.

By knowing the main psychological rules of interaction, students will learn to construct positive relationship with medical stuff, future patients and persons around.



CONTENT

Lecture I. Introduction to the science of psychology and its sub-fields..... 4

Lecture II. The basic psychological concept related to medicine: the human consciousness..... 15

Lecture III. Concepts of normality and abnormality……..... 26

Lecture IV. The main characteristics of illness……. 35

Lecture V. The psychosomatic (somatoform) concept of medicine…… 45

Lecture VI. The doctor – patient relationship……... 56

Lecture VII. The personality as a psychological concept related to medicine…… 75

Lecture VIII. The doctor personality…… 88

Lecture IX. The patient personality…….. 101

Lecture X. Psychofarmacology. The placebo effect..... 121

Lecture XI. Psychotherapy. Types of psychotherapy. Medical applications of psychotherapy…… 134

Lecture XII. The psychohygiene and psychoprophylaxis.…… 149

Appendix 160

Lecture I

INTRODUCTION TO THE SCIENCE OF PSYCHOLOGY AND ITS SUBFIELDS

Structure:

1. Psychology as a science. Research methods in psychology.
2. Brief history of psychology. Schools of thoughts in psychology.
3. Medical psychology.
4. Clinical psychology.

Key terms: psychology; the main goals of psychology; research methods: experiment, survey, naturalistic observation, case study; schools of thoughts in psychology: structuralism, functionalism, gestalt psychology, psychoanalysis, behaviorism, humanistic psychology, cognitive psychology; medical psychology; clinical psychology; psychotherapy.

1. Psychology as a science. Research methods in psychology.

Psychology is the scientific study of behavior and mental processes. The term ***psychology*** comes from the Greek words: *psyche* (soul) and *logos* (word or discourse) and reveals the original definition as discourse about the soul (later, about the mind). The psychological research is a systematic course of investigation intended to describe behavior, explain its causes and predict the circumstances under which it might recur.

Psychology is a multifaceted science. Psychologists study many aspects of behavior and mental processes that have practical implications for the life of all of us. They study topics like these: how do individuals use their senses of sight, hearing, and touch to make sense of the world, why some people like doing something; what personality factors influence career choices; how we remember and forget and which is the biological basis for memory; how do people remember what has happened to them or know how to plan for the future; what kind of psychological changes occur during old age; how we choose our spouses and become

attached to our parents and children – and many other issues that affect our day to day life. But psychologists are not content with merely describing behavior. They go beyond this to try explaining, predicting and sometimes modifying behavior to enhance the lives of individuals and to improve society in general. Thus, the main goals of psychology are:

– **Description,** which implies information about what is actually occurring.

– **Explanation,** which implies information about why events occur.

– **Prediction,** which implies forecast of future events on the basis of past events.

– **Modification,** that involves/entails changing or controlling aspects of the environment in order to change behavior in a way that would benefit both the individual and society.

Before we try *to modify* a behavior, we need an accurate *descripton* of it, an *explanation* of the behavior and it consequences, and some basis for *predicting* the results of the changes.

As scientific study, psychology implies using a *scientific method*, (a systematic, objective and organized way to get information, involving observation, description and experimental investigation).

The research methods used in psychology are: ***experiment, survey, naturalistic observation, and case study.***

The **experiment** has the advantages of maintaining control over conditions but sometime too much control may lead to an unnatural situation.

A **survey** is an attempt to estimate opinions, characteristics, or behavior. It can be conducted through interviews, questionnaires or public records.

Naturalistic observation involves watching and recording behavior as it naturally occurs.

A **case study** is an intensive investigation of the person, rather than a representative sample, usually because the observed is rare or unique.

All these methods involve measurement of variables using one or all of three kinds of measures: ***self-report, behavioral*** and ***physiological***.

Self-report is a method whereby subjects provide verbal statements about how they feel, what they think, or how they behave. The usefulness of self-reports is limited because subjects may lie or may not know their true thoughts or feelings.

Behavioral measures are quantified observations of how subjects actually behave.

Physiological assessments involve recording physical changes (more often are used the electroencephalograms and GSP-galvanic skin response).

2. Brief history of psychology. Schools of thoughts in psychology.

Psychology has come a long way since the time of Plato and Aristotle, when people tried to explain human nature and behavior. The early Greek and Roman philosophers wondered what the mind was and where it was located. The ancients pondered many of the same issues that preoccupy us today, but contemporary psychologists use more scientific methods to come to their conclusions. Aristotle (384-322 b.c.) introduced the concept of the mind as a ***tabula rasa*** that was empty until it was "written upon" by experience.

Psychology as a science is a little over 100 years old. In the late l9th century, philosophers and physiologists began to examine the ways people perceive and interact with the world around them.

In the late 1800s the emergence of scientific method gave the study of psychology a new focus. In 1879, the first psychological laboratory was opened in Leipzig, Germany, by Wilhelm Wundt (1832-1920), and soon afterwards the first experimental studies of memory were published. Wundt was instrumental in establishing psychology as the study of conscious experience, which he viewed as made up of elemental sensations. In addition to the type of psychology practiced by Wundt—which became known as **structuralism**—other early school of psychology were **functionalism**, which led to the development of **behaviorism**, and **gestalt psychology**. The American Psychological Association was founded in 1892 with the goals of encouraging research, enhancing professional competence, and disseminating knowledge about the field. With the ascendance of the Viennese psychologist Sigmund Freud and his method of **psychoanalysis** early in the twentieth century, emphasis shifted from conscious experience to unconscious processes investigated by means of free association and other techniques.

John B. Watson, pioneered the **behavioral approach**, which focuses on observing and measuring external behaviors rather than the internal workings of the mind. Since the 1970s, many psychologists have been influenced by the **cognitive approach,** which is concerned with the

relationship of mental processes to behavior. **Cognitive psychology** focuses on how people take in, perceive, and store information, and how they process and act on that information.

While all these approaches differ in their explanations of individual behavior, each contributes an important perspective to the psychological image of the total human being.

Applied psychology is the area of psychology concerned with applying psychological research and theory to problems posed by everyday life. The subfields of applied psychology include **school psychology**, which involves the evaluation and placement of students; **educational psychology**, which investigates the psychological aspects of the learning process; **industrial psychology** and **organizational psychology,** which study the relationship between people and their jobs. Community psychologists investigate environmental factors that contribute to mental and emotional disorders; health psychologists deal with the psychological aspects of physical illness, investigating the connections between the mind and a person's physical condition; Another relatively new specialty is **forensic psychology,** involving the application of psychology to law enforcement and the judicial system. Forensic psychologists may help create personality profiles of criminals, formulate principles for jury selection, or study the problems involved in eyewitness testimony.

Controversy swirls around many psychological issues in the way different is seen the nature of human beings. Many of these controversies were born in the very early days of psychology, with the emergence in the late nineteenth centuries of a number of different schools – groups of psychologists who shared a theoretical outlook.

The main ***seven schools of thought in psychology*** marked the history of psychology as a science. It is important that current theories in psychology are built on past contributions of these influential schools.

Structuralism. School of psychology developed by W. Wundt and E. Titchener that emphasized the study of elements of the mind. Titchener believed the new science should analyze consciousness by reducing it to its elemental units: the structure of the human mind was made up of more than 30.000 separate sensations, feelings, images and nothing else. But that method didn't survive because it was not truly scientific. Each introspectionist described his own sensations uniquely and was little consistency from one observer to another.

Functionalism. W. James and J. Dewey represented this school, concerned with what the mind does and its functions. They and the other functionalist thinkers wanted to amass knowledge that they could apply in everyday life. They developed many research methods beyond introspection, including questionnaires, mental tests, and objective descriptions of behavior.

Gestalt psychology. This school emphasized the pattern formed by the elements in the mind rather than the individual elements themselves. M. Wertheimer, K. Koffka and W. Kohler founded it. These theorists advanced the idea that it is not the individual elements in the mind (as the structuralists had maintained), but the gestalt – the pattern that these elements form in constructing a unified whole. They acknowledged consciousness but refused to look at it in little piece. They held that the whole is greater that the sum of its parts, a viewpoint that had particular impact on the study of perception.

Gestalt view of the whole as more than the sum of its parts. The Gestalt psychologists believed that mental experience was dependent not on a simple combination of elements but on the organization.

Psychoanalysis. The therapeutic approach developed by Sigmund Freud (1856-1939), that aims to eliminate anxiety by giving the patient insight into unconscious conflicts which affect behavior and emotions. Freud believed that powerful biological urges, most often sexual in nature, influence human behavior.

Freud's first attempt to get at the psychological cause of these patients' pain was through **hypnosis**, which he studied in Paris in 1885. He found the results to be less than he'd hoped, however, and soon borrowed from a Viennese contemporary the idea of getting a patient to simply talk about his or her problems. Freud created the idea of "free association", in which a patient is encouraged to speak in a non-narrative, non-directed manner, with the hope that he or she will eventually reveal the unconscious heart of the problem. This sort of unbridled, undirected self-exploration became one of the signature tenets of psychoanalysis.

Freud believed that human personality is composed of three parts: the ***id***, the ***ego***, and the ***super-ego***. The *id*, according to this schema, is comprised largely of instinctual drives for food and sex, for instance. These drives are essentially unconscious and result in satisfaction when they are fulfilled, and frustration and anxiety when they are thwarted.

The *ego* is linked to the id, but is the component that has undergone socialization and which recognizes that instant gratification of the id urges is not always possible. The *super-ego* acts in many ways like the *ego*, as a moderator of behavior; but whereas the *ego* moderates urges based on social constraints, the *super-ego* operates as an arbiter of right and wrong. It moderates the *id*'s urges based on a moral code.

Having theorized this framework of human personality, Freud used it to demonstrate how instinctual drives are inevitably confounded with strictly social codes (by the ego) and by notions of morality (by the super-ego). This conflict, psychoanalytic theory supposes, is at the heart of anxiety and neuroses. In dealing with these conflicts, Freud's psychoanalytic theory suggests that the human mind constructs three forms of adaptive mechanisms: namely, *defense mechanisms, neurotic symptoms*, and *dreams*. Freud believed dreams were vivid representations of repressed urges. He considered dreams to have two parts, the *manifest content*, the narrative that one is able to remember upon waking, and the *latent content*, the underlying, largely symbolic message. Because Freud believed dreams to represent unfulfilled longings of the *id*, psychoanalysis deals heavily with dream interpretation.

For Freud, a neurotic symptom (what we now consider a psychosomatic disorder) was some physical symptom that has a psychological, or in Freud's terms, neurological, origin. Psychoanalytic theory suggests that conditions like blindness, paralysis, and severe headaches can result from unfulfilled longings that the patient is unable to confront on a conscious level. Because of this inability, the patient develops some acceptable symptom, such as headaches, for which he or she can then seek medical attention. The final adaptive mechanism Freud suggested was ***defense mechanism***. Freud identified several defense mechanisms, such as *repression, displacement, denial, rationalization, projection, and identification.* Each has its own peculiar dynamic but all work to distance a person from a conflict that is too difficult to confront realistically.

Behaviorism. A theory of human development initiated by American educational psychologist Edward Thorndike, and developed by American psychologists John Watson and B.F. Skinner. Behaviorism is a psychological theory of human development that posits that humans can be trained, or conditioned, to respond in specific ways to specific stimuli and that given the correct stimuli, personalities and behaviors of

individuals, and even entire civilizations, can be codified and controlled. Edward Thorndike (1874-1949) initially proposed that humans and animals acquire behaviors through the association of stimuli and responses. He advanced two laws of learning to explain why behaviors occur the way they do: Ivan Pavlov's (1849- 1936) innovative work on *classical conditioning* also provided an observable way to study behavior. Watson's scheme rejected all the hidden, unconscious, and suppressed longings that Freudians attributed to behaviors and posited that humans respond to punishments and rewards. Behavior that elicits positive responses is reinforced and continued, while behavior that elicits negative responses is eliminated. Later, the behaviorist approach was taken up by B.F. Skinner (1904-1990) who deduced the evolution of human behavior by observing the behavior of rats in a maze.

The behaviorists believed that if they could determine how a person or animal would respond to a particular kind of stimulus they could learn what was most important about behavior, [The Stimuli-Reaction theory: S-R]. The behaviorists emphasized the role of the environment in shaping human nature and played down hereditary characteristics. A major objection to behaviorism has been its denial of cognitive processes.

Humanistic Psychology. School of psychology that emphasizes healthy human behavior. The first humanistic psychologists like A. Maslow and K. Rogers maintain that behaviorism tells us about behavior but little about people, while psychoanalysis tells us about the emotionally disturbed but not about the healthy. Humanistic psychology emphasizes a person's need for self-actualization, that is, to find self-fulfillment through the development of his or her unique potential.

Humanists objected to the pessimistic view of human nature advocated by psychodynamic psychologists who saw the selfish pursuit of pleasure as the root of all human behavior. In contrast, humanists emphasized people's innate potential, and the ability of people to determine their own destinies. The ultimate goal for the humanistic psychologist, therefore, is to help people realize their full potential and live up to their abilities.

Two particular theoretical approaches have come to characterize humanistic psychology**.** The "person-centered" approach to therapy advocated by Carl Rogers is based on his belief that trusting one's experiences and believing in one's self are the most important elements

of self-fulfillment. In person-centered therapy, abnormal behavior is considered to be the result of a person's failure to trust experience, resulting in a distorted or inaccurate view of the self. There is an incongruity between the person's current view of himself and his "ideal" self. Person-centered therapists attempt to help people gain self-understanding and self-acceptance by conveying empathy, warmth, and the unconditional belief that no matter what the client says or does, the client is still a worthwhile person. The second influential theory of humanistic psychology was developed by Abraham Maslow. Maslow believed that people are innately good and naturally driven to develop their potential or to achieve "self-actualization." He believed, however, that people were driven by a hierarchy of needs that must be fulfilled in a particular sequence in order for self-actualization to occur. First, physiological and safety needs must be met. Then people need to feel a sense of belonging. Once this is achieved, people work on their self-esteem needs and then finally self-actualization. Maslow believed that psychological problems result from a difficulty in fulfilling the self-esteem needs, which therefore block self-actualization.

Cognitive Psychology. Psychological school concerned with the way the mind processes information. The most recent psychological school that seeks to find out what kinds of thought processes go on in the mind. It represents a resurgence of interest in the earliest area of emphasis in psychology, the study of consciousness. Today's cognitive psychologists, however, study consciousness in a much more carefully controlled, objective, scientific way. They see people as actively engaged in information processing.

3. Medical psychology

The medical psychology is a subfield of psychology that interfaces with medicine, is focused on doctor-patient relationship, patient's attitude toward the disease and the health problem. Medical psychology is related with psychopathology, psychiatry, sociology, social psychology, neurophysiology, etc.

Postulates of medical psychology.

- importance of individuality and individualization;
- there are also personality particularities not only somatic ones;

– there are not diseases besides the patients with their individual particularities. Important for the recovery is sometimes to fight against the disease, sometimes to modify individual particularities.

Individual particularities result from the interaction of hereditary and environmental factors.

From the perspective of *bio-psycho-social model* of disorders interpretation:

– human beings are the product of hereditary and environmental factors;

– diseases are seen in context with the patient and his environment, not as independent entities;

– the aim of medical psychology is to construct a genuine therapeutic relationship between doctor and patient;

– Any doctor should have not only medical knowledge, but also some notions about personality psychology.

4. Clinical psychology

Clinical psychology is a subfield of medical psychology. The term "clinical psychology" was first used at the end of the nineteenth century in connection with the testing of mentally retarded and physically handicapped children.

The goal of clinical psychology is to use the principles of psychology and our understanding of human behavior to promote health, happiness, and quality of life.

With their varied experiences, clinicians are qualified to participate in research on, for example, cost effectiveness in health care, design of facilities, doctor-patient communication, or studies of various treatment methods. Approximately one-third of the psychologists working in the United States today are clinical psychologists. A number of clinical psychologists are in private practice, either alone or in group practice with other mental health professionals.

Contemporary clinical psychology is changing and growing at a rapid pace. The advent of managed health care, the changing needs of a multicultural society, changes in training models, the shift from primarily a male to a female profession, technological and other scientific advances, complex problems in today's culture, all have greatly impacted both the science and practice of contemporary clinical psychology.

Clinical psychologists apply research findings in the fields of mental and physical health to explain dysfunctional behavior in terms of normal processes. The problems they address are diverse and include: *mental illness, mental retardation, marital and family issues, criminal behavior, and chemical dependency.*

Clinical psychologists use psychological assessment and other means to diagnose psychological disorders and may apply psychotherapy to treat clients individually or in groups. In the United States, they are governed by a code of professional practice drawn up by the American Psychological Association. Individuals consult clinical psychologists for treatment when their behaviors or attitudes are harmful to themselves or others. Many different treatment types and methods are employed by psychologists, depending on the setting in which they work and their theoretical orientation.

The major types of therapy include psychodynamic therapies, based on uncovering unconscious processes and motivations, of which the most well known is Freudian psychoanalysis; phenomenological, or humanistic, therapies (including the Rogerian and Gestalt methods) which view psychotherapy as an encounter between equals, abandoning the traditional doctor-patient relationship; and behavior-oriented therapies geared toward helping clients see their problems as learned behaviors that can be modified without looking for unconscious motivations or hidden meanings. The work of the clinical psychologist is often compared with that of the psychiatrist, and although there is overlap in what these professionals do, there are also specific distinctions between them. As of 1996, clinical psychologists cannot prescribe drugs to treat psychological disorders, and must work in conjunction with a psychiatrist or other M.D. who is authorized to administer controlled substances.

Clinical psychologists are usually members of several professional organizations. Most are members of the *American Psychological Association (APA).* The APA was founded in 1892 and is the largest organization of psychologists anywhere in the world. The APA is divided into four directorates focusing on professional practice, education, public policy, and science.

Questions for self-evaluation:

1. Define psychology as a science.
2. Explain the main goals of psychology.

3. Explain each of the research methods used in psychology.
4. Enumerate the postulates of medical psychology from the bio-psycho-social model of disorders interpetation.
5. Enumerate the main seven schools of thought in psychology.
6. Name the parts of human personality, according to Freud's theory.
7. What does Freud's psychoanalytic theory suggest?
8. Name the main goal of clinical psychology.
9. What types of problems the clinical psychologists solve?
10. In what situations individuals may consult clinical psychologists?

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Lecture II

THE BASIC PSYCHOLOGICAL CONCEPT RELATED TO MEDICINE: THE HUMAN CONSCIOUSNESS

Structure:

1. The human consciousness.
2. The Structural Model of Personality: ID, EGO, Super-EGO.
3. Altered states of consciousness.

Key terms: consciousness, conscience, the conscious, the preconscious, the unconscious, ID, EGO, Super-EGO, sleep, hypnosis, meditation, biofeedback.

1. The human consciousness

Psychology studies the human behavior and mental processes. The connection between mental processes (sensation, perception, memory, thinking, language, creativity, etc) and behavior is due to consciousness. The good conscious control of behavior and mental processes helps the person to control his life's activities.

Generally, **consciousness** is defined as the awareness of the thoughts, images, sensations, and emotions that flow through one's mind. Consciousness is awareness of external stimuli and of one's own mental activity. Consciousness integrates our experience into a whole, but it also can be highly selective, allowing us to focus upon important information.

Conscience is the moral dimension of human consciousness, the means by which humans modify instinctual drives to conform to laws and moral codes. Sigmund Freud viewed the conscience as one of two components of the *super-ego*, the other being the *ego-ideal*. The conscience prevents people from doing things that are morally wrong, and the ego-ideal motivates people to do things that are considered morally right. This theory suggests that the conscience is developed by

parents, who convey their beliefs to their children. They in turn internalize these moral codes by a process of identification with a parent. Other psychologists have proposed different theories about the development of the conscience.

Sigmund Freud theorized that the human mind was divided into three parts**: the conscious, preconscious**, and **unconscious**. This schema first appeared in his earliest model of mental functioning, published in his classic work, *The Interpretation of Dreams* (1900).

People experience not only different levels, but also different states of consciousness, ranging from wakefulness (which may be either active or passive) to deep sleep.

Preconscious. Preconscious is an intermediate or transitional level of mind between the unconscious and the conscious. In psychoanalytic theory, knowledge, images, emotions, and other mental phenomena that are not present in immediate consciousness but are quickly accessible and can be brought into consciousness easily without the use of special techniques. Freud believed that the preconscious functions as an intermediate or transitional level of the mind, between the unconscious and the conscious, through which repressed material passes. Freud described this arrangement spatially, depicting the unconscious as a large room crowded with thoughts and the conscious area as a smaller reception room, with a doorkeeper between the two rooms selectively admitting thoughts from the unconscious to the consciousness.

A preconscious thought can quickly become conscious by receiving attention, and a conscious thought can slip into the preconscious when attention is withdrawn from it. In contrast, the repressed material contained in the unconscious can only be retrieved through some special technique, such as *hypnosis* or *dream interpretation.* (What Freud called the unconscious is today referred to by many psychologists as the subconscious).

Not all thoughts allowed into the "reception area" necessarily become conscious, however. Rather, they become available for consciousness, with one or another becoming conscious at a given time when attention is drawn to it in some way. Thus, the smaller room might more properly be thought of as a preconscious area, in which are gathered all of the thoughts that are not deliberately repressed. A preconscious thought can quickly become conscious by receiving attention, and a con-

scious thought can slip into the preconscious when attention is withdrawn from it.

Unconscious. In addition to the conscious level, consisting of thoughts and feelings of which one is aware, Freud proposed the existence of the unconscious, a repository for thoughts and feelings that are repressed because they are painful or unacceptable to the conscious mind for some other reason. In psychoanalytic theory, developed by Freud in the treatment of normal and abnormal personalities, the preconscious and unconscious minds are the repositories of secret or sexual desires that threaten our self-esteem, or ego. Once in the unconscious, these repressed desires and fears give rise to anxiety and guilt, which influence conscious behavior and thoughts. Freud attributed the cause of many psychological disorders to the conflict between conscious and unconscious urges. In order to understand abnormal behaviors and eliminate them, he theorized, an expert was required, who, in a trusting relationship with the patient, would employ techniques such as dream analysis and free association to retrieve materials buried in the unconscious mind. Thus, the driving forces behind behavior could be understood, and unresolved unconscious conflicts and anxiety could become a source of insight for the patient, eliminating the primary source of abnormal behavior.

Those thoughts that are restricted to the unconscious area remain repressed, meaning that they are totally invisible to the conscious self, and can be recovered only by hypnosis, free association, or some other technique.

2. The Structural Model of Personality: ID, EGO, Super-EGO.

Super-EGO. The *super-ego* is one of three basic components of human personality, according to Sigmund Freud. The *super-ego* judges actions as right or wrong based on the person's internal value system. Freud believed that a child develops the *super-ego* by storing up the moral standards learned from experience in society and from parents and other adults. When a parent scolds a child for hitting another child, for example, the child learns that such aggression is unacceptable. Stored in that child's *super-ego*, or conscience, is that moral judgment which will be used in determining future behavior. Another component of the *super-ego* is a person's own concept of perfect behavior, which presents a second standard used to govern actions. The complex interaction

among the *id*, the *ego*, and the *super-ego* is what determines human behavior, according to Freud.

EGO. In psychoanalytic theory, *ego* is the part of human personality that combines innate biological impulses (*id*) or drives with reality to produce appropriate behavior. The *ego* is that portion of the personality that imposes realistic limitations on such behavior. It decides whether *id- motivated* behavior is appropriate, given the prevailing social and environmental conditions. While the id operates on the "pleasure principle," the ego uses the "reality principle" to determine whether to satisfy or delay fulfilling the id's demands. The *ego* considers the consequences of actions to modify the powerful drives of the *id.* A person's own concept of what is acceptable determines the *ego'*s decisions. The ego also must "negotiate" with the *super-ego* (conscience) in the often bitter battle between the *id*'s drives and a person's own sense of right and wrong. Repression and anxiety may result when the *ego* consistently overrides the *id*'s extreme demands.

ID. In psychoanalytic theory *id* is considered the most primitive, unconscious element of human personality. The *id* is the part of the personality that includes such basic biological impulses or drives as eating, drinking, eliminating wastes, avoiding pain, attaining sexual pleasure, and aggression. The *id* operates on the "pleasure principle," seeking to satisfy these basic urges immediately with no regard to consequences. Only when tempered through interaction with the *ego* (reality) and *super-ego* (conscience) does the *id* conform to what is considered socially acceptable behavior? According to Freud, anxiety is caused by the conflict between the id's powerful impulses and the modifying forces of the ego and *super-ego.* The more id-driven impulses are stifled through physical reality or societal norms, the greater the level of anxiety. People express their anxiety in various ways, including nervousness, displaced aggression, and serious anxiety disorders. The *id*, motivated by two biological drives: sex and aggression and operates according to the pleasure principle, seeking satisfaction and avoiding pain. Guided by the reality principle, the ego's goal is to find safe and socially acceptable ways of satisfying the *id*'s desires without transgressing the limits imposed by the *super-ego.* A healthy balance between the more instinctual demands of the id and the moral demands of the *super-ego*, as negotiated by the *ego*, results in a "normal" or healthy personality.

3. Altered states of consciousness

Consciousness also has various modes, called **altered states of consciousness.** Altered state can be induced by drastically decreasing a subject's sensory input, by exposing a subject to a highly repetitive and boring sensory environment, by focusing a subject's attention, by bombarding a subject with intense sensory inputs, or by administering mind-altering drugs.

Altered states of consciousness share the following characteristics:

1. Shallow (one dimensional) mental processing.
2. Change in the way the self is experienced.
3. Loss of normal inhibitions.
4. Disconnection of perceptions from reality.
5. Increase in vividness (brightness) of the contents of consciousness.

There are several modes of consciousness: *sleep, hypnosis, meditation, biofeedback, altered states of consciousness caused by alcohol, stimulants, marijuana, and hallucinogens etc.*

Sleep, one mode of consciousness, is composed of several cyclical 90 – minute cycles of four stages, each with a characteristic brain wave pattern. *Dreams occur during the REM (rapid eye movement).* Although we clearly need REM sleep, the function of dreaming has not yet been established. According to one's mind, specific neural circuits associated with the reticular formation, control sleep.

Sleep research is usually conducted by connecting subjects to an EEG (electroencephalograph) and recording their brain waves as they drift into sleep. Different types of brain waves are typically recorded at different stages of sleep. *Beta waves* (14+ cycles per second) are fastest and are typical in a fully awake person. *Alpha waves* (8-13 cycles per second) are characteristic of relaxation. As a person falls asleep, *theta waves* (5-7 cycles per second) also become evident. As sleep becomes deeper, *delta waves* (4 or fewer cycles per second) become predominant.

There are four stages of sleep labeled 1,2,3 and 4, each progressively deeper. Delta sleep has been associated with restoration of the skeletal muscles or the sensory system involved in controlling them. Although stage 4 is characterized by deep relaxation, this is the stage (along with stage 3) during which most episodes of sleepwalking, sleep talking, and intense nightmares occur. In a typical night's sleep, you progress from stage 1 to stage 4, and back to stage 1, about every 90 minutes.

At this time, you are likely to enter REM (Rapid Eye Movement) sleep, the stage of sleep associated with dreaming. You dream about four or five times each night. REM sleep differs greatly from non-REM sleep. The scanning hypothesis speculates that the eye movements in REM are due to the dreamer's watching the dream's activity.

REM sleep is paradoxical in that it appears to be both a lighter stage of sleep (as indicated by EEGs and physiological measures) and a deeper stage of sleep (as evidenced by lack of muscle tone). If subjects are deprived of REM sleep, they will spend more time in REM sleep on the following night – the REM rebound. Several hypotheses have been proposed to explain the possible value of REM sleep. Perhaps it is the time the brain adapts to disturbing life events, since people need less REM sleep, as they grow older, (newborns spend about 50 percent of their sleep in REM; old people, less than 5 percent). Perhaps REM sleep plays a role in consolidating information into long term memory. Finally, REM sleep may provide a means of reducing built-up energy when our biological needs go unmet.

Sigmund Freud believed that dreams have two levels of meaning: the manifest content is the story the dreamer remembers; the latent content is the deeper, underlying meaning of the dream, which can be analyzed to reveal unconscious psychosexual conflicts. Most psychologists who use dream analysis favor interpretation of the dream's direct meaning (manifest content). Some psychologists are working to develop "dream management" techniques, which will allow subjects to control their dreams. Stephen La Berge, for instance, has tried to increase his lucid dreams - dreams in which he realizes he is dreaming – as a means of reducing nighttime conflicts.

The most common sleep disorder is *insomnia*, the inability to stay asleep or difficulty going to sleep. *Sleep apnea* is the stoppage of breathing after failing asleep, which may then be followed by awakening and gasping for air. *Narcolepsy* is a disorder in which people will suddenly fall asleep, losing muscle control and often entering the REM period immediately.

Hypnosis is difficult to define, and at present no clear explanation for the phenomenon exists.

Hypnosis is used to reduce the experience of pain, to treat certain behavior disorders such as smoking, and to improve memory recall. However, the improvement in memory hypnosis seems to produce, may

actually be the result of confabulation; therefore caution should be exercised in using information recalled during hypnosis.

Hypnosis is a highly responsive state induced by a hypnotist through the use of special techniques. While the term "hypnosis" comes from the Greek word for sleep (*hypnos)*, hypnotized people are not really asleep, hypnosis is actually an intense state of concentration. Their condition resembles sleep in that they are relaxed and out of touch with ordinary environmental demands, but their minds remain active and conscious.

Other characteristics of hypnosis include lack of initiative, selective redistribution of attention, enhanced ability to fantasize, reduced reality testing, and increased suggestibility. Also, hypnosis is often followed by post-hypnotic amnesia, in which the person is unable to remember what happened during the hypnotic session.

Classical hypnotic induction involves a series of steps. First, sensory input to the subject is restricted, and the subject is instructed to stop moving. Second, the subject's focus of attention is narrowed. This may be accomplished by asking him or her to focus on a specific point of light or a spot on the wall. Finally, the hypnotist begins a pattern of monotonous repetition. The hypnotist may repeatedly tell the subject to relax, to breathe slowly and deeply, and to focus attention on a fixed point.

There are **some degrees of hypnosis**: Under *light hypnosis*, the subject becomes sleepy and follows simple directions; under *deep hypnosis*, the person experiences dulling of sensory perception, similar to that of anesthesia. Under deep hypnosis, the subject can move about, open his or her eyes, and can even undergo medical procedures with no additional anesthetic. Magicians and illusionists use deep hypnosis to make a subject behave in unusual ways, such as to suspend the subject's body between two chairs in a posture that is completely stiff. The magician suggests that the subject's body become stiff and rigid, and the result is muscle tension powerful enough to support the body completely. Many researchers contend that the key factor in hypnosis is the subject's willingness to cooperate with the hypnotist, combined with the subject's belief that hypnosis works.

Most people (about 95 percent) can be hypnotized to some degree if they so desire. Another estimation is that about 70 percent of all people can be hypnotized at some level. People who are easily hypnotized are

described as "suggestible"; in fact, if the subject expects to be successfully hypnotized, it is much more likely that he or she will. People who are highly susceptible to hypnosis tend to have histories of daydreaming, imaginary companions, and absorption in their activities. *Hypnotic induction* is the process by which hypnosis is accomplished. In most situations, an individual performs the induction on a willing subject. Many scientists feel that an unwilling subject would be difficult to hypnotize, and most scientists raise ethical questions about any attempts to do so. While in an hypnotic trance, some subjects are able to recall forgotten experiences. This can be useful in treating amnesia or milder forms of memory loss.

Meditation is a retraining of attention that induces an altered state of consciousness. Some form of meditation has been used in every major religion, still there are large differences in the ways meditation can be practiced. Although the particular physiological changes that result vary depending on the type of meditation, generally they resemble deep relaxation, with lowered metabolic rates and an increase in alpha wave output. Supporters of meditation claim it reduces stress, increases happiness and enriches life.

In meditation, an altered state of consciousness is achieved by performing certain rituals and exercises. Typical characteristics of the meditative state include intensified perception, an altered sense of time, decreased distraction from external stimuli, and a sense that the experience is pleasurable and rewarding. While meditation is traditionally associated with Zen Buddhism, a secular form called Transcendental Meditation (TM) has been widely used in the United States for purposes of relaxation. It has been found that during this type of meditation, people consume less oxygen, eliminate less carbon dioxide, and breathe more slowly than when they are in an ordinary resting state.

Through meditation**,** yogis are able to achieve the state called *samadhi*, or *nirvana* in which awareness is separated from the senses. This and similar experiences in meditation and biofeedback differ from dreaming and hypnosis, since the subject regulates his or her own state of consciousness.

Biofeedback is the use of monitoring instruments to give a person continuous information about his or her biological state. By trial and error, the subject gradually learns to control these internal states and regulate a variety of physiological processes, such as heart rhythms,

body temperature, and muscle tension. Biofeedback has been used to increase the time spent in the state between sleep and wakefulness.

Altered states of consciousness caused by alcohol, stimulants, marijuana, hallucinogens etc.

Consciousness may be altered in a dramatic fashion by the use of psychoactive drugs, which affect the interaction of neurotransmitters and receptors in the brain. They include illegal "street drugs," tranquilizers and other prescription medications, and such familiar substances as alcohol, tobacco, and coffee.

The major categories of psychoactive drugs include depressants, which reduce activity of the central nervous system; sedatives, another type of depressant that includes barbiturates such as Seconal and Nembutal; anxiolytics (traditionally referred to as tranquilizers); narcotics including heroin and its derivatives which are addictive drugs that cause both drowsiness and euphoria, and are also pain-killers; psychostimulants, such as amphetamines and cocaine, which stimulate alertness, increase excitability and elevate moods; and psychedelics or hallucinogens, such as marijuana and LSD. Psychedelics, which affect moods, thought, memory, and perception, are particularly known for their consciousness-altering properties. They can produce distortion of one's body image, loss of identity, dreamlike fantasies, and hallucinations. LSD (*lysergic acid diethylamide*), one of the most powerful psychedelic drugs, can cause hallucinations in which time is distorted, sounds produce visual sensations, and an out-of-body feeling is experienced. Various states of consciousness are viewed differently by different cultures and even subcultures. In the United States, for example, hallucinations are devalued by mainstream culture as a bizarre sign of insanity, whereas the youth counterculture of the 1960s viewed drug-induced hallucinations as enlightening, "mind-expanding" experiences. In certain other societies, hallucinations are respected as an important therapeutic tool used by ritual healers.

Drugs are substances that can alter the functioning of a biological system. Psychoactive drugs interact with the central nervous system and alter mood, perception, thinking, and behavior.

Alcohol is the most widely used psychoactive drug. It is a depressant and suppresses nerve impulses. People sometimes feel elated when they drink a small amount of alcohol because it slows down the brain centers that normally control social inhibitions. With increased

doses, other central nervous system functions deteriorate. Blood alcohol levels of 0.05 percent will relax inhibitions; 0.01 percent is usually defined as drunkenness, levels of 0.3 percent to 0.4 percent may cause coma, and levels exceeding about 0.5 percent cause death.

Alcohol consumption has little effect on short-term and long-term memory, but it does affect the transfer of information from short-term to long-term memory. Alcoholic blackout is the loss of memory for events that occurred while drinking. State-dependent memory also influences recall, so that a person can recall incidences experienced under alcohol's influence when drinking, but not when sober.

Stimulants produce physiological and mental arousal and include drugs as mild as caffeine and nicotine or as powerful as cocaine and amphetamines. *Cocaine*, once an ingredient in Coca Cola, is today illegal, although it is becoming increasingly popular in middle-class America. It can be "snorted", smoked, or injected. It produces euphoria. Users report that it improves performance, although users overestimate their abilities. Since energy is expended without replenishing the source, when the drug effects wear off the user "crashes" with exhaustion. Chronic use damages the mucous membranes and can generally poison the system. Large doses can produce hallucinations and even death. One especially horrifying hallucination is the sensation of bugs crawling under one's skin. A new form, called "crack", is exceptionally powerful, producing a rush within seconds of being smoked.

The *amphetamines*, such as *Dexadrine* and *Benzedrine*, were once prescribed to help people stay awake or lose weight. Extended use of amphetamines leads to tolerance. With increasingly larger doses needed to produce the same euphoria. Overuse can lead to paranoia, meaningless wandering of thought, and periods of depression when the drug wears off. Heavy users show symptoms similar to those of schizophrenia. Amphetamine abuse can cause brain damage.

Hallucinogens have been extracted from plants and used since earliest human history. *Marijuana and hashish* are often called minor hallucinogens because of the mildness of their effects compared to the major hallucinogens, which include mescaline, LSD, and PCP.

LSD (*lysergic acid diethylamide*) is much stronger than natural hallucinogens such as psilocybin and mescaline. LSD blocks the effects of serotonin (a neurotransmitter), but other drugs block serotonin with similar effect. It produces a series of hallucinations and feelings of increased awareness and knowledge. In fact, LSD impairs thinking

ability as measured by performance on simple tasks. Panic reactions sometimes occur.

PCP (*phencyclidine*), also called *angel dust*, is another powerful hallucinogen. It tends to produce depersonalization, mental confusion, insomnia, delusions and hallucinations, and the urge to act violently. PCP molecules bind to receptor sites in the limbic system, but researchers do not yet understand exactly how the drug works.

Questions for self-evaluation:

1. Define consciousness and describe its characteristics.
2. Describe how consciousness can exist in different states.
3. Describe the various stages of sleep.
4. Describe the REM sleep main functions.
5. Compare and contrast hypnosis to other states of consciousness.
6. Describe the process of meditation and the physiological benefits it provides.
7. Describe how biofeedback works and the benefits it offers.
8. Describe the effects and actions of alcohol, stimulants, marijuana, LSD and PCP.
9. Discuss the influence of psychoactive drugs on learning, memory, and creativity.

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CONCEPTS OF *NORMALITY* AND *ABNORMALITY*

Structure:

1. The concepts of normality and abnormality.
2. Elements of health psychology.
3. Disease criteria. Mental disease.

Key terms: normality; abnormality; health; disturbance; disease; disease biomedical model; disease bio-psycho-social model; mental disease; the international classification of diseases (ICD-10; DSM-IV).

1. The concepts of normality and abnormality.

Normality is an abstract notion, used mainly in psychology in order to define a complex functional and dynamic equilibrium in a totality of active interferences and interdependencies with the environment.

This equilibrium results by the harmonic collaboration between different systems in the organism, according to its adaptive resources and compensating mechanisms, which varies from an individual to another with age.

If in the adaptive processes the functional reserves are used rationally and with economy, in the compensating processes the equilibrium is maintained with high energetic losses, increasing the loss of functional reserves, difficult to restore afterwards.

Compensating mechanisms are special protective body mechanisms which intervene when excessive environmental solicitations (too intense, too long) and the organism's functional reserves are reduced or exhausted, so that the adaptive mechanisms could no longer maintain the equilibrium.

Even if compensating mechanisms can cover for a while the functional deficit of the body, giving the illusion of normality, in fact there

is a disturbance of the functional processes leading to a state of inefficiency which can mark the beginning of a disease.

Normality criteria:

– Statistical criteria (the norm, the media, the way of thinking, acting in a certain situation etc.);

– Functional criteria (functioning according to his age and abilities);

– Adaptive criteria (the ability to adapt to his environment);

– Interpersonal criteria (ability to create good, stable relationship with other people);

– Cultural criteria (functioning according to the cultural norms);

– Moral criteria.

Normality implies a dynamic adaptation to the changing environmental conditions, but also the variations from a media considered normal in the social, cultural milieu.

Abnormality criteria:

– The abnormality is a deviation from the normality. This deviation can be positive as in gifted, genius person, or negative as in disharmonic, sick people.

– It can be also considered as a deviation from the statistical norm and implies a dysfunction, a sufferance at the psychological and social level.

When defining abnormality there are *4D criteria* to be considered:

1. **D**eviation from norm;
2. **D**ysfunction (transgression of interpersonal norm);
3. **D**istress (state of internal tension and anxiety);
4. **D**anger/Aggressiveness.

2. Elements of health psychology.

The field of **clinical health psychology** is defined as: the aggregate (collection) of the specific educational, scientific, and professional contributions of the discipline of psychology to the promotion and maintenance of health, the prevention and treatment of illness, the identification of etiologic and diagnostic correlates of health, illness, and related dysfunction, and to the analysis and improvement of the health care system and health policy formation (Matarazzo, 1982).

Since its beginnings in the early 1980s, health psychology has become one of the fastest growing areas of clinical psychology and the most popular area of research in graduate training programs. It has been

estimated that 50% of all deaths are caused by lifestyle factors such as smoking cigarettes, drinking too much alcohol, eating high fat food, not exercising, and refusing to wear seat belts (National Center for Health Statistics, S.Taylor, 2003).

Health psychologists work to help healthy people stay healthy and assist people with various illnesses or risk factors to cope more effectively with their symptoms. Health psychologists work toward helping others develop health enhancing lifestyles, which can be a surprisingly difficult task. For example, about 95% of those who lose weight tend to regain all their lost weight within five years. Over 50% of those who start an exercise program drop it within six months, while 75% drop it within nine months (Dishman, 1982). They also help in the treatment of chronic pain, panic disorders, migraine headaches, and other physical conditions with prominent biopsychosocial features. Health psychologists are often trained in clinical psychology, counseling psychology, social psychology or child clinical psychology but specialize in health-related problems and interventions.

Health psychologists typically work in hospital settings, however, many also work in academic, business, and outpatient clinic settings. Health psychologists often utilize specialized techniques such as biofeedback, hypnosis, relaxation training, and self-management strategies in addition to general psychotherapy in the course of the overall treatment process.

WHO (*The World Health Organization*) defines **health** as a state of psychological, somatic and social well-being that is subscribed to the more general term of normality.

This state implies several perspectives:

– From subjective perspective health means an accord with oneself.

– From dynamic perspective health is accordance between age and actual estate.

– From social perspective, health implies the way the other members of the group perceive the individual and the atmosphere they create around the person.

When one of these perspectives is abnormal we are talking about an incomplete state of health which can lead to disease.

Generally, health is defined as:

– Integrity state;

– Absence of symptoms;

– Well-being;
– Ability to grow up and to learn;
– Capacity of self-development (fulfilling or realizing the own potential).
– Capacity to face the quotidian and its exigencies, inclusive to our own emotions;
– Ability to adapt flexible to our own conflicts.

At the social level, health implies:

– Prevalence of cooperation and competition between individuals, rather than conflict;
– Solving conflicts in a peaceful way;
– Maintaining the equilibrium between tolerance and punishment when controlling the group members;
– Maintaining the cohesion of the group through attachment to common values and aims;
– Right rapport between rewards and punishments;
– Preserving the emotional security;
– Avoiding tensions which could induce disorders.

Mental health is the result of interaction of individual and group factors, being conditioned by intellectual and affective qualities, inborn or acquired, permitting active social integration and adaptation of the individual to his environment.

Mental health means the capacity of individual to fulfill a social, professional, interpersonal role, to form a family, and to face its responsibilities.

3. Disease criteria. Mental disease.

Disease is a disturbance at physical or/and psychical level.

Historically there are 2 conceptual models of disease: *biomedical model* and *bio-psycho-social model.*

Biomedical model considers only biological factors in a disorders appearing. It focuses on the sick organ, without taking into account the person as a whole. It considers that the doctor only is responsible for treating the disease.

The **bio-psycho-social model** derives from the general systems theory, which imply:

1. *biological system* centered on anatomical, structural, molecular level and on the biological functioning of the patient.

2. *psychological system* centered on the role of motivation and personality upon the illness and patients reactions to disease.

3. *social system* centered on cultural and familial influences on illness.

This model includes the following theories:

– psyche cannot be separated from soma.

– the causes of diseases are multifactorial.

– the importance of prevention in the treatment process.

– responsible for prevention, treatment and recuperation is not only the doctor and the medical team, but also the patient, his family and the society too.

Consequences of disease

- Semantic disturbances: pains, dyspnea, fever, diarrhea, feinting etc., or minor symptoms normally neglected by the individual but overrated during the disease.
- Nonspecific somato-psychological disorders like: insomnia, anxiety, asthenia, irascibility etc.
- Environmental modification for the patient following hospitalization.
- Relational modifications (emphasis on doctor-patient relationship, new patient-patient relationships), changing relations with friends, colleagues, etc.
- Behavioral modifications: affective and behavioral regression induced by psychological stress (exaggeration of his own sufferance, demanding or crying tone of the voice, childish attitude as a protective defense reaction), egocentrism, increased sensitivity, individual dependency on the doctor, dominance of affects such as crying, laugh, aggressiveness, anxiety, depression, etc.,
- Task evasion, social evasion especially in those patients with low social status, using the disease in order to draw attention upon him.
- Informational contamination from "veterans".
- Helping behavior among patients.

Any disease implies *onset, evolution* and *the end*.

– **Onset** can be seen from clinical and psychopathological point of view. It can start with first symptoms or without symptoms but with psychopathological disorders not observed clinically. This implies the exhaustion of functional reserves of the body. The correlation between clinical beginning and the psychopathological one is not always ob-

vious, especially in chronic disorders. The insidious onset takes days or weeks, sometimes years, when there is a struggle between adaptive processes and pathogenic agent.

– **The period of disease:** There is a characteristic evolution of the disease, when the etiopatho-genetic complex has the determinant role but the reactivity of the body influences the clinical presentation. This reactivity is also responsible for some nonspecific clinical presentations, seen especially in severe diseases and which can be more important in the prognosis of the disease than the diagnostic itself.

– **The end of disease.** There are 3 possibilities: *recovery, chronic evolution* and *death.*

Recovery means reestablishing integrally the functional and adaptive balance of the body. In this case there is a mobilization of defense mechanisms, etc. There is a positive finalization of all processes taking place during the illness, but the reactivity of the body is modified (for example: the antibodies produced during a contagious disease).

Chronic evolution implies a partially recovery, when the equilibrium is very fragile, persisting some sufferance, waving evolution.

Another possibility is the recovery with some defects, inducing sufferance, handicap, but without affecting the adaptive possibilities of the body.

Clinical death of 5-6 min., induces a hypoxia and some ireversible lesions in SNC. Biological death follows the lesions produced in clinical death.

A **mental disease** is seen as a disturbance at different level of psychic structure. It can appear in a period of normal body functioning. Mental disease induces an adaptive difficulty to personal and social level. It obstructs personal development, the ability to self fulfillment and creativity.

Most of mental disorders are caused by an enormous amount of misery, economic loss and decreased quality of life of individuals, and their families and their communities. At least 300 million people suffer from mental disorders, and it is probable that one third of all disability is caused by them.

The internationally recognized classifications of mental disorder, included as part of the International Classification of Diseases **(ICD-10)** from the WHO (*World Health Organization*) has had four revisions since

1948, and the Diagnostic and Statistical Manual **(DSM-IV)** from the American Psychiatric Association has undergone four revisions since 1952.

As in other areas of health, notions of mental health are gendered. Men and women think differently about their mental health and feeling of well-being, as it is shown by studies of psychiatric morbidity in the community and of patterns of helps-seeking behavior (Anson et al., 1993). Women more often define problems as "illness" than do men, and health professionals are more likely to medicalise women's problems than men's (Jebali, 1995).

The public perception of mental disorder is based in culturally constructed concepts of normality, abnormality, health and illness. In general, are mentally healthy in any given society, the persons who manage to find personal fulfillment while being integrated socially and economically into that society at whatever level suits them. People who find themselves unduly stressed or isolated by the norms and expectations of their social situation have to find acceptable means of expressing their mental distress; otherwise they will become more isolated or more stressed.

According to Shorter (1990) the social historian of psychiatry must pursue three separate narratives: *first*, that of underlying biology; *second*, the story of the stress and life experiences of individual patients; *third*, the story of changes in the models which the culture holds out for the communication of inner distress.

The main diagnoses associated with women are depression, neurosis, and eating disorders.

Views on how to „treat" people with mental disorders vary according to the position taken, by the proponents of these views, on what constitutes mental disorders. Those who view it as a medical problem will base their discussions on existing health care provision. Those who view it as a socio-economic problem will look for ways of changing social situations in order to provide more support and less stress for the individuals concerned.

Others, of course, view the situation from a completely different perspective, one that is interested only in the negative effects on society caused by individuals who display antisocial conduct as a result of mental disturbance. For the latter group, the discussion will revolve around the issue of public safety and the need for surveillance and protective custody for people with mental disorders.

Early texts on the treatment of mental disorder show pictures of swinging chairs, of bloodletting and of (cold) baths as effective modes of treatment, but even these sometimes bizarre approaches were only available to a small minority of patients. In reality, there was very little attention from medical staff. For some asylum „inmates", work and discipline were the main forms of therapy, while for others, it was cruel physical punishment and detention in substandard conditions.

As medical science developed in the early part of the twentieth century, infection was commonly associated with mental disorder, and a variety of physical treatments were pioneered. These included the following: shock treatment, surgery, water therapy and the most generally used approach to therapy manual work. However, for the majority of people in the public health care system and psychiatry had little to offer patients before the „drug revolution" of the 1950 s. As we entered the twenty first century, medication has replaced physical restraint, surgery and psychotherapy as the main method of treatment in hospital.

Questions for self-evaluation:

1. Define the main criteria of normality.
2. Explain the compensating mechanisms.
3. Explain the relation between normality and abnormality.
4. Name and explain the 4 D criteria of abnormality.
5. The criteria of health.
6. The notion of mental health.
7. Explain the difference between abnormality and disease (disturbance).
8. Explain the disease biomedical model.
9. Describe the disease bio-psycho-social model compared to the biomedical one.
10. Enumerate the consequences of diseases.
11. Describe the 3 possibilities for the end of disease.
12. The main characteristics of mental diseases.
13. Enumerate and explain the most used mental disease's methods of treatments.

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THE MAIN CHARACTERISTICS OF ILLNESS

Structure:

1. The psychological causes for the appearance of disorder.
2. Classifications of diseases (ICD-10; DSM- IV).
3. The pain perception. The affective states conditioned by the illness and pain.
4. The patient's attitude toward the illness.

Key terms: stress; crisis; acute stress disorder; trauma; post-traumatic stress disorder; mental disease; the international classification of diseases (ICD-10; DSM-IV); autoplastic picture of illness.

1. The psychological causes for the appearance of disorder.

The most prominent psychological causes, which may disturb the organism function and can lead to disorders, are:

- Crisis.
- Stress.
- Acute stress disorder.
- Trauma.
- Posttraumatic stress disorder.
- Difficult situation.
- Emergency situation.

Crisis - rapid changing of functional state of the individual secondary to emotional and behavioral reactions in an unusual and/or unpleasent context.

Stress – tension, in adaptation to a stressful situation (disease, interpersonal conflicts.

Acute stress disorder – anxiety thinking exposed to an extreme stressor (crime, accident, death, etc.) appearing immediate to one month after the event.

Trauma - reaction in face of a dangerous situation with psychological, behavioral inhibition or hypervigilence.

Posttraumatic stress disorder – hipervigilence, avoiding places, persons reminding the traumatic event, flash – backs.

Dificult situation – any unpleasant, heavy or potential dangerous situation.

Emergency situation – combination of circumstances that necessitate immediate action. When the appearance of emergency situations becomes chronic, it may lead to exhaustion.

Crisis is a personal (traumatic or stressing event) or social situation implying a sudden, unexpected change of the homeostasis of that individual or group, a disturbance of daily existence, following the exhaustion (collapse) of coping mechanisms.

There are 4 stages of crisis reaction:

1. **Impact,** shock and immediate response (astonishment, denial of the reality, etc).

2. **Heroic phase**: colaboration in order to dominate the anxiety, anger, regression, etc.

3. **Honey** moon phase after 1 week, hope that everything will be all right.

4. **Desillussion** phase, over 2 month, hostility, anger etc.

5. **Resolution**: acceptance of the situation and planing for the future or **overtiredness** (exhaustion) of personal resources and psychobehavioral disturbances.

Characteristics of crisis situations:

– Limited in time (a few days-weeks);

– The individual is unable to solve the situation with his own resources;

– High personal vulnerability (suicide risk, homicide, accidents, etc);

– Resolution by discovering new resources, coping strategies or developing some pathology;

– Empowering of personal experience and source for the progress if resolved satisfactorly.

Generally, crisis intervention imply the followings steps:

1. Considers the person in crisis as a **normal person** in an abnormal situation.

2. Immediate intervention with short interactive form of psychotherapy to promote (stimulate) the personal resources.

3. Facilitation of understanding of causes.

4. Focusing on problem solving.

5. Encouragement in own forces.

Stress. Walter Cannon, profesor at Harvard University uses the term *stress,* by mentioning the role of emotional factors in the evolution of diseasses. He linked the organic reaction (emotion) and the behavioral reaction to the stress: *fight* or *flight,* when dealing with a new, possibly dangerous situation.

The first one who extensively studied stress, was the canadian H. Selye, in 1936. Selye concludes that it must be an unspecific reaction of the human body to disease.

H. Selye considers that stress is an innate characteristic of living beings, lack of stress being equivalent to death. Selye introduced the distinction between *eustress* "good stress" and distress "bad stress" in 1983.

He identified and described *the general adjustment syndrome (GAS)* as the effort of the body makes as reaction to the environmental challenges, effort mostly determined by hiperreactivity of the suprarenal cortex.

Selye introduces the concept of stress during the 50's, as a general biologic reaction, "*a specific syndrome corresponding to any unspecific changes brought to a biological system".*

Stress comes from subjective feeling of inefficiency. It appears as a discrepancy felt by the subject between external request and self-evaluation.

Nowadays the term *stress* has two accepted meanings:

1. Situation or stimulus which give the human organism at state of tension.

2. The organism's state of tension itself, through which it mobilizes all it's resources, as a reaction to a physical or psychological aggresion.

Generally, *stress* represents a normal and necessary aspect of life, which man cannot elude. It can generate a temporary discomfort and also can induse long-term consequences.

While too much stress can alter somebody's health and well-being, some amount of stress is undoubtably necessary for survival.

Stress can diminish normal body functioning and even induce disease, but it also helps a person in danger and also improves learning.

Long term stress is a risk factor not only for high blood pressure, but for problems like depression and anxiety as well. Effective stress management is a vital part of healthy living, and can help keep your heart in top health. Effective tips for dealing with stress are highlighted here, along with simple approaches for integrating them into daily life.

1. Get organized

Setting clear timelines and priorities will help eliminate unexpected complications from daily events and create a sense of empowerment and control.

2. Work it off

A regular exercise program provides both physical and mental benefits. Physically, exercise helps release stress relieving hormones. Mentally, the time can serve as an important refuge in the hustle and bustle of daily life.

3. Develop strategies

Stress is never completely avoidable. To help deal with life's stressful situations, take some time to develop strategies to deal with unexpected moments. Whether it's having a backup ride for the kids or a Plan B for dinner, simple strategies will go a long way to simplifying and deconstructing stressful situations.

4. Take 5

Everyone needs some quiet time during a busy day. The "Take 5" rule works in both an organized and an unorganized way. Building in small segments of quiet time will allow time to catch your breath and review daily goals. Being able to detach from an unexpected situation, even for a few minutes, will provide valuable respite and a fresh point of view.

5. Set realistic goals

Nobody likes to fail. Yet, one of the fundamental failings of modern goal setters is a tendency to set overreaching, potentially unattainable goals. Keep daily goals well focused, task oriented, and realistic.

6. Take a nap

The idea of the afternoon nap is actually built into the fundamental functioning of many European cultures. Yet, in the hard working environment of American corporate and family culture, this valuable tool is often overlooked. Studies have shown that even short 15 or 20 minute nap breaks markedly improve mood, outlook, and stress-handling ability.

7. Stay involved

Boredom creates stress. Keep your days interesting and varied with a little preplanning. Hobbies, friends, and activities can all play a role.

8. Eat well

Poor nutrition both alters biochemical profiles, leading to feelings of exhaustion and stress, and also heightens poor body image, reinforcing these negative emotions. A balanced diet can help avoid these negative impacts.

9. Play

Personal recreation is a vital part of stress management. Spend some time each day engaged in activities you find enjoyable and fulfilling. Whether it's spending 20 minutes walking, curling up with a book or magazine, or just people watching at a café, personal time will leave you refreshed and feeling positive.

10. Connect

Social connections are fundamental to the human experience. Seek out connections with like minded individuals or groups to improve your sense of social connection.

2. Classifications of diseases (ICD-10; DSM- IV).

The *International Statistical Classification of Diseases and Related Health Problems,* 10th Revision *(ICD-10)* is a coding of diseases and signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or diseases, as classified by the *World Health Organization (WHO).* The code set allows more than 14,400 different codes and permits the tracking of many new diagnoses. Using optional sub classifications, the codes can be expanded to over 16,000 codes. Using codes that are meant to be reported in a separate data field, the level of detail that is reported by ICD can be further increased, using a simplified multiaxial approach. Work on ICD-10 began in 1983 and was completed in 1992.

WHO provides detailed information about ICD online, and makes available a set of materials online.

Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).

A reference work developed by the American Psychiatric Association and designed to provide guidelines for the diagnosis and classification of mental disorders. The *American Psychiatric Association* publishes the *Diagnostic and Statistical Manual of Mental Disorders,* widely referred to as *DSM-IV,* a reference work designed to provide guidelines for psychologists and others to use in the diagnosis and classification of mental disorders.

First published in 1917, each new edition of *Diagnostic and Statistical Manual of Mental Disorders* has added new categories. With the third edition, published in 1980, the *DSM* began recommending assessment of mental disorders according to five axes, or dimensions, that together establish an overall picture of a person's mental, emotional, and physical health, providing as complete a context as possible in which to make a proper diagnosis. The diagnostician evaluates the patient according to criteria for each axis to produce a comprehensive assessment of the patient's condition; the multiaxial system addresses the complex nature of more mental disorders.

Axis I lists 14 major clinical syndromes. These include disorders usually first diagnosed in childhood or adolescence (hyperactivity, mental retardation, autism); dementia, amnesia, and other cognitive disorders; substance-related disorders; schizophrenia and other conditions characterized by abnormalities in thinking, perception, and emotion; and sexual and gender identity disorders.

Axis II is for assessment of personality disorders lifelong, deeply ingrained patterns of behavior that are destructive to those who display them or to others. Some examples are narcissistic, dependent, avoidant, and antisocial personality types. This axis also includes developmental disorders in children.

Axis III considers any organic medical problems that may be present.

The IVth axis includes any environmental or psychosocial factors affecting a person's condition (such as the loss of a loved one, sexual abuse, divorce, career changes, poverty, or homelessness).

In axis V, the diagnostician assesses the person's level of functioning within the previous 12 months on a scale of 1 to 100. Besides diagnostic criteria, the *DSM-IV* also provides information about mental and emotional disorders, covering areas such as probable cause, average age at onset, possible complications, amount of impairment, prevalence, gender ratio, predisposing factors, and family patterns.

The current version (ICD-10) compiled in 1992, includes disabilities and factors influencing health status as well as factors that can cause death. The section on „Mental and behavioral disorders" contains 1000 categorical slots divided into nine groups (all conditions being coded with a letter of the alphabet, in this case F.).

The other major classification is the American Psychiatric Association's **DSM.** Debate continues among American psychiatrists on many

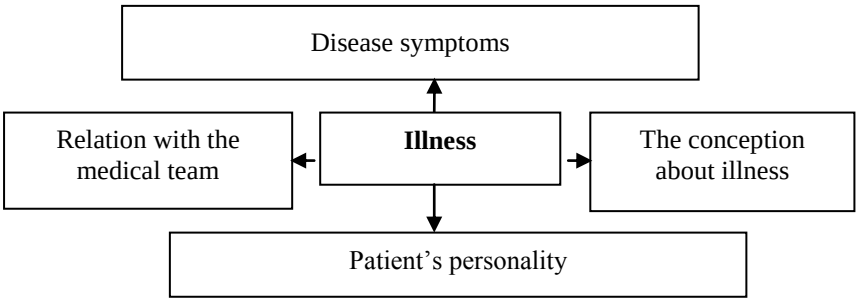
aspects of the current version, DSM-IV, which came into use in may 1994. One of the aims of this latest revision was to coordinate it with the ICD-10. This made it more useful for psychiatrists interested in international research but more difficult for clinicians to use in daily practice.

3. The pain perception. The affective states conditioned by the illness and pain.

Generally the disease implies:

– The subjective sensations of suffering.
– Physical, somatic disturbances.
– Socio-professional consequences.

The illness becomes specific by influence of some main factors as are presented below:



The sick role of a patient implies:

– Exemption of social responsibilities.
– The right to be helped.
– The obligation of the sick person to consider his sickness undesirable and to cooperate for his cure.
– The obligation of the sick person to ask for specialized help, which mean accepting the diagnosis and the treatment.

Illness behavior implies individual ability to perceive the sickness, to correctly interpret it and to take decisions to facilitate the cure, varying between normality and exaggeration, catastrophic reactions.

Maintaining factors of illness behavior:

- Personality traits (depression, hypochondria, anxiety).
- Education.
- Cultural model.
- Socio-economic status.

- Subjective reactions to disease like: inactivity, isolation, cure uncertainty, helplessness, guilty, death anxiety, etc

There are identified some types of disease perception:

– *Normal situation* - even if unwanted, mobilize the individual to fight against it and increase the adherence to the treatment.

– *Enemy* - meaning ignoring, denial of the disease or surrender in front of the disease.

– *Deserved punishment* – the sick person doesn't mobilize sufficiently;

– *Undeserved punishment* – anger, fight which mobilize all the resources.

– *Salvation* or *gain* – unconscious defensive mechanism (ex: soldiers wounded on the battle front).

– *benefice manipulation.*

– *weakness* something shameful for the sick person.

– *irreversible loss*: (ex: dental extraction).

– *special value,* help the patient to reevaluate his value system.

Additionally, patients may have specific emotional and behavioral responses like:

– Irritability or anger.

– Partial or total denial of disease.

– Depression.

– Anxiety.

– Resignation.

– Emotional and behavioral regression (egocentrism, social dependence, affects, aggression, depression, etc

– Evasion and responsibility escape.

– Informational contagious because of decreasing critical sense and anxiety.

4. The patient's attitude toward sickness

The acceptance of the disease implies acknowledging the disease and accepting the illness role. It can be:

– **realistic, rational balanced,** with a satisfactory cultural level), lead to medical consulting and treatment adherence.

– **unbalanced** (in neurotic persons, personality disorders, etc.) divided by:

– *the ignorance of the disease* (in mentally retarded persons, psychiatric, neurological patients, low cultural level, or focalized on other problems).

– *the denial of disease* which implies delay of medical consulting by hoping that it will pass by.

A basis of good resistibility of illness, in N.I. Rejnvalda's (1978) opinion, properties of an organism, nervous system, and their concrete diffraction in requirements inherent in the given person, aspirations and in activity induced by them are not in themselves. The active vital position and, accordingly, intensive counteraction of illness, as a rule, are based on the account of interests of a society. Patients, for whom appreciable social interests are characteristic, actively cooperate with the doctor during treatment.

The major precondition of successful treatment is development of conscious motivation on active overcoming of illness.

Many researchers surveyed various aspects of a problem "the person and illness ", putting forward the concepts connected to emotional – personal reaction of the patient on disease: "experience of illness". The problem "patient - illness", knowledge represents patients of the illness the big interest, however thus it is necessary to take into account influence of psychogenic factors, an emotional condition of the patient, a constant mutual induction of the patients discussing each sign and illnesses each other, possible complications, character of treatment, the forecast, etc.

Formation of an estimation of illness is influenced with contact to seriously ill patients, the data gathered from conversations with relations and familiar, with the personnel and other persons.

At the analysis of an *autoplastic picture of illness* of R. Konechnyj and M. Bouhal (1974) result the following typology of the attitude to illness:

1. *Normal*, that is corresponding to a condition of the patient or that reported to it about disease.

2. *Scornful (disrespectful)*, when the patient underestimates gravity of disease, it is not treated, concerning the forecast shows unreasonable optimism.

3. *Denying*, at which the patient " does not pay attention " to illness, drives away from itself ideas about it, does not address to the doctor.

4. Nosophobic, when the patient disproportionately is afraid of the illness, it is repeatedly surveyed, changes doctors, his fears are exaggerated, but cannot struggle with them.

5. Hypochondriac, at which the patient is convinced that suffers serious disease.

6. Nosophilic, connected with "the certain calm and pleasant feelings at illness.

The strongest positive takes of psychotherapy are reached, wrote V. I. Mjasishchev (1970) if it is possible not only to change the attitude of the patient to immediate psycho traumatic circumstances, but also his vital positions as a whole.

Questions for self-evaluation:

1. Describe each of the psychological cause of disorder's appearing.
2. What methods imply the effective stress management?
3. Describe some strategies for crisis intervention.
4. What is The International Statistical Classification of Diseases (ISD-10)?
5. Acording to what criteria in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) the disorders are clasified?
6. What implies the patient sick role?
7. Enumerate the maintaining factors of illness behavior.
8. Identify the main types of disease perception.
9. Name the main conditions for a successful treatment.
10. Describe the types of attitude toward sickness.
11. Define *the autoplastic picture of illness.*

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THE PSYCHOSOMATIC (SOMATOFORM) CONCEPT OF MEDICINE

Structure:
1. Psychosomatic medicine.
2. Psychosomatic (somatoform) disorders.
3. Psychosomatic disorders classification.

Key terms: psychosomatic medicine; psychosomatic pain; psychosomatic (somatoform) diseases; "Type A" personality; conversion reaction; somatization disorder; conversion disorder; hypochondriasis; pain disorder.

1. Psychosomatic medicine

Psychosomatic medicine is an interdisciplinary medical field studying the relationships of social, psychological, and behavioral factors on bodily processes and well-being in humans and animals. Science has demonstrated that there is an incredibly powerful link between the mind and the body. The influence that the mind has over physical processes including the manifestations of physical disabilities that are based on intellectual infirmities, rather than actual injuries or physical limitations, that are treated by phrases such as the power of suggestion, the use of "positive thinking" and concepts like "mind over matter".

The academic forbearer of the modern field of behavioral medicine and a part of the practice of consultation-liaison psychiatry, psychosomatic medicine integrates interdisciplinary evaluation and management involving diverse specialties including psychiatry, psychology, neurology, surgery, allergy, dermatology and psychoneuroimmunology. *Clinical situations where mental processes act as a major factor affecting medical outcomes are areas where psychosomatic medicine has competence.*

Psychosomatic medicine is considered a subspecialty of the fields of psychiatry and neurology. Medical treatments and psychotherapy are used to treat psychosomatic disorders.

Psychosomatic pain is the most frequently diagnosed and least understood form of both acute and chronic back pain. Significantly, most

treatment resistant chronic back pain sufferers, those with unresolved back pain, meaning that there is no clear diagnosis, by definition suffer from an underlying and misdiagnosed psychological ailment or condition. While medical schools are beginning to address this very significant medical subject, psychosomatic illness has long been relegated to the back burner of medical education. Consequently, medical practitioners are simply not prepared for or able to understand, much less treat, this condition. As a result, many individuals are misdiagnosed with this "scapegoat condition," leaving individuals with very real physiological, structural, and medical conditions undiagnosed.

Unfortunately, while solutions are available, they are still relatively unknown. As the medical community begins to educate itself, so they can be better prepared to deal with this condition, we are beginning to see the first steps towards a holistic approach to this problem. Psychosomatic medicine has been talked about for centuries, even Sigmund Freud was fascinated by it in his time, yet it is only in the last few years that we see a real movement to deal with this ongoing epidemic.

2. Psychosomatic (somatoform) disorders

Some physical diseases are believed to have a mental component derived from the stresses and strains of everyday living. This is the case, for example, of lower back pain and high blood pressure, which appear to be partly related to stresses in everyday life. Psychosomatic disorders are disorders in which mental factors play a significant role in the development, expression, or resolution of a physical illness.

Unfortunately, when an illness is labeled psychosomatic there is often an immediate stigma or negative perception associated with it.

Very often, when an individual suffering from neck pain, back pain and hears the term psychosomatic, they immediately respond defensively. When a condition is labeled as psychosomatic the connotation attached is that the condition is "all in the mind" or somehow "imaginary." There is even a mental illness stigma attached, with the patient protesting, "I am not crazy, this pain is real!" Even people close, at times members of the individual's own family, will say unkind things like, "I knew he was faking it" or "I knew she was just trying to get attention, I felt sorry for her!" For these reasons and others, the resistance to a psychosomatic diagnosis is considerable, often socially and culturally based.

It is difficult to classify some disorders as purely physical, or purely somatoform. However, while it is necessary to identify if an illness has a

physical basis, it is recognized more and more that the effort to identify disorders as purely physical or mixed psychosomatic is increasingly obsolete as almost all physical illness have mental factors that determine their onset, presentation, maintenance, susceptibility to treatment, and resolution. Addressing such factors is the remit of the applied field of behavioral medicine. In modern society, psychosomatic aspects of illness are often attributed to stress, making the remediation of stress one important factor in the development, treatment, and prevention of psychosomatic illness.

In *psychodynamic theory,* somatization is conceptualized as an *ego defense* - the unconscious rechanneling of repressed emotions into somatic symptoms. Sigmund Freud's famous case study of Anna O. featured a woman who suffered from numerous physical symptoms, which Freud believed were the result of repressed grief over her father's illness.

Psychosomatic or somatoform disorder, also known as Briquet's syndrome (named after Paul Briquet), or Brissaud–Marie syndrome (named after Édouard Brissaud and Pierre Marie), is a mental disorder characterized by physical symptoms that mimic physical disease or injury for which there is no identifiable physical cause.

The symptoms that result from a somatoform disorder are due to mental factors. *In people who have somatoform disorder, medical test results are either normal or don't explain the person's symptoms.* People who have this disorder may undergo several medical evaluations and tests to be sure that they do not have an illness related to a physical cause or central lesion. *Patients with this disorder often become very worried about their health because the doctors are unable to find a cause for their health problems.* Their symptoms are similar to the symptoms of other illnesses and may last for several years.

A diagnosis of a somatoform disorder implies that mental factors are a large contributor to the symptoms' onset, severity and duration. Somatoform disorders are not the result of conscious malingering or factious disorders.

By studying the causes of psychosomatic diseases appearing, Sigmund Freud introduced the idea that *unconscious* thoughts can be converted into physical symptoms *(conversion reaction).*

The formal study of psychosomatic illnesses began in Europe in the 1920s. The journal *Psychosomatic Medicine* had been founded in the United States. Eventually, sophisticated laboratory experiments replaced

clinical observation as the primary method of studying psychosomatic illness. Researchers in the field of psychophysiology measured such responses as blood pressure, heart rate, and skin temperature to determine the physiological effects of human behavior. Animal's researches have also contributed to the growing body of knowledge about psychosomatic disorders.

Three theories have been particularly popular in explaining why certain persons develop psychosomatic disorders and what determines the forms these illnesses take.

- One theory contends that *psychological stress* affects bodily organs that are constitutionally weak or weakened by stress.

- Another theory links specific types of illness with particular types of stress.

- The third theory suggests that physiological predispositions combined with psychological stress produce psychosomatic illness.

The parts of the body most commonly affected by psychosomatic disorders are *the gastrointestinal* and *respiratory systems*. Gastrointestinal disorders include gastric and duodenal ulcers, ulcerative colitis, and irritable bowel syndrome. (Anorexia nervosa and bulimia are sometimes considered psychosomatic disorders, but they also appear under the category of "anxiety disorder eating disorders" in *DSM-IV*). Respiratory problems caused or worsened by psychological factors include asthma and hyperventilation syndrome.

Psychosomatic disorders also affect the skin (eczema, allergies, and neurodermatitis) and genitourinary system (menstrual disorders and sexual dysfunction).

Probably the most well-known psychosomatic connection is that of stress and coronary heart disease. Cardiovascular complaints include coronary artery disease, hypertension, tachycardia (speeded-up and irregular heart rhythm), and migraine headaches. The term *"Type A"* has been used for over twenty years to describe the aggressive, competitive, impatient, controlling type of person whom researchers have found to be more prone to heart disease than people who are more easygoing and mild-mannered and less hostile and concerned with time.

People suffering from psychosomatic disorders have been helped by treatment of either their physical symptoms, the underlying psychological causes, or both. If the disorder is in an advanced stage (such as in severe asthma attacks, perforated ulcers, or debilitating colitis) sympto-

matic treatment must be undertaken initially as an emergency measure before the emotional component can be addressed.

Psychological approaches range from classic psychoanalysis, which addresses a person's early traumas and conflicts, to behavior therapy that focuses on changing learned behaviors that create or increase anxiety. Medications such as tranquilizers or antidepressants may be effective in relieving symptoms of psychosomatic disorders. Hypnosis has successfully been used to treat hyperventilation, ulcers, migraine headaches, and other complaints. Today, psychologists commonly treat psychosomatic ailments with the aid of such relaxation techniques as *progressive relaxation, autogenic training, transcendental meditation,* and *yoga***.** *Biofeedback* has been used in treating a number of different clinical problems, including tachycardia, hypertension, and both tension and migraine headaches.

3. Psychosomatic disorders classification

The American Psychiatric Association (APA) have classified somatoform disorders in the DSM-IV and the World Health Organization (WHO) have classified these in the ICD-10. Both classification systems use similar criteria. Most current practitioners will use one over the other, though in cases of borderline diagnoses, both systems may be referred to.

The somatoform disorders recognized by the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* of the American Psychiatric Association are:

– *Somatization disorder.*
– *Conversion disorder.*
– *Hypochondriasis.*
– *Pain disorder.*
– *Body dysmorphic disorder.*
– *Undifferentiated somatoform disorder - only one unexplained symptom is required for at least 6 months.*
– *Included among these disorders are false pregnancy, psychogenic urinary retention, and mass psychogenic illness (so-called mass hysteria).*
– *Somatoform disorder not otherwise specified (NOS).*

The most frevently diagnosed somatoform disorders are:

– *somatization disorder;*
– *conversion disorder;*
– *hypochondriasis* and

– pain disorder.

The clinical signs of them are proposed below.

Somatization Disorder

DSM-IV states that for a symptom to qualify for somatization disorder, it has to be without medical explanation. Some of the numerous symptoms that can occur with somatization disorder include: vomiting; abdominal pain; nausea; bloating; diarrhea; pain in the legs or arms; back pain; joint pain; pain during urination; headaches; shortness of breath; palpitations; chest pain; dizziness; amnesia; difficulty swallowing; vision changes; paralysis or muscle weakness; sexual apathy; pain during intercourse; impotence; painful menstruation and irregular menstruation; excessive menstrual bleeding, etc.

Epidemiology of Somatization Disorder. The reports of prevalence of somatization disorder depend on the assessment methods used. Community surveys have reported prevalence of less than 1% and primary care findings have usually been between 1 and 2%. The disorder is twice as common in women as in men. Diagnosis is considerably less stable over time than suggested in the original descriptions of the syndrome.

Treatment of Somatization Disorder. Somatization disorder is difficult to treat. Continuing care by one doctor using only the minimum of essential investigations can reduce the patients' use of health services and may improve their functional state.

Once other causes have been ruled out and a diagnosis of somatization disorder is secured, the goal of treatment is to help the person learn to control the symptoms. There is often an underlying mood disorder which can respond to conventional treatment, such as antidepressant medications.

Regularly scheduled appointments should be maintained to review symptoms and the person's coping mechanisms. Test results should be explained.

Psychiatric assessment can help to clarify a complicated history, to negotiate a simplified pattern of care and to agree the aims of treatment with the patient, the family and the responsible physician. The aim of treatment is often to limit further progression rather than to cure.

Conversion Disorder

Conversion disorder is a psychiatric condition in which emotional distress or unconscious conflict is expressed through physical symptoms.

Conversion disorder is a somatoform disorder that involves motor or sensory problems that would "suggest" a neurological condition. Psychological factors, however, can be shown to be associated with the onset or worsening of symptoms.

People with conversion disorder express emotional conflict or severe anxiety due to stress through physical symptoms that affect voluntary or sensory function. These may include problems with walking or moving an arm, or even blindness. This disorder generally occurs in people whose usual coping methods are overwhelmed.

According to psychodynamic theory, conversion symptoms seem to be maintained by operant conditioning. The person derives "primary gain" by keeping an internal conflict or need out of awareness. The symptom has a symbolic value that is a representation and partial solution of a deep-seated psychological conflict.

Conversion disorder is a usually mental illness condition where the person has physical symptoms and demonstrable structural or physiological changes in which emotional factors are believed to play a major etiologic role. Blindness, inability to speak, numbness (lack of sensation), paralysis - there are some symptoms of conversion disorder.

There is no one exact cause of conversion disorder, although researchers think the part of the brain that controls your muscles and senses may be involved.

For the treating conversion disorder patient take psychotherapy and stress management training may help reduce symptoms.

Alternative treatment for the affected body part or physical function will require physical or occupational therapy until the symptoms disappear such as, paralyzed limbs must be exercised to prevent muscle wasting.

In case of conversion disorder people have some complication like person delay seeking treatment; their symptoms aren't clearly linked to stress and come on slowly, or don't improve quickly, more-serious psychiatric conditions along with conversion disorder.

Diagnostic criteria for conversion disorder as defined in the DSM-IV are as follows:

- One or more symptoms or deficits are present that affect voluntary motor or sensory function that suggest a neurologic or other general medical condition.

- Psychological factors are judged to be associated with the symptom or deficit because conflicts or other stressors precede the initiation or exacerbation of the symptom or deficit.

- The symptom or deficit causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or warrants (demands) medical evaluation.

The symptoms of conversion disorder involve the loss of one or more bodily functions. These may include blindness, paralysis or the inability to speak. The loss of physical function is involuntary and diagnostic testing does not show a physical cause for the dysfunction.

Generally, in the treatment of conversion disorder the psychiatric treatment is recommended to help the person understand the underlying psychological conflict. The integrity of the affected body part or function must be maintained until the conflict is resolved and the symptoms usually disappear.

Hypochondriasis disorder

The term hypochondriasis is now defined by DSM-IV and ICD-10 in terms of disease conviction and disease phobia. DSM-IV describes the condition as a "preoccupation with a fear or believe of having a serious disease based on the individual interpretation of physical signs of sensations as evidence of physical illness. Appropriate physical evaluation does not support the diagnosis of any physical disorder than can account for the physical signs or sensations or for the individual's unrealistic interpretation of them. The fear of having, or belief that one has a disease, persists despite medical reassurance."

Hypochondriasis is characterized by severe anxiety over the possibility of having a disease. A person interprets physical symptoms and sensations as signs of a serious medical illness despite medical reassurance that they are not. Hypochondriasis and the other somatoform disorders are among the most difficult and most complex psychiatric disorders to treat in the medical setting.

The term hypochondria is from the Greek - literally 'below the cartilage', referring to the lower ribs and the underlying spleen and liver. Its application to mental states comes from the theory of humours, relating moods to the liver and spleen. In hypochondriasis, this preoccupation lasts at least 6 months and persists despite appropriate medical evaluation and reassurance.

The diagnosis is suggested by the history and examination and confirmed when symptoms persist for more than 6 months and cannot be attributed to depression or another psychiatric disorder.

A person with hypochondriasis may be especially concerned about a particular organ system (such as the cardiac or digestive system). A doctor's reassurance and even a complete medical evaluation often will not calm the person's fears. Or, if it does calm them, other worries may emerge days later.

It generally begins in late childhood and ratio is same for both the sex and worry or fear lasts for at least six months.

Hypochondriasis may result in depression, stress, impairment from social activity, problem in daily life or nervousness. Patients are not lying about their symptoms but they consider that they are sick. Even after medical examination they don't accept it.

Although the exact cause of this problem is unknown, stressful life situations may overwhelm a person and contribute to the development of generalized anxiety. A history of excessive worry may also be a predisposing factor in its development.

Hypochondriasis Treatment A supportive relationship with a health care provider is the mainstay of treatment. There should be one primary provider to avoid unnecessary diagnostic tests and procedures.

Supportive care, psychotherapy, medicines are used in combination to cure this disease. Treatment with serotonin reuptake inhibitors, a class of antidepressants, may be effective.

Psychotherapy usually does not work well in treating hypochondriasis. Cognitive-behavior therapy may also relieve symptoms. Most people with the disorder are not eager to see a mental health professsional. However, a savvy therapist can help the person to cope with symptoms rather than curing them. Doctors and therapists should take the physical symptoms seriously, because the symptoms are real.

The health care provider should inform the person that no organic disease is present, but that continued medical follow-up will help control the symptoms. The person with hypochondria feels real distress, so the symptoms should not be denied or challenged by others.

If the person has anxiety or depression that responds to treatment with medication, the prognosis can be quite good. Otherwise, a person with hypochondriasis may be susceptible to chronic distress and functional impairment.

Pain disorder

A disorder, in which pain in one or more anatomic sites is exclusively or predominantly caused by psychological factors, is the main focus of the patient's attention, and results in significant distress and dysfunction.

Pain in one or more anatomical sites is the predominant focus of the clinical presentation and is of sufficient severity to warrant clinical attention. Psychological factors are judged to have an important role in the onset, severity, exacerbation, or maintenance of the pain.

Pain may show adverse effect in relationship, social, academic, occupational, recreational abilities or other areas of functioning.

Distress, depression, anxiety and drug abuse is occurring as a result of pain disorder. It is more common in women and may occur at any age. Pain is not false and also it is not intentionally produced.

Pain associated with psychological factors is common in many psychiatric conditions, especially mood and anxiety disorders, but in pain disorder, pain is the predominant complaint. Any part of the body may be affected, but the back, head, abdomen, and chest are probably the most common.

The pain causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

The primary symptom of pain disorder is chronic pain for several months that limits a person's social, occupational, or recreational abilities.

Pain disorder may develop due to a conversion mechanism and some patients may have what is called a "pain-prone personality" they have long-standing feelings of guilt and worthlessness about themselves, and they chronically feel that they are in need of punishment or atonement, pain gives them this.

Unfortunately, pain that is "psychological" in nature is often stigmatized both by medical professionals and the general public. A poor understanding of the connections between mind and body can lead to the misperception that if pain has a psychological cause it isn't "real" and should be able to be controlled without medical or mental health treatment.

The treatment of pain disorder associated with a psychiatric disorder is the treatment of the primary condition. Skill is required to maintain a working relationship with patients unwilling to accept a psychological basis for their pain. Any associated physical disorder should be treated and adequate analgesics provided. The management of chronic pain should be individually planned, comprehensive, and

involve the patient's family. Behavioral treatments are useful. However, many patients with chronic pain lack the motivation needed to make full use of these methods. In some cases such treatment aims to reduce social reinforcement of maladaptive behavior, and to encourage the patient to seek ways to overcome disability.

Pharmacological and behavioral therapies may be combined for some patients. Multidisciplinary pain clinics provide expertise in and resources for arrange of treatments. Although many patients are unwilling to accept such treatment and others are considered unsuitable, the evidence is that they are cost-effective for participants.

Antidepressants, drug therapy, psychotherapy, supportive measures such as hot and cold packs, physical therapy, distraction techniques, and pharmacotherapy are used to overcome pain disorder.

Questions for self-evaluation:

1. Enumerate the main symptoms of psychosomatic (somatoform) diseases.
2. Explain why psychosomatic medicine is an interdisciplinary medical field.
3. The psychosomatic diseases classification.
4. Explain the conversion symptoms according to psychodynamic theory.
5. Diagnostic criteria for conversion disorder.
6. Describe the symptoms of hypochondriasis disorder.
7. What measures imply the hypochondriasis treatment?
8. Describe the causes and the symptoms of somatoform pain disorder.
9. What measures imply the treatment of pain disorder?

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THE DOCTOR – PATIENT RELATIONSHIP

Structure:

1. The doctor-patient relationship. Models of the doctor-patient relationship.
2. Medical consultation.
3. Strategies for therapeutic act optimization.
4. Iatrogenesis in medical practice.

Key terms: doctor-patient relationship; doctor-centered consultation; patient-centered consultation; functions of the medical consultation; strategies for therapeutic act optimization; iatrogenesis; incidence of iatrogenesis;

1. The doctor-patient relationship. Models of the doctor-patient relationship.

The doctor-patient relationship is the frame in which the medical practice takes place. As any dual correlation, the relation D-P has as well as two participants: the doctor and the patient. The patient needs qualified help and consultation. The doctor who possesses special study - gives this help.

By Piaget, this relation is developed in three main aspects:

– intellectual (informational);
– emotional;
– moral.

Both, the doctor and the patient posses a special status (a sum of rights and responsibilities).

The social status is realized throughout the social role which implies any special behavioral complex shown (manifested) by somebody to others.

A major determinant of the nature of the doctor–patient relationship and the extent and forms of communication within the consultation is the doctor's clinical practice style. Two polar types of consultation style

have been identified, based on video-recordings of consultations; these have been designated *'doctor-centered'* and *'patient-centered'.*

A doctor-centered consultation is characterized by the traditional Parsonian model and paternalistic approach, based on the assumption that the doctor is the expert and the patient merely required to cooperate. Doctors adopting this approach focus on the physical aspects of the patients' disease and employ tightly controlled interviewing methods to elicit the necessary medical information. Questions were thus mainly of a 'closed' nature, such as 'how long have you had the pain?' and 'is it sharp or dull? These questions aim to provide information to enable the doctor to interpret the patient's illness within his or her own biomedical disease framework, while providing little opportunity for patients to express their own beliefs and concerns.

At the other end of the continuum are doctors whose consultation style conforms to a *'patient-centered' approach.* These doctors adopt a much less controlling style and encourage and facilitate their patients to participate in the consultation, thus fostering a relationship of 'mutuality'. An important feature of this approach is the greater use of "open questions", such as 'tell me about the pain', how you feel?' and 'what do you think is the cause of the problem? This approach also requires that doctors spend more time actively listening to patients' problems through picking up and responding to patient cues, encouraging patients to express their own ideas or feelings, clarifying and interpreting patients' statements, and generally using a more participative style with the various options presented and discussed with patients.

Studies show that individual doctors can be classified fairly consistently as holding either doctor-centered or patient-centered consultations. This suggests that doctors develop a particular consulting style and do not vary this significantly in relation to the patient's problems. However, doctors classified as having a patient-centered style tend to be the most flexible, showing the greatest ability to respond to differences in patients' needs or the circumstances of the consultation.

Types of errors most frequently encountered during the establishment and development of doctor-patient relationship:

– Inappropriate attitude features of the doctor: rush, impatience, fatigue, boredom, raised voice.
– Acceptance of insufficient communication with the patient.
– Excess of or lack of authority with the patient.

– Engaging in conflict situations.

– Underestimating difficult patients, with increased psychogenic tendencies.

– Polimedication as an expression of the doctor's submission to patient's insistence.

Role conflicts in the doctor/patient relationship:

– Psychological resistance of some patients to the doctor's authority.

– Affective ambivalence of the patient.

– Refusal or inability to communicate of certain patients.

Deficiencies in doctor-patient communication:

– Failure to appropriately greet the patient, introducing oneself and explaining one's actions.

– Failure to get easily accessible information, mainly due to fears and expectations.

– Accepting imprecise information, failure in seeking clarifications.

– Failure to verify with the patient what the doctor understood from the situation.

– Failure to elicit questions or to appropriately answer to questions

– Neglecting obvious clues or clues not provided verbally or in a different manner by the patient.

– Avoiding information concerning the patient's personal, family, social status, including problems in these areas.

– Failure to elicit information about the patient's feelings and the perception of the illness.

– Directive style with closed questions, frequent interruption and failure to make the patient speak freely.

– Rushed focusing without testing theories.

– Failure to provide appropriate information concerning the diagnosis, treatment, side effects or prognosis, or in verifying the patient's understanding of these issues.

– Failure to understand the patient's viewpoint.

– Poor comforting.

The *goal* of any patient-doctor relationship should be one of mutual respect and collaboration, working together to achieve your best possible medical outcomes. Most of the time that is exactly what happens. But sometimes the relationship goes away, and that may require repairing the patient-doctor relationship.

Sometimes the problems are the doctor's fault. From the first meeting, he may have been abrupt, or arrogant, or he simply has a lousy bedside manner. If that's the case, there is nothing to be repaired. It's just the doctor's personality.

However, sometimes the problem is caused by the patient herself. She may have had a good relationship with her doctor for a period of time, but something happened to make her doctor subsequently balk at providing additional care. In that case, she may choose to try to repair her relationship with her doctor.

If this is your circumstance, you'll need to assess whether the problem was caused by you or your doctor. If you caused it, then the steps below will help you work to repair the relationship. If not, if you feel the deteriorated relationship is your doctor's fault, then you'll need to decide whether it's worth repairing, or more to the point, possible to repair.

2. Medical consultation

The success of any consultation depends on how well the patient and doctor communicate with each other. There is now firm evidence linking the quality of this communication to clinical outcomes.

The dual focus. Patients are not exclusively physically ill or exclusively emotionally distressed. Often they are both. At the start of a consultation it is usually not possible to distinguish between these states. It is the doctor’s task to listen actively to the patient’s story, seeking and noticing evidence for both physical illness and emotional distress.

*Involving patients.*Changes in society and health care in the past decade have resulted in real changes in what people expect from their doctors and in how doctors view patients. In addition, greater emphasis has been placed on the reduction of risk factors, with attempts to persuade people to take preventive action and avoid risks to health. Many patients want more information than they are given. They also want to take some part in deciding about their treatment in the light of its chances of success and any side effects. Some patients, of course, do not wish to participate in decision making; they would prefer their doctor to decide on a single course of action and to advise them accordingly. The skill lies in achieving the correct balance for each patient.

A comprehensive model. The “three function” model for the medical encounter provides a template for the parallel functions of the clinical interview. This is now widely used in medical schools.

Starting the interview

Research has shown the importance of listening to patients' opening statements without interruption. Doctors often ask about the first issue mentioned by their patients, yet this may not be what is concerning them most. Once a doctor has interrupted, patients rarely introduce new issues. If uninterrupted, most patients stop talking within 60 seconds, often well before. The doctor can then ask if a patient has any further concerns, summarize what the patient has just said.

Detecting and responding to emotional issues

Even when their problems are psychological or social, patients usually present with physical symptoms. They are also likely to give verbal or non-verbal cues. Verbal cues are words or phrases that hint at psychological or social problems. Non-verbal cues include changes in posture, eye contact, and tone of voice that reflect emotional distress.

It is important to notice and respond to cues at the time they are offered by patients. Failure to do so may inhibit patients from further disclosures and limit the consultation to discussion of physical symptoms. Conversely, physical symptoms must be taken seriously and adequately evaluated. Several of the skills of active listening are valuable in discussing physical, psychological, and social issues with patients. These skills have been clearly shown to be linked to recognition of emotional problems when used by general practitioners.

Three functions of the medical consultation

1 Build the relationship

– Greet the patient warmly and by name.
– Detect and respond to emotional issues.
– Active listening.

2 Collect data

– Do not interrupt patient.
– Elicit patient's explanatory model.
– Consider other factors.
– Develop shared understanding.

3 Agree a management plan

– Provide information.
– Appropriate use of reassurance.
– Negotiate a management plan.
– Make links.
– Negotiate behaviour change.

– Responding to patients' "cues".

Exemples of verbal cues:

– State your observation—"You say that recently you have been feeling fed-up and irritable".
– Repeat the patient's own words—"Not well since your mother died"
– Seek clarification—"What do you mean when you say you always feel tired?"

Non-verbal cues

– Comment on your observation—"I can hear tears in your voice"
– Ask a question—"I wonder if that upsets you more than you like to admit?"

Traditionally, the management of newly presenting patients has two stages: *assessment* and then *treatment.* However, this two stage approach has limitations. When underlying disease pathology is diagnosed there may be delays in starting effective treatment. If no disease is found reassurance is often ineffective. In both cases many patients are left feeling uncertain and dissatisfied. Lack of immediate information and agreed plans may mean that patients and their families become anxious and draw inappropriate conclusions, and an opportunity to engage them fully in their management is missed. If simple diagnosis is supplemented with fuller explanation, patient satisfaction and outcomes are improved. This can be achieved by integrating assessment and treatment.

The aim of an integrated consultation is that the patient leaves with a clear understanding of the likely diagnosis, feeling that concerns have been addressed, and knowledge of the treatment and prognosis (that is, the assessment becomes part of the treatment).

Somatic symptoms are subjective and have two components, a somatic element (a bodily sensation due to physiology or pathology) and a psychological element (related to thoughts and beliefs about the symptoms). Traditional management focuses only on the somatic component, with the aim of detecting and treating underlying pathology. Addressing the psychological component in the consultation as well, with simple psychological interventions, is likely to reduce distress and disability and reduce the need for subsequent specialist treatment.

Seeing the same doctor on each visit increases patient satisfaction. Continuity may also improve medical outcomes, including distress, compliance, preventive care, and resource use. Problems resulting from

lack of continuity can be minimized by effective communication between doctors.

3. Strategies for therapeutic act optimization

Simple techniques can be used to improve doctor-patient communication. *The first stage* is building a relationship in which a patient gives his or her history and feels understood. *The second stage* is for the doctor to share his or her understanding of the illness with the patient. In cases that are more complicated it may be most effective to add an additional brief session with a practice or clinic nurse.

Patients require information about the likely cause of their illness, details of any test results and their meaning, and a discussion of possible treatments. Even when this information has been given in a consultation, however, many patients do not understand or remember what they are told. Hence, the provision of simple written information can be a time efficient way of improving patient outcomes.

One way of providing written information is to copy correspondence such as referral and assessment letters to the patient concerned. For those not used to doing this, it may seem a challenge, but any changes needed to make the letters understandable (and acceptable) to patients are arguably desirable in any case. Letters should be clearly structured, medical jargon minimized, pejorative terms omitted and common words that may be misinterpreted (such as "chronic") explained.

Well written patient information materials (leaflets and books) are available, as are guidelines for their development.

Worry about health (health anxiety) is a common cause of distress and disability in those with and without serious disease. **Reassurance** is therefore a key component of starting treatment. The first step is to elicit and acknowledge patients' expectations, concerns, and illness beliefs. This is followed by history taking, examination, and if necessary investigation. The psychological factors of beliefs and attitudes about illness and treatment are major determinants of outcome. Hence, strategies that increase understanding, sense of control, and participation in treatment can have large benefits. One example is written management plans agreed between doctor and patient. This approach is the basis of the Department of Health's "Expert Patient Programme," which aims to help patients to "act as experts in managing their own condition, with appropriate support from health and social care services."

Mismatch of expectations and experiences

What patients want	What some patients get
To know the cause.	No diagnosis.
Explanation and information	Poor explanation that does not address their needs and concerns.
Advice and treatment.	Inadequate advice.
Reassurance.	Lack of reassurance.
To be taken seriously by a sympathetic and competent doctor.	Feeling that doctor is uninterested.

Premature reassurance (such as "I'm sure its nothing much") may be construed as the doctor not taking the problem seriously. Finally, the explanation should address all of a patient's concerns and is best based on the patient's understanding of how his or her body functions, which may differ from the doctor's.

– Read referral letter or notes, or both, before seeing patient.

– Encourage patients to discuss their presenting concerns without interruption or premature closure.

– Explore patients' presenting complaints, concerns, and understanding (beliefs).

– Inquire about disability.

– Inquire about self care activities.

– Show support and empathy.

– Use silence appropriately.

– Use non-verbal communication such as eye contact and nods.

Showing your understanding of patients' concerns

– Relay key messages such as, "The symptoms are real," "We will look after you," and "You're not alone".

– Take patients seriously and make sure they know it.

– Don't dismiss presenting complaints, whether or not relevant pathology is found.

– Explain your understanding of the problem, what it is, what it isn't, treatment, and the future.

– Consider offering a positive explanation in the absence of relevant physical pathology.

– Reassure.

– Avoid mixed messages.

– Encourage and answer questions.

– Share decisions.

– Communicate the management plan effectively, both verbally and in writing.

– Provide self care information, including advice on lifestyle change.

– Explain how to get routine or emergency follow up, and what to look out for that would change the management plan.

Providing information

– Invite and answer questions.

– Use lay terms, and build on patient understands of illness wherever possible.

– Avoid medical jargon and terms with multiple meanings.

– Involve relatives.

– Provide written material when available.

– Provide a written management plan when appropriate.

General reassurance

– To know it will be OK.

– To know I will be looked after.

– To know there are others like me.

Reassurance about cause

– To know what it is.

– To know what it is not.

– To know it's not serious.

– "There are several possible causes, not just cancer".

– "It's not cancer".

– "It will get better".

Reassurance about cure

– To know it can be treated.

– To know it will be treated.

– To know how it will be treated.

– To know the complaint will go away.

Being positive

Doctors themselves are potentially powerful therapeutic agents. There is evidence that being deliberately positive in a consultation may increase this effect.

Using tests as treatment

Tests should ideally be informative and reassuring for both doctors and patients. However, there is increasing evidence that tests may not reassure some patients and may even increase their anxiety. This is most

likely with patients who are already anxious about their health. When weighing the pros and cons of ordering a test, doctors should take account of the potential psychological impact on their patient (both positive and negative).

Providing explanations after negative investigation

Even when tests are reported as normal, some patients are not reassured. Such patients may benefit from an explanation of what is wrong with them, not just what is not wrong. A cognitive behavioral model can be used to explain how interactions between physiology, thoughts, and emotion can cause symptoms without pathology. Simple headache provides an analogy: the pain is real, and often distressing and disabling, but is usually associated with "stress." Diagnoses such as "tension headache" and "irritable bowel syndrome" can be helpful in reducing patients' anxiety about sinister causes for their symptoms.

Planning for the future

Sometimes patients unnecessarily avoid or reduce their activities for fear it will make their illness worse. This coping strategy magnifies disability. Planning a graded return towards normal activities is one of the most effective ways of helping such patients. A plan should specify clearly what activity, for how long, when, with whom, and how often. It is best if the plan is written down and reviewed regularly. A collaborative approach increases the chances of success.

Aspects of interview style that aid assessment of patients' emotional problems

- Make good eye contact.
- Clarify presenting complaint.
- Use directive questions for physical complaints.
- Begin with open ended questions, moving to closed questions later.
- Make empathic comments.
- Pick up verbal cues.
- Pick up non-verbal cues.
- Do not read notes while taking patient's history.
- Deal with over-talkativeness.
- Ask more questions about the history of the emotional problem.

Eliciting a patient's explanatory model

When people consult a doctor, they do so with explanatory ideas about their problems and with anxieties and concerns that reflect these ideas. They are also likely to have hopes an expectations concerning the

care that they will receive. It is important not to make assumptions about patients' health, beliefs, concerns, and expectations but to elicit these as a basis for providing information and negotiating a management plan. People's health beliefs and behaviours develop and are sustained within families, and families are deeply affected by the illness of a family member. "Thinking family" can help to avoid difficult and frustrating interactions with family members.

Providing information

Doctors should consider three key questions when providing information to a patient:

– What does the patient already know?
– What does the patient want to know?
– What does the patient need to know?

The first question emphasizes the importance of building on the patient's existing explanatory model, adding to what he or she already knows, and correcting inaccuracies. The second and third reflect the need to address two agendas, the patient's and the doctor's. In addition, it is important for the doctor to show ongoing concern and emotional support, making empathic comments, legitimizing the patient's concerns, and offering support.

Negotiating a management plan

The ideal management plan is one that reflects current best evidence on treatment, is tailored to the situation and preferences of the patient, and addresses emotional and social issues. Both patient and doctor should be involved in developing the plan, although one or the other may have the greater input depending on the nature of the problem and the inclinations of the patient.

Appropriate use of reassurance

Reassurance (encouragement) is effective only when doctors understand exactly what it is that their patients fear and when they address these fears truthfully and accurately. Often it is not possible to reassure patients about the diagnosis or outcome of disease, but it is always possible to provide support and to show personal concern for them. Reassurance is an essential skill of bedside medicine (Hippocrates (469-399 bc), the "father of bedside medicine").

Dealing with difficult emotions: denial, anger, and fear

Denial. When patients deny the seriousness of their illness you should never be tempted to force them into facing it. The decision on

how to address denial must be based on how adaptive the denial is, what kind of support is available to the patient, and how well prepared the patient is to deal with the fears that underlie the denial.

When interviewing an individual

– Ask how family members view the problem.
– Ask about impact of the problem on family function.
– Discuss implications of management plan for the family.

When a family member comes in with patient

– Acknowledge relative's presence.
– Check that patient is comfortable with relative's presence.
– Clarify reasons for relative coming.
– Ask for relative's observations and opinions of the problem.
– Solicit relative's help in treatment if appropriate.
– If patient is an adolescent accompanied by an adult always spend part of consultation without the adult present.
– Never take sides.

Ascertain expectations

– What does patient know?
– What does patient want? - Investigation? Management? Outcomes?

Advice on options

– Elicit patient's preferences.

Develop a plan

– Involve patient.
– Tailor preferred option to patient's needs and situation.
– "Think family".

Check understanding

– Ensure that patient is clear about plan.
– Consider a written summary.
– Questions that cannot be answered in one word require patient to expand.

Move towards closed questions at the end of a section of the consultation.

Repeat back to patient to ensure that you have understood.

Encourage patient both verbally ("Go on") and non-verbally (nodding).

Legitimizing patient's feelings. "This is clearly worrying you a great deal," followed by, "You have an awful lot to cope with," or, "I think most people would feel the same way".

Surveying the field. Repeated signals that further details are wanted:

Empathic comments. "This is clearly worrying you a great deal".

Offering support. "I am worried about you, and I want to know how I can help you best with this problem".

Negotiating priorities. If there are several problems draw up a list and negotiate which to deal with first.

Summarizing. Check what was reported and use as a link to next part of interview. This helps to develop a shared understanding of the problems and to control flow of interview if there is too much information being defensive. Acknowledge the feelings that are expressed and ask about the reasons for these. Take concerns seriously and indicate that you will take appropriate action.

Making the link between emotions and physical symptoms

Particular strategies may be needed to help people who present with physical symptoms of psychological distress but who have not made the link between these and their emotional and life problems. However, it is essential that you do not go faster than the patient and try to force the patient to accept your explanation.

Ensuring that the patient feels understood is essential. It is crucial to get the patient on your side and show that you are taking his or her problems seriously. Start from the patient's viewpoint and find out what the patient thinks may be causing the symptoms, while at the same time picking up any verbal and non-verbal cues of emotional distress.

Broadening the agenda can begin when all the information has been gathered. The aim is to broaden the agenda from one where the problem is seen essentially as physical to one where both physical and psychological problems can be acknowledged. Acknowledging the reality of the patient's pain or other symptoms is essential and must be done sensitively. Summarize by reminding the patient of all the symptoms, both physical and emotional, that you have elicited and link them to life events if this is possible.

Negotiating explanations can involve various techniques. Only one or two will be appropriate for each patient, and different techniques may be useful at different times. Simple explanation is the commonest, but it is insufficient to say "Anxiety causes headaches." A three stage explanation is required in which anxiety is linked to muscle tension, which then causes pain. A similar approach can be used to explain how depression

causes lowering of the pain threshold, which results in pain being felt more severely than it otherwise would be.

Once the patient and doctor have agreed that psychological distress is an important factor in the patient's illness, they can start to examine management options to address this. Even if the patient has significant physical disease, it is important to detect and manage psychological comorbidity.

There are some strategies to help patients to change their behaviour.

Explore motivation for change

– Build rapport and be neutral.
– Help draw up list of problems and priorities.
– Is problem behaviour on patient's agenda?
– If not, raise it sensitively.
– Does patient consider the behaviour to be a problem?
– Do others?

Clarify patient's view of the problem

– Help draw up a balance sheet of pros and cons.
– Empathize with difficulty of changing.
– Reinforce statements that express a desire to change.
– Resist saying why you think patient ought to change.
– Summarize frequently.
– Discuss statements that are contradictory.

Promote resolution

If no change is wanted negotiate if, when, and how to review

– Enable informed decision making.
– Give basic information about safety or risks of behaviour.
– Provide results of any examination or test.
– Highlight potential medical, legal, or social consequences.
– Explain likely outcome of potential choices or interventions.
– Get feedback from patient.
– Give patient responsibility for decision.

4. Iatrogenesis in medical practice

The terms iatrogenesis and iatrogenic artifact refer to inadvertent adverse effects or complications caused by or resulting from medical treatment or advice. In addition to harmful consequences of actions by physicians, iatrogenesis can also refer to actions by other healthcare pro-

fessionals, such as psychologists, therapists, pharmacists, nurses, dentists, and others. Iatrogenesis is not restricted to conventional medicine: it can also result from complementary and alternative medicine treatments.

Some iatrogenic artifacts are clearly defined and easily recognized, such as a complication following a surgical procedure. Some less obvious ones can require significant investigation to identify, such as complex drug interactions. Furthermore, some conditions have been described for which it is unknown, unproven or even controversial whether they are iatrogenic or not; this has been encountered particularly with regard to various psychological and chronic-pain conditions. Research in these areas continues.

Causes of iatrogenesis include chance, medical error, negligence, social control and the adverse effects or interactions of prescription drugs. In the United States, an estimated 44,000 to 98,000 deaths per year may be attributed in some part to iatrogenesis.

Etymologically, the term "iatrogenesis" means "brought forth by a healer" (iatros means healer in Greek); as such, in its earlier forms, it could refer to good or bad effects. Literally meaning "physician-induced," the term **iatrogenic** describes diseases inadvertently resulting from medical treatments or procedures.

Since at least the time of Hippocrates, people have recognized the potential damaging effects of a healer's actions. The old mandate "first do no harm" (primum non nocere) is an important clause of medical ethics, and iatrogenic illness or death caused purposefully, or by avoidable error or negligence on the healer's part became a punishable offense in many civilizations.

With the development of scientific medicine in the 20th century, it could be expected that iatrogenic illness or death would be more easily avoided. Antiseptics, anesthesia, antibiotics, and better surgical techniques have been developed to decrease iatrogenic mortality.

Examples of iatrogenesis imply: risk associated with medical interventions adverse effects of prescription drugs over-use of drugs, (causing - for example - antibiotic resistance in bacteria) prescription drug interaction, medical error, wrong prescription, perhaps due to illegible handwriting, typos on computer, negligence, faulty procedures, techniques, information, methods, or equipment.

An iatrogenesis can be caused by:

– Absence of confidential contact.

– Misses in speech of the doctor, it is especial at the first occurring.

– The unreasonable use of medical terminology.

Iatrogenic conditions do not necessarily result from medical errors, such as mistakes made in surgery, or the prescription or dispensing of the wrong therapy, such as a drug. In fact, intrinsic and sometimes adverse effects of a medical treatment are iatrogenic. For example, radiation therapy and chemotherapy, due to the needed aggressiveness of the therapeutic agents, frequently produce iatrogenic effects such as hair loss, anemia, vomiting, nausea, brain damage, lymphedema, infertility, etc. The loss of functions resulting from the required removal of a diseased organ also counts as iatrogenesis, thus we find (for example) iatrogenic diabetes brought on by removal of all or part of the pancreas.

Other situations may involve actual negligence or faulty procedures, such as when pharmacotherapists produce handwritten prescriptions for drugs.

A very common iatrogenic effect is caused by drug interaction, i.e., when pharmacotherapists fail to check for all medications a patient is taking and prescribe new ones which interact agonistically or antagonistically (potentiate or decrease the intended therapeutic effect). Such situations can cause significant morbidity and mortality. Adverse reactions, such as allergic reactions to drugs, even when unexpected by pharmacotherapists, are also classified as iatrogenic.

The evolution of antibiotic resistance in bacteria is iatrogenic as well. Bacteria strains resistant to antibiotics have evolved in response to the over prescription of antibiotic drugs. Certain drugs are toxic in their own right in therapeutic doses because of their mechanism of action.

In psychology, iatrogenesis can occur due to misdiagnosis. Conditions hypothesized as partially or completely iatrogenic include bipolar disorder, dissociative identity disorder, fibromyalgia, somatoform disorder, chronic fatigue syndrome, posttraumatic stress disorder, substance abuse ,etc.. The degree of association of any particular condition with iatrogenesis is unclear and in some cases controversial. The over-diagnosis of psychological conditions (with the assignment of mental illness terminology) may relate primarily to clinician dependence on subjective criteria. The assignment of pathological nomenclature is rarely a benign process and can easily rise to the level of emotional iatrogenesis, espe-

cially when no alternatives outside of the diagnostic naming process have been considered.

Incidence and importance. Iatrogenesis is a major phenomenon, and a severe risk to patients. A study carried out in 1981 more than one-third of illnesses of patients in a university hospital were iatrogenic, nearly one in ten were considered major, and in 2% of the patients, the iatrogenic disorder ended in death. Complications were most strongly associated with exposure to drugs and medications. In another study, the main factors leading to problems were inadequate patient evaluation, lack of monitoring and follow-up, and failure to perform necessary tests.

In the United States, figures suggest estimated deaths per year of:

- 12,000 due to unnecessary surgery;
- 7,000 due to medication errors in hospitals;
- 20,000 due to other errors in hospitals;
- 80,000 due to infections in hospitals;
- 106,000 due to non-error, negative effects of drugs.

The iatrogenesis is not short-term reaction of the patient to the wrong statement or action of the doctor, and the fixed neurotic frustration having usually true reasons in the person of the patient and character of their attitudes with the doctor. It represents some kind of the negative placebo - effect connected to certain expectations, fears and installations of the patient concerning illness, the doctor and treatments.

With more effective and powerful treatments have come side effects that may be more common and harmful. There are efforts by medical specialists and consumers to quantify and reduce iatrogenic side effects. These efforts are hampered by the natural reluctance of physicians (and other providers) to have their errors publicized and the prospect of malpractice lawsuits. Physicians rarely report iatrogenic events, even though most claim to have witnessed them. Efforts to make reporting mandatory are resisted by the medical profession; therefore, lack of such reporting makes it more difficult to identify and minimize hazards.

Despite these obstacles, the hazards of medicine are emerging in an increasing number of studies and reports. In USA, a 2000 presidential report described iatrogenic error and illness as "a national problem of epidemic proportions," causing tens of thousands of annual deaths. The report estimated the cost of lost income, disability, and health care costs

to be $29 billion a year. The report concluded that half of adverse medical events were preventable.

The Centers for Disease Control and Prevention (CDC) estimate that each year nearly 2 million people acquire infections while hospitalized and about 90,000 die from those infections. More than 70 percent of hospital-acquired bacterial infections have become resistant to at least one of the drugs commonly used to treat them. Staphylococcus aureus (staph), the leading cause of hospital-acquired infections, is resistant to 95 percent of first-choice antibiotics, and about 30 percent of second-choice antibiotics.

The CDC proposes several methods of reducing hospital-acquired infections. The most important include: *more discriminating antibiotic use* and *improved hygiene of hospital staff*, the main source of infections.

Questions for self-evaluation:

1. Define the notion of doctor-patient relationship.
2. Explain the cause of major deficiencies in doctor-patient communication.
3. Types of errors encountered in the doctor-patient relationship.
4. Define the medical consultation.
5. Explain the two polar types of consultation style.
6. Describe strategies for therapeutic act optimization.
7. Three functions of the medical consultation.
8. Relate about mismatch of patient's expectations and doctor's experiences.
9. What questions doctors should consider when providing information to a patient?
10. The oportunity of making the link between emotions and physical symptoms.
11. Enumerate strategies to help patients to change their behaviour.
12. Define the iatrogenesis in context of medical practice.
13. Enumerate causes of iatrogenesis.
14. Describe the incidence and side effects of iatrogenesis.
15. Describe some methods of reducing hospital iatrogenesis.

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THE PERSONALITY AS A PSYCHOLOGICAL CONCEPT RELATED TO MEDICINE

Structure:

1. Personality. Theories of Personality.
2. Aspects of personality.
3. Personality development.
4. Personality disorders.

Key terms: personality; temperament; caracter; aptitudes; personality disorders; melancholic; choleric; phlegmatic; sanguine; antisocial personality disorder**;** psychopath and sociopath.

1. Personality. Theories of Personality

The personality is the unique pattern of enduring psychological and behavioral characteristics by which each person can be distinguished from other people. Personality is fundamental to the study of psychology. The major systems evolved by psychiatrists and psychologists since Sigmund Freud to explain human mental and behavioral processes can be considered theories of personality. These theories generally provide ways of describing personal characteristics and behavior, establish an overall framework for organizing a wide range of information, and address such issues as individual differences, personality development from birth through adulthood, and the causes, nature, and treatment of psychological disorders.

Perhaps *the earliest known theory of personality* is that of the Greek physician Hippocrates (c. 400 B.C.), who characterized human behavior in terms of four temperaments, each associated with a different bodily fluid, or "humor." The sanguine, or optimistic, type was associated with blood; the phlegmatic type (slow and lethargic) with phlegm; the melancholic type (sad, depressed) with black bile; and the choleric (angry) type with yellow bile. Individual personality was determined by the amount of each of the four humors. Hippocrates'

system remained influential in Western Europe throughout the medieval and Renaissance periods. Abundant references to the four humors can be found in the plays of Shakespeare, and the terms with which Hippocrates labeled the four personality types are still in common use today. The theory of temperaments is among a variety of systems that deal with human personality by dividing it into types. A widely popularized (but scientifically dubious) modern typology of personality was developed in the 1940s by William Sheldon, an American psychologist. Sheldon classified personality into three categories based on body types: *the endomorph (heavy and easy-going), mesomorph (muscular and aggressive), and ectomorph (thin and intellectual or artistic).*

A major weakness of Sheldon's morphological classification system and other type theories in general is the element of oversimplification inherent in placing individuals into a single category, which ignores the fact that every personality represents a unique combination of qualities.

Well-known trait theorist Gordon Allport (1897-1967) extensively investigated the ways in which traits combine to form normal personalities, cataloguing over 18,000 separate traits over a period of 30 years. He proposed that each person has about seven central traits that dominate his or her behavior. Allport's attempt to make trait analysis more manageable and useful by simplifying it was expanded by subsequent researchers, who found ways to group traits into clusters through a process known as factor analysis.

Raymond B. Cattell reduced Allport's extensive list to 16 fundamental groups of interrelated characteristics, and Hans Eysenck claimed that personality could be described based on three fundamental factors: *psychoticism* (such antisocial traits as cruelty and rejection of social customs), *introversion-extroversion*, and *emotionality-stability* (also called neuroticism). Eysenck also formulated a quadrant based on intersecting emotional-stable and introverted-extroverted axes.

Twentieth-century views on personality have been heavily influenced by the ***psychodynamic approach of Sigmund Freud***. Freud proposed a three-part personality structure consisting of the *id* (concerned with the gratification of basic instincts), the *ego* (which mediates between the demands of the id and the constraints of society), and the *super-ego* (through which parental and social values are

internalized). In contrast to type or trait theories of personality, the dynamic model proposed by Freud involved an ongoing element of conflict, and it was these conflicts that Freud saw as the primary determinant of personality. His psychoanalytic method was designed to help patients resolve their conflicts by exploring *unconscious* thoughts, motivations, and conflicts through the use of *free association* and other techniques. Another distinctive feature of Freudian *psychoanalysis* is its emphasis on the importance of childhood experiences in personality formation. Other psychodynamic models were later developed by colleagues and followers of Freud, including Carl Jung, Alfred Adler, and Otto Rank (1884-1939), as well as other neo-Freudians such as Erich Fromm, Karen Horney, Harry Stack Sullivan (1892-1949), and Erik Erikson.

Another major view of personality developed during the twentieth century is the ***phenomenological approach***, which emphasizes people's self-perceptions and their drive for *self-actualization* as determinants of personality. This optimistic orientation holds that people are innately inclined toward goodness, love, and *creativity* and that the primary natural motivation is the drive to fulfill one's potential. Carl Rogers, the figure whose name is most closely associated with phenomenological theories of personality, viewed authentic experience of one's self as the basic component of growth and wellbeing. This experience together with one's *self-concept* can become distorted when other people make the positive regard we need dependent on conditions that require the suppression of our true feelings.

The *client-centered therapy* developed by Rogers relies on the therapist's continuous demonstration of empathy and unconditional positive regard to give clients the self-confidence to express and act on their true feelings and beliefs. Another prominent exponent of the phenomenological approach was Abraham Maslow, who placed self-actualization at the top of his hierarchy of human needs. Maslow focused on the need to replace a deficiency orientation, which consists of focusing on what one does not have, with a growth orientation based on satisfaction with one's identity and capabilities.

The behaviorist approach views personality as a pattern of learned behaviors acquired through either classical (Pavlovian) or operant (Skinnerian) conditioning and shaped by *reinforcement* in the form of rewards or punishment. A relatively recent extension of

behaviorism, ***the cognitive-behavioral approach*** emphasizes the role cognition plays in the learning process. Cognitive and social learning theorists focus not only on the outward behaviors people demonstrate but also on their expectations and their thoughts about others, themselves, and their own behavior. For example, one variable in the general theory of personality developed by social learning theorist Julian B. Rotter is internal-external orientation. "Internals" think of themselves as controlling events, while "externals" view events as largely outside their control. Like phenomenological theorists, those who take a social learning approach also emphasize people's perceptions of themselves and their abilities (a concept called "self-efficacy" by Albert Bandura). Another characteristic that sets the cognitive-behavioral approach apart from traditional forms of behaviorism is its focus on learning that takes place in social situations through observation and reinforcement, which contrasts with the dependence of classical and *operant conditioning* models on laboratory research.

2. Aspects of personality

The personality main peculiarities are: ***temperament, character, aptitudes.***

Temperament is an individual's characteristic, including energy level, prevailing mood and sensitivity to stimulation. Individual variations in temperament are most readily observed in newborn babies. Even immediately after birth, some babies are calm while others cry a lot. Some respond favorably to being held while others squirm and protest. Some are soothed by soft music and others do not stop crying long enough to hear it. Because of these immediately observable variations, temperament is often considered a biologically based characteristic. Hippocrates discussed variations in temperament as early as the 5th century B.C. His hypothesis that there are four basic human temperaments that correspond to various bodily characteristics choleric, sanguine, melancholic, and phlegmatic endured for many years before modern theories became accepted.

The environment can nurture changes both positive and negative to reshape an infant's natural tendencies. Natural tendencies can ameliorate or worsen environmental situations. Acknowledging the interactions of both temperament and environment during development should make possible continued progress in understanding of the

intricate multiple influences on a human's life and growth. Neither temperament nor biology is destiny.

Temperament is that aspect of our personalities that is genetically based, inborn, there from birth or even before. That does not mean that a temperament theory says we don't also have aspects of our personality that are learned, it's just that Eysenck focused on "nature," and left "nurture" to other theorists.

Eysenck initially conceptualized personality as two, biologically-based categories of temperament: The two dimensions or axes, extraversion-introversion and emotional stability-instability, define four quadrants. These are made up of:

- *Stable extraverts* (sanguine qualities such as - outgoing, talkative, responsive, easygoing, lively, carefree, leadership).
- *Unstable extraverts* (choleric qualities such as - touchy, restless, excitable, changeable, impulsive, irresponsible).
- *Stable introverts* (phlegmatic qualities such as - calm, even-tempered, reliable, controlled, peaceful, thoughtful, careful, passive).
- *Unstable introverts* (melancholic qualities such as - quiet, reserved, pessimistic, sober, rigid, anxious, moody).

The temperament is a biological basis for character. The character's qualities may be developed. **Character** is most often used in reference to a set of basic innate, developed, and acquired motivations that shape an individual's behavior. These qualities of an individual's motivation are shaped during all stages of childhood. By late adolescence, around age 17, the traits that make up individual's character are normally integrated into a unique and distinctive whole. There is widespread agreement among psychologists that, while much research remains to be done to delineate the genetic, instinctive, organic, cognitive, and other aspects of character, the development of a reasonably stable and harmonious character is an essential part of a psychologically healthy existence.

Traits and tendencies often found in the personality pattern that we call character are:

Integrity	Honesty
Rectitude	Sense of honor
High moral standards	Sense of duty
Conscientiousness	Courage
Intelligence	Seriousness

Self-discipline	Self-control
Self-denial	Self-reliance
Self-sacrifice	Justness
Fairness	Diligence
Carefulness	Tidiness
Foresight	Perseverance etc

An aptitude is something that you have the potential to be good at; it refers to your innate ability to do well at tasks that require a specific type of skill. Aptitude is not dependent on previous learning.

Aptitudes are natural talents, special abilities for doing, or learning to do, certain kinds of things easily and quickly. They have little to do with knowledge or culture, or education, or even interests. They have to do with heredity. Musical talent and artistic talent are examples of such aptitudes.

Some people can paint beautifully but cannot carry a tune. Others are good at talking to people but slow at paperwork. Still others can easily repair a car but find writing difficult. These basic differences among people are important factors in making one person satisfied as a banker, another satisfied as an engineer, and still another satisfied working as an editor. Our aptitude testing will identify your natural abilities.

Every occupation, whether it is engineering, medicine, law or management, uses certain aptitudes. The work you are most likely to enjoy and be successful in is work that uses your aptitudes. For example, if you are an engineer but possesses aptitudes not used in engineering, your work might seem unrewarding. If you lack the engineer's aptitudes, your work may be difficult or unpleasant.

The primary purpose of taking aptitude tests is to find areas in which you have ability. It has been proven that people tend to be more satisfied and successful in occupations that challenge their aptitudes and do not demand aptitudes that they lack.

3. Personality development

The concept of **personality** refers to the profile of stable beliefs, moods, and behaviors that differentiate among children (and adults) who live in a particular society. The profiles that differentiate children across cultures of different historical times will not be the same because the

most adaptive profiles vary with the values of the society and the historical era. Contemporary theorists emphasize personality traits having to do with individualism, internalized conscience, sociability with strangers, and the ability to control strong emotion and impulse, and personal achievement.

An important reason for the immaturity of our understanding of personality development is the heavy reliance on questionnaires that are filled out by parents of children or the responses of older children to questionnaires. Because there is less use of behavioral observations of children, our theories of personality development are not strong.

There are ***five different hypotheses regarding the early origins of personality.*** *One assumes* that the child's inherited biology, usually called a temperamental bias**,** is an important basis for the child's later personality. Alexander Thomas and Stella Chess suggested there were nine temperamental dimensions along with three synthetic types they called the difficult child, the easy child, and the child who is slow to warm up to unfamiliarity. Longitudinal studies of children suggest that a shy and fearful style of reacting to challenge and novelty predicts, to a modest degree, an adult personality that is passive to challenge and introverted in mood.

A second hypothesis regarding personality development comes from Sigmund Freud's suggestion that variation in the sexual and aggressive aims of the *id*, which is biological in nature, combined with family experience, leads to the development of the *ego* and *super-ego.* Freud suggested that differences in parental socialization produced variation in anxiety which, in turn, leads to different personalities.

A third set of hypotheses emphasizes direct social experiences with parents. After World War II, Americans and Europeans held the more benevolent idealistic conception of the child that described growth as motivated by affectionate ties to others rather than by the narcissism and hostility implied by Freud's writings. John Bowlby contributed to this new emphasis on the infant's relationships with parents in his books on attachment. Bowlby argued that the nature of the infant's relationship to the caretakers and especially the mother created a profile of emotional reactions toward adults that might last indefinitely.

A fourth source of ideas for personality centers on whether or not it is necessary to posit a self that monitors, integrates, and initiates reaction. This idea traces itself to the Judeo-Christian assumption that it

is necessary to award children a will so that they could be held responsible for their actions. A second basis is the discovery that children who had the same objective experiences develop different personality profiles because they construct different conceptions about themselves and others from the same experiences. The notion that each child imposes a personal interpretation to their experiences makes the concept of self critical to the child's personality. An advantage of awarding importance to a concept of self and personality development is that the process of identification with parents and others gains in significance. All children wish to possess the qualities that their culture regards as good. Some of these qualities are the product of identification with each parent.

A final source of hypotheses regarding the origins of personality comes from inferences based on direct observations of a child's behavior. This strategy, which relies on induction, focuses on different characteristics at different ages. Infants differ in irritability, three-year-olds differ in shyness, and six-year-olds differ in seriousness of mood. A major problem with this approach is that each class of behavior can have different historical antecedents. Children who prefer to play alone rather than with others do so for a variety of reasons. Some might be temperamentally shy and are uneasy with other children while others might prefer solitary activity.

The current categories of child psychopathology influenced the behaviors that are chosen by scientists for study. Fearfulness and conduct disorder predominate in clinical referrals to psychiatrists and psychologists. A cluster of behaviors that includes avoidance of unfamiliar events and places, fear of dangerous animals, shyness with strangers, sensitivity to punishment, and extreme guilt is called the internalizing profile. The cluster that includes disobedience toward parent and teachers, aggression to peers, excessive dominance of other children, and impulsive decisions is called the externalizing profile. These children are most likely to be at risk for later juvenile delinquency. The association between inability of a three-year-old to inhibit socially inappropriate behavior and later antisocial behavior is the most reliable predictive relation between a characteristic scene in the young child and later personality trait.

Influences on personality development comes from a variety of temperament but especially ease of arousal, irritability, fearfulness,

sociability, and activity level. The experiential contributions to personality include early attachment relations, parental socialization, identification with parents, class, and ethnic groups, experiences with other children, ordinal position in the family, physical attractiveness, and school success or failure, along with a number of unpredictable experiences like divorce, early parental death, mental illness in the family, and supporting relationships with relatives or teachers.

The most important personality profiles in a particular culture stem from the challenges to which the children of that culture must accommodate. Most children must deal with three classes of external challenges:

1. unfamiliarity, especially unfamiliar people, tasks, and situations;

2. request by legitimate authority or conformity to and acceptance of their standards

3. domination by or attack by other children.

In addition, all children must learn to control two important families of emotions: *anxiety, fear, and guilt,* on the one hand, and on the other, *anger, jealousy, and resentment.*

By six years of age, children assume that some of the characteristics of their parents belong to them and they experience vicariously the emotion that is appropriate to the parent's experience. A six-year-old girl identified with her mother will experience pride should mother win a prize or be praised by a friend. However, she will experience shame or anxiety if her mother is criticized or is rejected by friends. The process of identification has great relevance to personality development. The child's ordinal position in the family has its most important influence on receptivity to accepting or rejecting the requests and ideas of legitimate authority. First-born children in most families are most willing than later-born to conform to the requests of authority.

They are more strongly motivated to achieve in school, more conscientious, and less aggressive. The child's social class affects the preparation and motivation for academic achievement. Children from middle-class families typically obtain higher grades in school than children of working or lower-class families because different value systems and practices are promoted by families from varied social class backgrounds. The patterns of socialization used by parents also influence the child's personality.

3. Personality disorders

Personality disorders constitute a separate diagnostic category (Axis II) in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Unlike the major mental disorders (Axis I), which are characterized by periods of illness and remission, personality disorders are generally ongoing (constant). Often, they first appear in *childhood* or *adolescence* and persist throughout a person's lifetime. Aside from their persistence, the other major characteristic of personality disorders is inflexibility. Persons affected by these disorders have rigid personality traits and coping styles that they are unable to adapt to changing situations and that impair (damage) their social and/or occupational functioning.

A further difference between personality disorders and the major clinical syndromes listed in Axis I of *DSM-IV* is that *people with personality disorders generally do not perceive that there is anything wrong with their behavior and are not motivated to change it.* Although the *DSM-IV* lists specific descriptions of ten personality disorders, these conditions are often difficult to diagnose. Some characteristics of the various disorders overlap. In other cases, the complexity of human behavior makes it difficult to pinpoint a clear dividing line between pathology and normality in the assessment of personality. There also has been relatively little research done on some of the personality disorders listed in *DSM- IV.*

The most effectively-diagnosed personality disorder is the antisocial personality. The outstanding traits of this disturbance are an inability to feel love, empathy, or loyalty towards other people and a lack of guilt or remorse for one's actions. Due to the lack of conscience that characterizes it, the condition that is currently known as *antisocial personality disorder* was labeled moral insanity in the nineteenth century. More recent names associated with this personality type are *psychopath* and *sociopath.* Unable to base their actions on anything except their own immediate desires, persons with this disorder demonstrate a pattern of impulsive, irresponsible, thoughtless, and sometimes criminal behavior. They are often intelligent, articulate individuals with ability to charm and manipulate others; at their most dangerous, they can become violent criminals who are particularly dangerous to society because of their ability to gain the trust of others combined with their lack of conscience or remorse (guilt, shame). There

are both biological and psychosocial theories of the origin of antisocial personality disorder.

Two of the major components of the antisocial personality: the constant need for *thrills (adventures), excitement* and the *lack of anxiety about punishment,* may be at least partially explained by research suggesting that antisocial individuals experience chronic under arousal (stimulation) of the central and autonomic nervous systems. In one experiment, anticipation of an electric shock produced a dramatically lower increase of tension in teenagers diagnosed with antisocial personality disorder than in other individuals. In terms of environmental influences, connections have been suggested between the antisocial personality and various patterns of familial interaction, including parental rejection or inconsistency and the retraction of punishment when repentance is claimed.

Some personality disorders resemble chronic but milder versions of the mental disorders listed in Axis I of *DSM-IV*. In *schizotypal personality disorder,* for example, the schizophrenic's hallucinations or voices are moderated to the less extreme symptom of an "illusion" that others are present when they are not. Speech patterns, while not incoherent like those of schizophrenia, tend to be vague and digressive. Similarly, *avoidant personality disorder* has characteristics that resemble those of social phobia, including hypersensitivity to possible rejection and the resulting social withdrawal in spite of a strong need for love and acceptance.

The *paranoid* and *schizoid* personality disorders are usually manifested primarily in odd or eccentric behavior. The former is characterized mainly by suspiciousness of others, extreme vigilance against anticipated misdeeds (faults), and insistence on personal autonomy. The latter involves emotional coldness and passivity, indifference to the feelings of others, and trouble (difficulty) forming close relationships. Several personality disorders, including antisocial personality, are associated with extreme and erratic (unpredictable) behavior. The most dramatic is the *histrionic* personality type, which is characterized by persistent attention-getting behavior that includes exaggerated emotional displays (such as tantrums (irritability)) and over reaction to trivial problems and events. Manipulative suicide attempts may also occur. *Narcissistic* personality disorder consists primarily of an inflated sense of self-importance coupled with a lack of empathy for

others. Individuals with this disorder display an exaggerated sense of their own importance and abilities and tend to fantasize about them. Such persons also have a sense of entitlement, (privilege) expecting (and taking for granted) special treatment and concession (indulgence) from others.

Paradoxically, individuals with narcissistic personality disorder are generally very insecure and suffer from low self-esteem. Another personality disorder that is characterized by erratic (unpredictable) behavior is the *borderline personality*. Individuals with this disorder are extremely unstable and inconsistent in their feelings about themselves and others and tend toward impulsive and unpredictable behavior.

Several personality disorders are manifested primarily by anxiety and fearfulness. In addition to the avoidant personality, these include the dependent, compulsive, and passive-aggressive personality disorders.

Persons with *dependent personality disorder* are extremely passive and tend to subordinate their own needs to those of others. Due to their lack of self-confidence, they avoid asserting themselves and allow others to take responsibility for their lives. *Compulsive personality disorder* is characterized by behavioral rigidity, excessive emotional restraint, and overly conscientious compliance with rules. Persons with this disorder are overly cautious and indecisive and tend to procrastinate (postpone) and to become overly (excessively) upset by deviations from rules and routines. *Passive aggressive personality* disorder involves covert (clandestine) aggression expressed by a refusal to meet the expectations of others in such areas as adequate job performance, which may be sabotaged through procrastination, forgetfulness, and inefficiency. This disorder is also characterized by irritability, volatility, and a tendency to blame others for one's problems.

Questions for self-evaluation:

1. Give the definition of personality.
2. Enumerate the theories of personality.
3. Define character, as a social trait of personality.
4. Define temperament as a biological basis for character.
5. Explain the two, biologically-based categories of temperament, by Eysenck.
6. Explain the nature of aptitudes.

7. Explain the concept of personality.
8. Describe the hypothesis regarding personality development.
9. Describe the antisocial personality.
10. Which are the influences on personality development?
11. Enumerate the common characteristic of personality disorders.

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Lecture VIII

THE DOCTOR PERSONALITY

Structure:

1. The doctor's professional status.
2. Factors which affect the doctor's personality.
3. Specific aspects of patient-physician communication.
4. Strategies for effective communication with patients.

Key terms: doctor's personality; patient-physician communication; communication barriers; strategies of effective communication.

1. The doctor's professional status.

Doctor is seen as someone who posses a professional competence to soothe the patient's sufferance, cure the disease and save patient's life.

According to the psychosocial investigations, the doctor's main qualities (traits) are as follows:

– interrelational abilities (honesty, cordially, etc.);
– moral abilities;
– intellectual abilities (professional knowledge).

Professional status of a doctor implies:

- Technical competencies verified by exams, ritualized and expressed by diplomas, titles, etc.
- Minimal competency in maximal field.
- Universalism in offering medical assistance – equality for treatment.
- Functional specificity – using professional authority to build professional doctor-patient relationship.
- Affective (emotional) neutrality – a doctor never judges, punishes or has intimate relationships with his patient.
- Altruism.

- The obligation to get the patient's consent.

Doctor's role implies:

- Respecting doctor's rights and obligations.
- Communication disponibility with the patient.
- Using an adequate language to be understood by the patient according to his educational level.
- Attitudinal adaptation according to patient's personality.
- Authority in medic-surgical emergency.
- Guide in chronic disorders, in prophylaxis.
- Therapeutic mirror.
- Patience.
- Professional and social doctor's prestige working as a placebo for the outcome of the patient.

The main expectation from doctor professional role:

- Apply a high degree of skill and knowledge to the problems of illness.
- Act for welfare of patient and community rather than for own self-interest, desire for money, advancement, etc.
- Be objective and emotionally detached (it should not judge patient's behavior in terms of personal value system or become emotionally involved with them.
- Be guided by rules of professional practice.
- Granted rights to examine patients physically and to enquire into intimate areas of physical and personal life.
- Granted considerable autonomy in professional practice.
- Occupy position of authority in relation to the patient.

There is no type of doctor that is "best" for everyone. This is a very personal and individual choice. The right doctor is one with whom the patient can have frank and open conversations. The doctor and patient will also have similar health beliefs. A well matched doctor will value the patient as a person and has knowledge and acceptance of the mental and physical health concerns.

A *good doctor* must demonstrate respect for a patient. Good doctors understand that a sick or injured patient is highly vulnerable. Being respectful goes a long way toward helping that patient explain symptoms, take responsibility for decision-making, and complying with instructions.

Doctor should have the ability to share information in terms his/her patients can understand. It's OK to use med-speak and complicated terms, but they should be accompanied by an explanation at the same time.

A good doctor doesn't interrupt or stereotype his/her patients**.** It's easy for all of us to interrupt when we know time is short or we are in a hurry, but a practitioner who is a good communicator knows that if it can't be done right to begin with, it will need to be done over. Listening carefully and respectfully will go a long way toward better outcomes for the patient.

A good doctor has the ability to effectively manage patients' expectations. By helping his/her patient understand what the next steps will be, and what the possible outcomes and their ramifications might be, the doctor can go a long way toward helping that patient understand his problem.

There are more challenges than ever in today's healthcare environment. Limited appointment time, the ability of patients to do their own research which then needs to be discussed with practitioners, and the numbers of patients who are undiagnosed or misdiagnosed; these challenges and others make effective communications between patients and their practitioners more important than ever.

Good communications really boils down to two things: *respect for each other,* and the *ability to manage expectations.*

2. Factors which affect the doctor's personality.

There is a clear link between the health and well-being of both: doctors and the organization they work within. This interaction is complex and as yet not well understood. Studies of physical and mental health disorders among doctors suggest that occupational health physicians have a key role in the assessment of underperformance. Actually, stress in health professionals is high, with 28% showing above threshold symptoms compared to 18% of workers as a whole in the UK. Between 10 and 20% of doctors in the UK become depressed at some time during their career and the risk of suicide is raised compared to the general population. Evidence from Switzerland suggests that levels of burn out among doctors are high. Alcoholism also affects a high proportion of doctors compared to other professional groups and along with drug dependency is an increasing problem.

Doctors are no different than the wider population where performance relates to well-being as well as to skills and knowledge.

As Parsons recognized, doctors serve the state as agents of social control in their role as *gatekeeper to the sick role* with authority to determine who is 'healthy' and who is 'sick', but also have an obligation to act in the best interests of individual patients. When patients request, or even demand, a sick note, problems can arise for the doctor in determining whether disease exists and the designation of 'sick' and privileges of the sick role can be justified. For example, back pain is the major reason for time off work but it is often difficult to determine its cause or severity except by relying on patients' reports, which could present problems in evaluating the legitimacy of their claims to the sick role. In such situations of uncertainty, should doctors give priority to the interests of the patient, or to their societal function in ensuring that people do not malinger or occupy the sick role inappropriately?

Similarly, should doctors inform the licensing authority if they are aware that a patient diagnosed with epilepsy is driving a car and thus contravening the state's regulations, even if they know how important it is for the patient to drive, and should doctors inform patients who are thinking of being tested for human immunodeficiency virus (HIV) of the potential problems of being diagnosed as a carrier for insurance premiums when this might discourage testing?

A further **source of conflict** for doctors arises from the competing interests of individual patients and the wider patient population. For example, doctors are often involved in rationing scarce resources of staff time, beds and medical equipment and might have to decide which patients should be given a transplant or undergo other medical procedures, as well as the priority to be assigned to treating different cases. In the absence of clear and explicit criteria, such choices rest on the judgment of individual clinicians. A recent illustration is the decision made by some consultants not to administer tests and carry out coronary artery by-pass surgery on people who continue to smoke.

Doctors can also *experience conflicts between maintaining the confidentiality* of the doctor–patient relationship and disclosing information to a patient's parent or spouse. This raises the question of whether medical confidentiality is absolute or whether there are any situations when interests are best served by passing on information about a patient. For example, are there are any circumstances in which a doctor at a

clinic should disclose that a patient has acquired immunodeficiency syndrome (AIDS), or is positive for HIV, when this is against the patient's wishes? Such situations frequently pose dilemmas for doctors and raise questions concerning their primary duties and responsibilities, as well as possibly presenting conflicts in relation to their own beliefs and values. However, there are powerful arguments to support the view that priority should be given to maintaining the confidentiality of the doctor–patient relationship. In particular, this has the benefit of preserving patients' trust in doctors and their willingness to consult and discuss their problems freely in the future; destroying this trust undermines the very foundation of the relationship between doctor and patient.

The social interaction between doctor and patient can also influence doctors' own feelings of satisfaction. For example, failure to elicit patients' worries and interpretation of symptoms can sometimes lead doctors to believe that patients have consulted inappropriately and that their time and skills are being wasted. This can be illustrated in relation to consultations for childhood respiratory conditions, which account for 30% of all consultations for children aged below 11 years. Many of these consultations are for a condition that is 'trivial' from a biomedical perspective. Eliciting and addressing such lay beliefs could avoid potential conflicts and enhance doctors' job satisfaction, as well as promoting the quality and effectiveness of patient care.

3. Specific aspects of patient-physician communication.

Patient-physician communication is an integral part of clinical practice. When done well, such communication produces a therapeutic effect for the patient, as has been validated in controlled studies. Patients, who understand their doctors are more likely to acknowledge health problems, understand their treatment options, modify their behavior accordingly, and follow their medication schedules. In fact, effective patient-physician communication can improve a patient's health as quantifiably as many drugs, perhaps providing a partial explanation for the powerful placebo effect seen in clinical trials.

Today, the communication and interpersonal skills of the physician-in-training are no longer viewed as immutable personal styles that emerge during residency but, instead, as a set of measurable and modifiable behaviors that can evolve. Based on emerging literature on the value of effective communication, medical students and postgraduates are increa-

singly given instruction on techniques for listening, explaining, questioning, counseling, and motivating. As such techniques are central to delivering a full and tailored health prescription, 65% of medical schools now teach communications skills.

These efforts to improve and measure communication skills are timely, as the barriers to effective communication between patients and physicians are growing. Despite evidence indicating that the average length of the patient-physician encounter has not changed significantly in recent years, specific survey data indicate a correlation between patient participation in capitated health plans and shorter office visits.

However, even demands associated with time, language, and technology, as Internet-available information, which potentially limits face-to-face opportunities, are not an excuse for neglecting one's communication skills. During the typical 15- or 20-minute patient-physician encounter, the physician makes nuanced choices regarding the words, questions, silences, tones, and facial expressions he or she chooses. These choices either enhance or detract from the overall level of excellence of the physician's delivery of care.

Barriers to patient-physician communication.

- Speech disability or language articulation.
- Foreign language spoken.
- Disphonia.
- Time constrains on physician or patient.
- Unavailability of physician or patient to meet face –to-face.
- Illness.
- Altered mental state.
- Medication effects.
- Psychological or emotional distress.
- Gender differences.
- Racial or cultural differences.
- Other.

From obtaining the patient's medical history to conveying a treatment plan, the physician's relationship with his patient is built on effective communication. In these encounters, both verbal and nonverbal forms of communication constitute this essential feature of medical practice.

Although much of the communication in these interactions necessarily involves information-sharing about diagnosis and therapy

options, most physicians will recognize that these encounters also involve the patient's search for a psychosocial healing "connection," or therapeutic relationship. For example, a patient with broken relationships with family, friends, coworkers, or the community in general, will often struggle when describing his illness and symptoms for the first time. That patient's contact with his physician is often a first step toward reconnection.

Therefore, it is essential for the physician to listen to patient concerns, provide comfort and healing, and foster the relationship in general. This aspect of the patient-physician relationship is hard to define and, yet, with little doubt, can be found at the heart of any truly therapeutic relationship. In settings involving the communication of bad news, especially when there is no appropriate biomedical response, the strength of such a therapeutic relationship will be tested, and its value quickly becomes obvious. The physician who can communicate bad news in a direct and compassionate way will not only help the patient cope, but will also strengthen the therapeutic relationship, so that it endures and further extends the healing process. Specific communication skills that involve preparing in advance, validating emotions, and dealing with family members have been described for this difficult setting.

More broadly and measurably, research into the degree of care used by physicians in patient-physician communication has been shown to improve patient outcomes.

4. Strategies for effective communication with patients.

Medical professionals debate the best strategies for effective communication, as well as the ability of these strategies to be taught or evaluated objectively. Certainly, each physician must develop his or her own style of communication. At the same time, many professional and academic organizations have now also defined key elements of communications skills needed by physicians. For example, the Accreditation Council for Graduate Medical Education recommends that *physicians become competent in five key communication skills:*

1. listening effectively;
2. eliciting information using effective questioning skills;
3. providing information using effective explanatory skills;
4. counseling and educating patients; and

5. making informed decisions based on patient information and preference.

Although these and similar lists of recommended patient-physician communication strategies are valid and useful, there are some learned skills that will help doctor to deal in a good way the medical consultation.

1. Assess what the patient already knows. Before providing information, find out what a patient already knows about his or her condition. Many times, other physicians or health care providers have already communicated information to the patient, which can have the effect of coloring patient perceptions and perhaps even causing confusion when new information is introduced. For instance, a nephrologist may talk about the patient "getting better" based on improving renal function tests, while a cardiologist is focused on the patient's severe, irreversible cardiomyopathy. In other scenarios, patients will come to the physician with preconceived notions about a particular condition, perhaps based on less than-authoritative sources. It is important, therefore, to determine what a patient already understands or misunderstands at the outset.

2. Assess what the patient wants to know. Not all patients with the same diagnosis want the same level of detail in the information offered about their condition or treatment. Studies have categorized patients on a continuum of information-seeking behavior, from those who want very little information to those who want every detail the physician can offer. Thus, physicians should assess whether the patient desires, or will be able to comprehend, additional information. For the physician without advance knowledge of the patient, this level of need will emerge by degrees as the discussion unfolds and as the physician attempts to synthesize and present information in a clear and understandable manner.

As when obtaining informed consent, a standard first step in presenting information to a patient would be to describe the risks and benefits of the procedure and then to simply allow the patient to decide how much additional information he or she wants. However, as suggested elsewhere in this section, this step may require direct questions, strategic silences, and frequent verification that the information is actually being comprehended.

One telling sign of whether the patient understands the information is the nature of the questions patients ask; if questions reflect compre-

hension of the information just presented, a further level of detail may be warranted. If questions reflect confusion, it is advisable that the physician return to basic information. If the patient has no questions or is obviously uncomfortable, this is a good opportunity for the physician to stop the discussion, ask explicitly how much information the patient desires, and adjust accordingly. Continuing to provide further information is not always the best approach.

3. Be empathic. Empathy is a basic skill physicians should develop to help them recognize the indirectly expressed emotions of their patients. Once recognized, these emotions need to be acknowledged and further explored during the patient-physician encounter. Further, physicians should not ignore or minimize patient feelings with a redirected line of inquiry relentlessly focused on "real" symptoms. Patient satisfaction is likely to be enhanced by physicians who acknowledge patients' expressed emotions. Physicians who do this are less likely to be viewed as uncaring by their patients.

4. Slow down. Physicians who provide information in a slow and deliberate fashion allow the time needed for patients to comprehend the new information. Other techniques physicians can use to allow time include pausing frequently and reinforcing silence with appropriate body language. A slow delivery with appropriate pauses also gives the listener time to formulate questions, which the physician can then use to provide further bits of targeted information. Thus, a dialogue punctuated with pauses leads to deeper comprehension on both sides.

One study found that physicians typically wait only 23 seconds after a patient begins describing his chief complain before interrupting and redirecting the discussion. Such premature redirection can lead to late-arising concerns and missed opportunities to gather important data.

As a side note, patient satisfaction is also greater when the length of the office visit matches his or her previsit expectation. In situations involving the delivery of bad news, the technique of simply stating the news and pausing can be particularly helpful in ensuring that the patient and patient's family fully receive and understand the information. Allowing this time for silence, tears, and questions can be essential.

5. Keep it simple. Physicians should avoid engaging in long monologues in front of the patient. Far better for the physician to keep to short statements and clear, simple explanations. Those who tailor information to the patient's desired level of information will improve

comprehension and limit emotional distress. Again, physicians should be sure to ask whether patients have any questions so that understanding can be checked and dialogue promoted. It is wise for the physician to avoid the use of jargon whenever possible, particularly with elderly patients.

In patients of all ages, a physician cannot assume the understanding of treatment risks that are described with percentages or numbers. Such "low numeracy skills" of patients require that physicians take special care in outlining the relative risks of diagnostic procedures and treatments.

6. Tell the truth. It is important to be truthful. In addition, it is important that physicians not minimize the impact of what they are saying. For example, euphemisms may soften the delivery of sad information but can be extremely misleading and create confusion.

Saying that a patient has "gone" or has "left us," for example, could be interpreted by an anxious family member as meaning that the patient has left his room to have a radiologic film taken or to undergo a test. Alternatively, physicians who use "D" words (e.g., dying, died, dead), when appropriate, effectively communicate the circumstance and minimize confusion.

7. Be hopeful.

Although the need for truth-telling remains primary, the therapeutic value of conveying hope in situations that may appear hopeless should not be underestimated. Particularly in the context of terminal illness and end-of-life care, hope should not be discouraged.

For example, in situations such as the imminent death of a patient, hope can be conveyed to the family by assuring them that therapy can be effective in allaying pain and discomfort. Thus, even when physicians must convey a grim prognosis to a patient or must discuss the same with family members, being able to promise comfort and minimal suffering has real value.

8. Watch the patient's body and face. Much of what is conveyed between a physician and patient in a clinical encounter occurs through nonverbal communication. For both physician and patient, images of body language and facial expressions will likely be remembered longer after the encounter than any memory of spoken words.

Patients' facial expressions are often good indicators of sadness, worry, or anxiety. The physician who responds with appropriate concern

to these nonverbal cues will likely impact the patient's illness to a greater degree than the physician wanting to strictly convey factual information. At the very least, the attentive physician will have a more satisfied patient.

Conversely, the physician's body language and facial expression also speak volumes to the patient. The physician who hurriedly enters the examination room several minutes late, takes furious notes, and turns away while the patient is talking, almost certainly conveys impatience and minimal interest in the patient. Over several such encounters, the patient may interpret such nonverbal behavior as a message that his or her visit is unimportant, despite any spoken assurances to the contrary. Thus, it is imperative that the physician be aware of his or her own implicit messages, as well as recognizing the nonverbal cues of the patient.

9. Be prepared for a reaction. Patients vary, not only in their willingness and ability to absorb information, but in their reactions to physician communications. Most physicians quickly develop a sense for the various coping styles of patients, a range of human reactions that has been categorized in several specific clinical settings.

For instance, a certain percentage of individuals will meet almost any bad medical news in a nonemotional, stoic manner. The physician, however, should not interpret this nonreaction as a lack of patient concern or worry. In some cases, these same individuals go on to exhibit distress by other means (e.g., an increased reporting of physical symptoms, additional nonverbal communication of pain, or other behaviors aimed at gaining the attention of the treatment team).

At the other end of the emotional spectrum, the sizable proportion of patients with mild or diagnosable depression and/or anxiety will likely react to bad news with frank displays of crying, denial, or anger.

A small percentage of patients who have difficulty forming a trusting relationship with a physician may react to bad news with distrust, anger, and blame. For such patients, establishing a lasting bond of trust with their physicians can be extremely difficult, and although all attempts to communicate should be made, unsettled feelings on both sides are to be expected.

In responding to any of these patient reactions, it is important to be prepared. The first step is for the physician to recognize the response, allowing sufficient time for a full display of emotions. Most importantly, the physician simply needs to listen quietly and attentively to what the

patient or families are saying. Sometimes, the physician can encourage patients to express emotion, perhaps even asking them to describe their feelings. The physician's body language can be crucial in conveying empathic concern in these encounters.

The patient-physician dialogue is not finished after discussing the diagnosis, tests, and treatments. For the patient, this is just a beginning; the news is sinking in. The physician should anticipate a shift in the patient's sense of self, which should be handled as an important part of the encounter not as an unpleasant plot twist to a physician's preferred story line.

Communication traps to avoid.

- Using highly technical language or jargon when communicating with the patient.
- Not showing appropriate concern for problems voiced by the patient.
- Not pausing to listen to the patient.
- Not verifying that the patient has understood the information presented.
- Using an impersonal approach or displaying any degree of apathy in communications.
- Not becoming sufficiently available to the patient.

Questions for self-evaluation:

1. Name the factors which affect the doctor’s personality.
2. Explain the common problems in a doctors’ practice.
3. Which are the barriers to patient-physician communication?
4. Define the patient-physician communication as an integral part of clinical practice.
5. Characterize a good doctor from a patient point of view.
6. Describe the strategies of recommended patient-physician communication.
7. Enumerate the communication traps to avoid in a D-P relationship.

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THE PATIENT PERSONALITY

Structure:

1. Patient characteristics and behaviours.
2. The patients' expectations from their doctors.
3. A "good" patient.
4. Difficult patients.
5. Therapeutic compliance.

Key terms: the patient sick role; the patients' expectations; patient complaints; a "good" patient; therapeutic compliance; therapeutic non-compliance; difficult patients.

1. Patient characteristics and behaviours

Generally, *the patient possesses a difficult psychological state*, marked by any essential peculiarities as:

1. The marginal situation (state) between the health and disease, which make the patient very sensitive, unstable and conflicted.

2. The situation of a sick person is seen as alarming and makes the patient adopt any strategy for protection and adaptation to the new social role.

3. The narrowing of an activity sphere.

4. Egocentrism (the personal problems become more important than others).

5. The anxiety increases if the disease becomes chronic.

6. Reducing responsibilities (professional, social, familiar).

The sick role of a patient is a temporary social role that has been instituted by society with the aim of returning sick people to a state of health and restoring them to fully functioning members of society as quickly as possible. The sick role is also regarded as a universal role, in that its obligations and expectations apply to all sick people, whatever their age, gender, ethnicity, occupation or status in other spheres.

Patient sick role imply the following obligations and privileges:

1. Must want to get well as quickly as possible.

2. Should seek professional medical advice and cooperate with the doctor.

3. Allowed (and may be expected) to shed some normal activities and responsibilities.

4. Regarded as being in need of care and unable to get better by his or her own decisions and will.

Although having less power than doctors in the consultation, patients can nevertheless influence the interaction by their willingness to ask questions and assume a more participative role. It appears that younger people are more likely to expect a relationship of mutual participation than elderly people. Patients with a high social and educational level also tend to participate more in the consultation in terms of asking questions and asking for explanations and clarification than patients from a lower socioeconomic background and educational level. This possibly reflects their greater knowledge and confidence and the smaller status gap between doctor and patient.

Patients are often passive and unquestioning during initial hospital consultations, whereas by the second or third consultation they generally initiate questions themselves and take a more participative approach.

Interaction in the consultation and the information and explanations provided by doctors has been shown to reflect their assumptions of the interests of different patient groups (Street 1991). For example, there is some evidence that doctors volunteer more explanations to some groups of patients, including more educated patients and male.

A particular feature of general practice is the opportunity for personal continuity of care, with doctors and patients often knowing each other over a long period. Consultations therefore often take place in a familiar context and can benefit from the doctor's prior awareness of the patient's social situation, past history and concerns. By contrast, patients rarely experience this personal continuity in a hospital situation. In addition, communication on the ward is frequently limited by patient's feelings of a lack of privacy and difficulties of interaction can arise if the doctor or medical team stands at the end of the bed rather than coming close to and preferably sitting at the same level as the patient.

The content of consultations is also influenced at a macro level by the system of financing of health care. Consultations financed on a fee-for-service basis generally occupy a longer time and doctors' practice style is more patient-oriented than when they are paid on a per capita or

salaried basis. This is because a fee-for-service payment is often associated with a greater availability of resources, there is less institutional pressure to achieve a high patient throughput, and doctors feel a greater need to achieve a high level of patient satisfaction. Patients who are paying on a fee-for-service basis also tend to expect a longer consultation and a full discussion with the doctor and are frequently more active in asking questions.

2. The patients' expectations from their doctors

Parsons depicted the role of sick people as involving four general expectations.

First, sick people are allowed, and might even be required, to give up some of their normal activities and responsibilities, such as going to work or playing football.

Second, they are regarded as being in need of care. These two expectations and privileges are, however, contingent on the sick person fulfilling the ***third*** obligation of wanting to get well as quickly as possible, and the ***fourth*** of seeking professional medical advice and, most importantly for the doctor–patient relationship, cooperating with the doctor. Parsons points out that the specific expectations of the sick person, such as the number and type of activities the person is expected to give up, will be influenced by the nature and severity of the condition. It is also recognized that not all illness requires people to relinquish their normal social roles and occupy the status 'sick'. For example, much minor illness is coped with without recourse to the doctor and does not require any changes to a person's everyday life. Similarly, people with a chronic illness might need to consult the doctor regularly, but rather than occupying a permanent sick role they are generally expected to try to achieve their maximum level of functioning and to occupy the status 'sick' only if they experience a change in their usual health.

Usually, patients want many things from their doctors, not all of which are possible. Below, however, is a list of things that patients seem to want from their doctor and which should be possible.

Eye contact. There is nothing worse than walking into a consulting room and not getting any eye contact from the doctor.

Partnership. Patients want to be people who doctors do things with, not people that doctors do things to. Patients want to be consulted

about their condition, their treatment, and how things will progress from the consultation.

Communication. Communication between doctor and patient is the key to a successful consultation. Many patients still feel that they are entering "foreign territory" when they go to see their doctor. In many cases they are scared, they don't understand what the doctor is saying, and they are not able to take everything in that they are told. Just as doctors may have trouble understanding a patient's explanation of symptoms, so patients may have trouble understanding a doctor's explanation of the diagnosis.

Time. Patients want to spend more time with their doctor: they want time to be able to explain things and have things explained to them. We all know that there is a shortage of doctors, and we know that a doctor's time is valuable. However, if one wish could be granted for patients it would be for more time with their doctor.

Appointments (engagements). Patients want to get to see their doctor within a reasonable time; not weeks, but rather a few days, or, in the case of a person who is unwell, a few hours if possible.

3. A "good" patient

There are some practical advises how to be a good patient, based especially on doctors' expectations, as practitioners:

- Will be mindful of the doctor's limited time. While some references tell us a patient has an average of only 8-10 minutes per appointment with his doctor, other references say the average is 16-20 minutes. The discrepancy may be due to the kind of visit, whether the doctor is primary care or a specialist, or even health insurance coverage. Regardless of the difference, it makes most sense for us patients to prepare ahead for the probability that the visit will be shorter than we expect.

– **Will be concise in his communication, preparing carefully for meetings with his practitioner**. A well-organized patient prepares questions ahead of appointments, and sticks to the facts. With so little appointment time, you'll want to be sure your doctor has all the important information about your problems, and has time to answer all your questions.

– **Will ask the meaning of words and concepts he doesn't understand**. Doctors are trained to use a lexicon of med-speak that baffles us patients. General medical terms are used by all doctors or

many specialties. Other words and concepts are specific to body systems, conditions, diseases or treatments. In all cases, you'll walk away much more satisfied from your visit, having learned what you need to know, if you stop your doctor and ask for a definition or description when he uses a concept or term you don't understand.

– **If interrupted, will ask the doctor to stop and listen respectfully**. Some studies say it takes only 23 seconds before a doctor interrupts his patient. Dr. Jerome Groopman, author of How Doctors Think, states that doctors interrupt their patients within 18 seconds of the start of their conversation. If your doctor interrupts you, politely ask him to listen to your entire list of symptoms, or to let you ask your entire question. Sometimes a simple gesture such as gently holding up your hand will alert your doctor to stop and listen to you.

– **Will ask his doctor what to expect next.** No matter what point you are in your transition through the system: before, during or after diagnosis or treatment, asking your doctor what happens next will help you understand what is going on immediately, and what your outcomes might be. For example, if your doctor says he is sending you for a medical test, you might ask what he expects the results will be, or what the possible outcomes might be, and what they would mean. If he can manage your expectations, you will have more confidence about the process and its outcomes.

– **Will know which questions to ask the doctor, and which to save for others.** The questions, such as directions to a testing center, or the time of your next appointment, or where you should park your car, can be asked of others on the doctor's staff. That conserves your short appointment time for the important, medical aspects of your care.

Generally, by "promoting your own health," we mean doing four things: *become as knowledgeable* as possible about your own health conditions; *take good care of yourself*; *make the most of your encounters with your doctor;* and *keep careful records*.

- Become as knowledgeable as possible. Learning as much as possible about your heart condition is a simple matter of self-preservation. Even under an ideal health care system (which, most assuredly, we don't have,) doctors won't always have the time or the inclination to discuss every important aspect of all your medical conditions. The more you teach yourself about those conditions, the better off you'll be. You'll be better able to interpret what your doctor is

saying, and you'll even be able to steer your discussions into the areas that are most pertinent to you. You'll have a better understanding of what your doctor thinks should be accomplished, and a better grasp of what you can do to help accomplish it. Knowledge allows you to become an active participant, rather that a passive one, in managing your health care.

– Take good care of yourself. It goes without saying that you will enjoy better health if you do all those things you know you should be doing, things like giving up tobacco, maintaining an ideal body weight, cutting down on saturated fats, and getting plenty of exercise. If your doctor has you on a particular medical regimen (such as taking prescription drugs), make sure you follow that regimen religiously.

You gain direct health benefits from doing these things, as you well know. What you may not have realized, however, is the secondary gain you receive. By taking a genuine interest in trying to keep yourself healthy, you also endear yourself to your physician. You enlist him to your cause. Doctors should be engaged in the care of each of their patients, of course. That's what it is supposed to mean to be a doctor. But, they can't. They're under steady, unrelenting and overwhelming pressure to make the interests of their patients secondary to the interests of the HMO, of the government, and ultimately, of society at large. They simply cannot go to bat for all their patients.

The many doctors who still maintain a strong sense of professional pride (the recalcitrants, the ones you have tried to choose for yourself) will still try to advocate for their patients, at least as circumstances allow. These, however, need to marshal their energies carefully. When they do go out on a limb for their patients, they are much more likely to do so for patients who are assiduously trying to help themselves. If the patient won't accept responsibility for his own health, it's not realistic to expect the doctor to jeopardize her career for the patient's health.

– Set goals. Before each doctor's appointment, set down in writing the specific goals you'd like to accomplish during that visit. Some goals will be fairly specific and straightforward ("Find out what my cholesterol level is."); others will be more open ended ("Any ideas why I'm tired all the time?"). But anything you want to accomplish during this visit should be listed as a goal.

Write down your questions and comments. Under each goal, write down the questions you would like to have answered, or comments you

want to make, regarding that goal. Consider communicating with your doctor before the visit.

– **Have pertinent data with you.** Don't assume your doctor has all the information he needs. Always bring a list of all the medication you're taking, and who prescribed it. If another doctor has performed an examination, test, or procedure since your previous visit, brings a record of that encounter with you.

– **Take notes.** During the visit itself, check off each of your questions as they are answered, each comment as you makes it, and each goal as it is accomplished. Take notes on the pertinent points your doctor makes with you. Some recommend tape recording doctors' visits. If you choose to do so, remember to ask the doctor's permission first, as it is illegal to surreptitiously record conversations in many states. Also keep in mind the following: if you ask to tape the visit, your doctor will immediately have visions of hearing that recording played back to her three years later in a court of law. If you tape record, expect your doctor to be more circumspect, and possibly less forthcoming, in her comments to you.

– **Repeat what you heard your doctor say**. When your doctor makes an important point, repeat it back to her in your own words. That gives her the opportunity to confirm what you just heard her say, or alternatively, to restate her comment in case the message you got was not the message she tried to convey. Along the same lines, if your doctor gives you specific instructions, write them down, and let the doctor see what you've written.

– **Don't stray from the point.** Your doctor has limited time to spend with you - very limited, with most health plans. Don't waste this time by talking about your sister's wedding. Stick to the script, or you will not meet your goals.

– **Take a support person with you**. Taking a spouse, or good friend with you can be helpful. By listening to your conversation with your doctor, your support person can later confirm (or call into question) what you think you heard from your doctor. If what she heard is different than what you heard, you can then clarify the discrepancy. During the visit itself, your support person can also remind you to bring up an issue you wanted to discuss, if you are forgetting to do so.

– **Keep careful records.** Especially nowadays, when patients change doctors and health plans as often as they change shoes, assuming that your medical past is able to keep up with you is a very bad assumption.

You should keep your own records. At the very least, you should have a copy of your most recent medical history and physical examination, of all hospital discharge summaries, and of the results of any major tests or procedures you have had (such as CAT scans, treadmill tests, or heart catheterizations).

The effective patient doesn't allow the health care system to put in danger his health by losing his records. Instead, he gets copies of those records him, and keeps his files up to date. Doctors and hospitals often don't want to release medical records to patients themselves (fearing litigation), but the information stored in those records belongs to the patient, and the patient has every right to them. Your doctor, of all people, should understand this, and if you've chosen your doctor wisely, he will help you obtain the records you need.

4. Difficult patients

Some doctors are just frustrated. They can't solve a diagnosis or find a treatment option that works well for the patient, and they no longer want to treat the patient due to that frustration. Although this complaint is more a reflection on the doctor than on the patient, it is likely the patient is frustrated by the doctor's inability to do her job, too. That may lead to an extreme reaction on the part of the patient, fueling the fire.

Some patients don't pay their medical bills, yet they are surprised when a doctor doesn't want to spend time with them any further. Imagine a boss refusing to give a paycheck to an employee for the hours that employee put into his job. That's how doctors feel when they don't get paid for their work, too.

Sometimes doctors refuse to see patients out of a belief that a disease doesn't exist. Patients who have been diagnosed with diseases like fibromyalgia or chronic fatigue have been refused treatment by doctors who do not believe those are 'real' diagnoses.

Some doctors just don't want to work with empowered patients. They can be bothered, or they are intimidated. Doctor didn't want to deal with someone who was doing her own research.

Doctors risk arrest and loss of their licenses to practice when they over-prescribe pain meds. Many patients who are in real pain have trouble finding doctors who can help them because doctors fear prescribing the drugs these individuals need.

Patients need to be aware of the reasons a doctor might deny them the care they seek. Awareness of our own behaviors helps us take the first steps toward repairing the relationship with our doctors, and providing us with a better chance of getting access to the care we need.

Difficult patients, who can vex even the most mild-mannered physicians, span the spectrum of challenging behavior. Some specialize in self-diagnosis, demanding unnecessary tests and medication. Others monopolize your time and energy or they verbally abuse the staff. Amid the many in your patient population who are gratifying to treat, these few rabble-rousers can make you wonder why you ever got into the business of healing. They complain, criticize, shout, swear and may even try to hit you. Difficult patients are an unfortunate fact of life in healthcare. But knowing how to identify, understand and respond to them can make your work life safer and less stressful.

Feeling angry, frustrated, guilty or defeated at the end of some consultations is an experience common to all doctors. These emotions are more often provoked by patients labelled 'difficult', 'heartsink' or even 'hateful'. These terms ('heartsink patient' in particular) have become politically incorrect as they imply judgement (and blame) on the patient, are offensive to the patient and ignore the fact that the emotions generated are the consequence of a complex interplay between patient, doctor and healthcare system. This view claims that difficult patients do not exist, only difficult consultations. The fact remains that certain patients tend to have difficult consultations more often than others and that reflecting on. Isolation and fear can lead to anger, which can escalate into violence. "Look for isolated patients who are cut off from their families and communities," says Simms, a clinical specialist in adult and family mental health nursing.

While numerous classifications of difficult patients actually exist, some types are widespread as following:

“A universal pain” pacient. “These patients do take a lot of time and energy and we can end up exacerbating the whole thing by our response,” The first step, says Shakaib Rehman, associate professor of medicine at Medical University of South Carolina, is to recognize that it’s not necessarily the patient who is difficult; rather, the situation makes them so. A large number of patients who express anger, for example, have not been given the right information at the right time. “Most experienced physicians realize that difficult patients are not the

same as say, someone with diabetes or hypertension," says Rehman, who delivers workshops on doctor-patient communication. "You yourself can have a difficult conversation with the phone company, and suddenly, it's you who are difficult."

The fearful patient. The underlying cause of your patient's irksome behavior may not in fact be what you think. Often, for example, it's fear, which can drive an otherwise reasonable person to become overly emotional, quick-tempered, or disagreeable. Certainly, when you're ill, you feel more vulnerable."

When interviewing patients during exams, he says, it sometimes helps to simply ask them to describe their worst health concerns. "Sometimes their fear is something that wouldn't even cross my mind, like a patient with a persistent cold who immediately thinks lung cancer," says Welters. "Just telling them, 'No, I don't think that's what it is,' can put their mind at ease."

Allow them to speak without interruption while you maintain eye contact. Ask open-ended questions that encourage patients to provide more detail. "And how is this affecting your personal life?" can throw wide the gate of communication.

Empathy is equally important, but it must be sincere. "Don't say things like 'I understand,' because you really don't know what they're feeling," says Welters. "It comes across as false. Instead, use phrases such as, 'I understand from other patients who have had this condition that these are the things you might be feeling.''

The "drug seeker". Some patients are difficult to manage because they've become dependent on pain medication or another controlled substance. Often, these patients have a legitimate medical condition and are experiencing discomfort. Unfortunately, they become relentless in their pursuit of stronger drugs.

"Some patients will go to great lengths to get them from you and others," says Welters. "I had one patient who went from hospital to hospital saying she wasn't getting pain medication or anti-anxiety medication or sleeping pills from her physician. Ultimately, she started forging her own prescriptions."

The angry patient. If you've been in practice for any amount of time, you've no doubt experienced the angry patient who walks in with a chip on her/his shoulder and untenable expectations on her/his mind. She/he finds fault with the medical profession in general and, often, with

you, personally. “It’s important to keep your cool under any circumstance, but these are the ones who really test that,” says Wolf. “They say things like, ‘You’re late. What kind of care is this? I don’t know why I’m here; you can’t fix me anyway.’’

What works? Let the person vent briefly. Then follow up with a comment, such as, “I can see you’re very angry.” This sort of reflective response counts with these patients because it legitimizes their feelings. Often, adds Wolf, these are patients who feel impotent either in life or in the doctor-patient relationship. You can help to re-empower them. “Tell them, what you really want to do is work together to address their health concern,” says Wolf. “Let them know that they’re the one who ultimately makes the call on whether or not they choose to take the medication you prescribe. If you allow them to choose it on their own, they’ll choose it.”

All in the family. It’s not always the patient who causes problems, of course; sometimes it’s the spouse or adult children. “When you have a patient who is terminally ill, in particular, it’s usually the family who has the more unrealistic expectation of what can be done,” says Centor. “That’s a very difficult situation, partly, when they demand unnecessary tests for a patient that you know will only cause suffering and not do any good. It eats at your heart. You don’t want to get angry at the family, but you are angry at the family.”

His strategy for dealing with unruly families? Suggest they seek a second opinion. “Life and death situations are very emotional for families and for physicians,” says Centor. “It’s healthy to bring in another doctor who can back up what you are saying, which helps the family accept what you’ve already told them.” In a hospital setting, you might also obtain written confirmation from the ethics committee that they agree with your prescribed course of treatment.

The no-can-do-er patient. Though not actively combative, the non-compliant patient can be equally frustrating. Patients ignore healthcare advice for a variety of reasons, including fear of possible side effects, cost concerns, a belief that the treatment will be ineffective, and language or cultural barriers, to name a few. You can help your patients stick with a treatment plan, however, by taking the time to explain the reason for the test or medication you’ve prescribed and the consequences of failing to follow through. Where possible, use visual aids heart scans, blood pressure results to help drive the point home.

Here's one more reason: Many people simply forget most of what you've told them. If they can't remember, they can't comply. At the end of each visit, ask your patient if she has any questions or concerns. Then ask her to repeat back your instructions. Even better: Provide a written summary of the diagnosis, recommended treatment plan, alternative options, and the potential risks and benefits.

Emotionally needy patient. There is also, of course, the dependent or emotionally needy patient. "These patients want your attention all the time until it becomes suffocating," says Centor. "They feel they're the most important person in the world. They go from doctor to doctor until they find you and they eventually leave you, too, when you can't be there for them all the time."

You've likely dealt with such somatizing patients, who present with a mix of physical ailments for which there is no medical explanation. "This is very challenging for all of us," says Wolf. He says that some studies suggest half of all patients have at least one complaint with no biomedical basis. "I think doctors get frustrated and a lot of us resort to testing as a way of not dealing with that patient, perhaps not consciously, but we really don't know what else to do."

Instead, try judicious, limited testing. "When you're dealing with these patients for the first time, there's inevitably some diagnostic testing that needs to be done to make sure we're not missing something, but eventually, for patterns of physical symptoms that don't have a strong biological basis, try the lower cost, less risky treatment instead, especially if it's done for symbolic reasons," says Wolf.

Sometimes a request for a test is reasonable, but when it's expensive, dangerous, or totally unnecessary, you have to explain to the patient why you're not going to do that and you have to be willing to get fired for it."

It may seem counterintuitive, but you might also try seeing somatizing patients more often. "I try to bring them back more frequently than they can come up with complaints," says Wolf.

Depending on the severity of symptoms, he will usually recommend visits every two weeks to three months. This seeming "visit overkill" can actually reassure such patients, telling them that you're available to help them, no matter what. "Eventually, the focus of the interview moves away from how bad these symptoms are to how things are going in their life," says Wolf.

“The non-payer” pacient. For patients who fail to pay their bills, recognize that they’re not necessarily trying to wreak havoc on your accounts receivable. They may be working with their insurance company to resolve a claim dispute. Or, more likely, they may be having financial trouble at home. Ask late payers what your office can do to help write a letter to the patient’s insurer? Set up a payment plan? If the patient is truly struggling financially, your office may also choose to reduce its rate for services rendered, or work with hospitals and specialists to negotiate lower rates. “It’s like any business,” say Welters. “You have to negotiate with patients who can’t pay their whole bill, but can pay part of it. We sometimes reduce our fees for procedures performed.”

“Enough’s enough” pacient. If, despite all your best efforts, a patient continues to behave poorly, then you’ve got a responsibility to your practice to cut that person loose. “It probably should happen more often than it does,” says Welters. “I had one patient who called four or five times a day and spent an hour on the phone with our staff. I told her this is really interfering with our ability to care for other people.”

Doctors who become patients are also a group who can experience particular problems in the doctor–patient relationship. A study of recently *sick doctors* found that some doctor patients complained that they were not given information about their illness or were not counseled appropriately because it was assumed that they were already adequately informed, whereas they felt a need to occupy a more usual patient role and for the treating doctor to provide relevant clinical information and discuss their illness as they would with any other patient. Other doctor-patients thought they were too involved in the decision making and management of their illness because the treating doctor was unable to take control of the consultation. Some also commented that their doctor seemed embarrassed to treat them, with these problems being most common where the treating doctor was of a lower grade or younger than the patient. Most doctors commented that they found it instructive to experience the doctor–patient encounter from the patient’s perspective and some suggested that this transformed their professional sympathy into empathy.

Once you understand what makes some patients so difficult, it can be easier to follow the experts' suggested dos and don'ts.

Make sure you:

Observe: Notice a patient's words, voice or attitude to pick up on rising anger levels. Overly compliant behavior is also a warning sign that a patient has lost his identity and sense of competence, which can lead to vulnerability, fear, anger and violence. "Worries and loss of control often are triggers of aggression," says Simms, who urges nurses to trigger a sense of capability in patients, not one of vulnerability.

Connect: Uncover and directly address a patient's underlying feelings with comments such as, "You sound worried. What can we do to help?" Establishing a personal connection can go a long way toward gaining cooperation, Kuhn says.

Show Respect: Make eye contact, and try to approach patients at eye level. Always address patients as Mr. or Mrs., and speak in a friendly manner.

Slow Down: Rushing can be counterproductive, especially when caring for those with dementia.

Recruit Help: Enlist relatives to help break the isolation, create solutions and provide support.

Be Informed: Know your employer's patient bill of rights, as well as its policies and procedures for dealing with difficult patients.

Avoid:

Bullying: Don't use your caregiver status to threaten patients.

Making Assumptions: Most patients are not intentionally abusive or disruptive. They often are responding to an irritation, vulnerability, cognitive impairment, inability to express them or loss of identity.

Putting Up Walls: Distance just fuels patients' anger.

Tolerating Disruptive Behavior: Clearly explain what is unacceptable to avoid problems later.

Taking It Personally: "You can't expect that everyone at work will act pleasantly," Godfrey says. "Interpersonal mishaps or confrontations are guaranteed when you work with the public."

5. Therapeutic compliance

In the Oxford dictionary, **compliance** is defined as the practice of obeying rules or requests made by people in authority (Oxford Advanced Learner's Dictionary of Current English). In healthcare, the most commonly used definition of compliance is "*patient's behaviours* (in terms of taking medication, following diets, or executing life style chan-

ges) coincide with healthcare providers' recommendations for health and medical advice.

The **therapeutic compliance** refers to the match between medical prescription and their applications by the patient in order to obtain the cure of an illness. This therapeutic compliance implies a passive role of a patient, according to the medical model of the disease. Nowadays there is an emphasis on the active role of the patient and on the therapeutically negotiation in the doctor-patient relationship for the final therapeutically plan, which is called *therapeutic adherence* to treatment. This implies a professional transaction between doctor and patient in order to obtain final for of treatment, acceptable for both parts.

Thus, *therapeutic non-compliance* occurs when an individual's health-seeking or maintenance behavior lacks congruence with the recommendations as prescribed by a healthcare provider. Other similar terms have been used instead of compliance, and the meaning is more or less identical. For example, the term *adherence* is often used interchangeably with compliance. Adherence is defined as the ability and willingness to abide by a prescribed therapeutic regimen. Recently, the term *"concordance"* is also suggested to be used. Compared with "compliance", the term concordance makes the patient the decision-maker in the process and denotes patients-prescribers agreement and harmony. Although there are slight and subtle differences between these terms, in clinical practice, these terms are used interchangeably.

Examples of non-compliance:

- treatment modifications without consulting the doctor;
- demand of hospital discharge without medical advice;
- stop of treatment without medical advice.

Factors implicated in the therapeutic compliance imply:

Individual factors:

a. *Cognitive factors:*

- intelligence necessary to understand the medical prescriptions and the consequences;
- attention and memory for conversation retaining;
- importance of the medical language;
- the responsibility of the doctor to ask the patient if he/she understood the issues;

b. *Patient's defense mechanisms and coping strategies:*

- denial of the disease which implies no need of treatment;

- humor, as mature defense mechanism which can help the patient face the situation;
- avoidance of the situation which implies postponement the medical presentation, alcohol and other drug use, etc;
- confrontation with the situation: realistic confrontation/exaggeration;

c. *Social representation of the disease, treatment, etc*

- disease as shame, stigma, Divine punishment, challenge, etc;
- medicine as miraculous devices for cure (in alcoholism) or by the contrary, as unhealthy for the individual.

d. *Demographic factors*:

- age: children and old persons are less compliant than other age categories;
- sex of the patient: males complain more and complies less.

e. *Social support*

Factors due to the disease:

– degree of severity;

– degree of psycho-somatic discomfort (more pain means more compliance);

– fluctuation in symptoms: more compliance when symptoms are present than when symptoms absent;

– co morbidities: when several diseases are associated, compliancy decreases.

Factors due to therapeutic plan:

– plan too complex, with many restrictions and too many different types of pills;

– adverse effects of medicines or even secondary effects can lead to decreases in compliance;

– interaction between medicines.

Factors linked to the therapeutic relationship:

– good relationship means good compliance.

Methods to increase therapeutic compliance:

– medical education for doctors to observe the best moments for explanations;

– explaining to the patient the rationale for choosing a certain therapeutic plan;

– explaining to the patient the possibility of adverse effects of the medicines;

– shaping an adequate doctor/patient relationship, based on trust;

– using a simple therapeutic schema, explained to the patient and repeated by this one.

The therapeutic non-compliance

From the perspective of healthcare providers, therapeutic compliance is a major clinical issue for two reasons. Firstly, non-compliance could have a major effect on treatment outcomes and direct clinical consequences. Non-compliance is directly associated with poor treatment outcomes in patients with diabetes, epilepsy, AIDS (acquired immunodeficiency syndrome), asthma, tuberculosis, hypertension, and organ transplants. In hypertensive patients, poor compliance with therapy is the most important reason for poorly controlled blood pressure, thus increasing the risk of stroke, myocardial infarction, and renal impairment markedly.

Besides undesirable impact on clinical outcomes, non-compliance would also cause an increased financial burden for society. For example, therapeutic non-compliance has been associated with excess urgent care visits, hospitalizations and higher treatment costs. Additionally, besides direct financial impact, therapeutic non-compliance would have indirect cost implications due to the loss of productivity, without even mentioning the substantial negative effect on patient's quality of life.

Furthermore, as a result of undetected or unreported therapeutic non-compliance, physicians may change the regimen, which may increase the cost or complexity of the treatment, thus further increasing the burden on the healthcare system.

Hence, from both the perspective of achieving desirable clinical and economic outcomes, the negative effect of therapeutic non-compliance needs to be minimized. However, in order to formulate effective strategies to contain the problem of non-compliance, there is a need to systematically review the factors that contribute to non-compliance. An understanding of the predictive value of these factors on non-compliance would also contribute positively to the overall planning of any disease management program.

As a result, if they can get the necessary help from healthcare providers or family members, they may be more likely to be compliant with therapies.

Likewise, low compliance also occurs in adolescents and children with chronic disease. Their poorer compliance may be due to a lack of understanding or other factors relating to their parents or guardians. For adolescents, this period is often marked by rebellious behavior and disagreement with parents and authorities. They usually would prefer to live a normal life like their friends. This priority could therefore influence their compliance.

Misconceptions or erroneous beliefs held by patients would contribute to poor compliance. Patient's worries about the treatment, believing that the disease is uncontrollable and religious belief might add to the likelihood that they are not compliant to therapy. In a review to identify patient's barriers to asthma treatment compliance, it was suggested that if the patients were worried about diminishing effectiveness of medication over time, they were likely to have poor compliance with the therapy. In patients with chronic disease, the fear of dependence on the long-term medication might be a negative contributing factor to compliance.

Patients who had low motivation to change behaviors or take medication are believed to have *poor compliance.* There were studies reporting that for children or adolescents, treatment may make them feel stigmatized, or feel pressure because they are not as normal as their friends or classmates. A negative attitude towards therapy should be viewed as a strong predictor of poor compliance.

A patient-prescriber relationship is another strong factor which affects patients' compliance. A healthy relationship is based on patients' trust in prescribers and empathy from the prescribers. Studies have found that compliance is good when doctors are emotionally supportive, giving reassurance or respect, and treating patients as an equal partner (Lawson et al 2005). More importantly, too little time spent with patients was also likely to threaten patient's motivation for maintaining therapy.

Poor communication with healthcare providers was also likely to cause a negative effect on patient's compliance. In addition, multiple physicians or healthcare providers prescribing medications might decrease patients' confidence in the prescribed treatment.

Good communication is also very important to help patients understand their condition and therapy.

Health literacy means patients are able to read, understand, remember medication instructions, and act on health information. Patients with

low health literacy were reported to be less compliant with their therapy. On the contrary, patients who can read and understand drug labels were found to be more likely to have good compliance. Thus, using written instructions and pictograms on medicine labels has proven to be effective in improving patient's compliance.

But, patient's knowledge about their disease and treatment is not always adequate. Some patients lack understanding of the role their therapies play in the treatment; others lack knowledge about the disease and consequences of poor compliance, lack understanding of the value of clinic visits. Some patients thought the need for medication was intermittent, so they stopped the drug to see whether medication was still needed.

However, education is not always "the more the better". The patients who knew the life-long consequences might show poor compliance. Nevertheless, there is no report of similar observations in other age groups. In addition, patients' detailed knowledge of the disease was not always effective. They suggested that there was a gap between what the patients were taught and what they were actually doing.

Additionally, *forgetfulness* is a widely reported factor that causes non-compliance with medication or clinic appointments. Also, written instructions are better than oral advice for reminding patients to take medication.

Questions for self-evaluation:

1. In what consists the sick role of a patient?
2. Enumerate the main peculiarities of a patient.
3. Explain the term a "good" patient.
4. Enumerate the main patients' expectations from their doctors.
5. Define the "difficult" patient.
6. Explain in what boils down the strategy of any good communication.
7. What methods can be used to increase therapeutic compliance?
8. What problems create the therapeutic non-compliance?
9. Describe the patients with "poor compliance".
10. Describe the behaviour of health literacy patient.

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PSYCHOFARMACOLOGY. THE PLACEBO EFFECT

Structure:
1. Psychopharmacology.
2. Placebo: definitions and effects.
3. The placebo phenomenon and the doctor-patient relationship.

Key terms: psychopharmacology; psychoactive drugs; psychiatric medications; the placebo effect; the nocebo effect.

1. Psychopharmacology (from Greek psȳkhē, "breath, soul"; pharmakon, "drug"; and "logia" science) is the study of drug-induced changes in mood, sensation, thinking, and behavior.

The field of psychopharmacology studies a wide range of substances with various types of psychoactive properties. The professional and commercial fields of pharmacology and psychopharmacology do not mainly focus on psychedelic or recreational drugs, as the majority of studies are conducted for the development, study, and use of drugs for the modification of behavior and the alleviation of symptoms, particularly in the treatment of mental disorders (psychiatric medication). Psychopharmacology focuses primarily on the psychoactive and chemical interactions with the brain. Physicians who research psychiatric medications are psychopharmacologists, specialists in the field of psychopharmacology.

Psychoactive drugs may originate from natural sources such as plants and animals, or from artificial sources such as chemical synthesis in the laboratory. These drugs interact with particular target sites or receptors found in the nervous system to induce widespread changes in physiological or psychological functions. The specific interaction between drugs and their receptors is referred to as *"drug action"*, and the widespread changes in physiological or psychological function is referred to as "drug effect".

The use of psychoactive drugs predates recorded history. Hunter-gatherer societies tended to favor psychedelics, dissociatives and deliri-

ants, and today their use can still be observed in many surviving tribal cultures. The exact drug used depends on what the particular ecosystem a given tribe lives in can support, and are typically found growing wild. Such drugs include various psychedelic mushrooms and cacti, along with many other plants. These societies generally attach spiritual significance to such drug use, and often incorporate it into their religious practices.

With the proliferation of agriculture, new psychoactives came into use as a natural by-product of farming. Among them were opium, cannabis, and alcohol derived from the fermentation of cereals and fruits. Most societies began developing herblore, lists of herbs which were good for treating various physical and mental ailments.

In the latter half of the 20th century, research into new psychopharmacologic drugs exploded, with many new drugs being discovered, created, and tested.

Only since the 1950s has the use of psychiatric drugs to restore mental health, or at least limit aberrant behavior, been a part of medical therapeutics, when a number of new classes of pharmacological agents were discovered. Additionally, psychedelic drugs (*LSD* and *psilocybin)* and *empathogens* (MDMA) were popularized among many psychiatrists for a certain time, as very helpful tools to assist psychotherapy. *Lithium* is widely used to allay the symptoms of affective disorders and especially to prevent recurrences of both the manic and the depressive episodes in manic-depressive individuals.

Since scientists have found a direct relationship between dopamine blockage and reduction of schizophrenic symptoms, many believe that schizophrenia may be related to excess dopamine.

In *psychopharmacology*, researchers are interested in any substance that crosses the blood-brain barrier and thus has an effect on behavior, mood or cognition. Drugs are researched for their physicochemical properties, physical side effects, and psychological side effects.

Clinical studies are often very specific, typically beginning with animal testing, and ending with human testing. In the human testing phase, there is often a group of subjects, one group is given a placebo, and the other is administered a carefully measured therapeutic dose of the drug in question. After all of the testing is completed, the drug is proposed to the concerned regulatory authority, and is either commercially introduced to the public via prescription, or deemed safe enough for over the counter sale.

Though particular drugs are prescribed for specific symptoms or syndromes, they are usually not specific to the treatment of any single mental disorder. Because of their ability to modify the behavior of even the most disturbed patients, the antipsychotic, and antidepressant agents have greatly affected the management of the hospitalized mentally ill, enabling hospital staff to devote more of their attention to therapeutic efforts and enabling many patients to lead relatively normal lives outside of the hospital.

There are **six main groups of psychiatric medications.**

- **Antidepressants**, which treat disparate disorders such as clinical depression, dysthymia, anxiety, eating disorders and borderline personality disorder;
- **Stimulants**, which treat disorders such as attention deficit, hyperactivity disorder and narcolepsy, and suppress the appetite;
- **Mood stabilizers,** which treat bipolar disorder and schizoaffective disorder;
- **Anxiolytics** and **hypnotics** which treat anxiety disorders;
- **Depressants**, which are used as hypnotics, sedatives, and anesthetics;
- **Antipsychotics**, which treat psychoses such as schizophrenia and mania.

Antidepressants are drugs used to treat clinical depression, and they are also often used for anxiety and other disorders. Most antidepressants will restrain the catabolism of serotonin or norepinephrine or both. Such drugs are called selective serotonin reuptake inhibitors (SSRIs), and they actively prevent these neurotransmitters from dropping to the levels at which depression is experienced. SSRIs will often take 3–5 weeks to have a noticeable effect: the brain struggles to process the flood of serotonin, and reacts by downregulating the sensitivity of the autoreceptors which can take up to 5 weeks. Bi-functional SSRIs are currently being researched, which will occupy the autoreceptors instead of 'throttling' serotonin.

Common antidepressants: Citalopram (Celexa); Escitalopram (Lexapro); Paroxetine (Paxil); Fluoxetine (Prozac); Sertraline (Zoloft); Duloxetine (Cymbalta); Venlafaxine (Effexor); Bupropion (Wellbutrin); Mirtazapine (Remeron); Isocarboxazid (Marplan), Phenelzine (Nardil).

Stimulants

Stimulants are some of the most widely prescribed drugs today. A stimulant is any drug that stimulates the central nervous system. Adderall, a collection of amphetamine salts, is one of the most prescribed pharmaceuticals in the treatment of attention-deficit hyperactivity disorder (ADHD). Stimulants can be addictive, and patients with a history of drug abuse are typically monitored closely or even barred from use and given an alternative. Discontinuing treatment without tapering the dose can cause psychological withdrawal symptoms such as anxiety and drug craving. Stimulants are not physiologically addictive.

Common stimulants:

– Caffeine, typical stimulant found in many;
– Methylphenidate (Ritalin, Concerta), atypical stimulant;
– Dexmethylphenidate (Focalin), D-isomer of methylphenidate;
– Dextroamphetamine (Dexedrine), D-Amphetamine-based stimulant;
– Dextroamphetamine & levoamphetamine (Adderall), D, l-Amphetamine salt mix;
– Methamphetamine (Desoxyn), D-Methamphetamine-based stimulant;
– Modafinil (Provigil).

Stimulants, sometimes referred to as "uppers", reverse the effects of fatigue on both mental and physical tasks. Two commonly used stimulants are nicotine, which is found in tobacco products, and caffeine, an active ingredient in coffee, tea, some soft drinks, and many non-prescription medicines. Used in moderation, these substances tend to relieve malaise and increase alertness. Although the use of these products has been an accepted part of U.S. culture, the recognition of their adverse effects has resulted in a proliferation of caffeine-free products and efforts to discourage cigarette smoking.

Therapeutic levels of stimulants can produce exhilaration, extended wakefulness, and loss of appetite. These effects are greatly intensified when large doses of stimulants are taken. Physical side effects, including dizziness, tremor, headache, flushed skin, chest pain with palpitations, excessive sweating, vomiting, and abdominal cramps, may occur as a result of taking too large a dose at one time or taking large doses over an extended period of time.

Psychological effects include agitation, hostility, panic, aggression, and suicidal or homicidal tendencies. Paranoia, sometimes accompanied by both auditory and visual hallucinations, may also occur. Overdose is often associated with high fever, convulsions, and cardiovascular collapse.

Because accidental death is partially due to the effects of stimulants on the body's cardiovascular and temperature-regulating systems, physical exertion increases the hazards of stimulant use.

Mood stabilizers

In 1949, the Australian John Cade discovered that lithium salts could control mania, reducing the frequency and severity of manic episodes. This introduced the now popular drug, lithium carbonate to the mainstream public, as well as being the first mood stabilizer to be approved by the U.S. Food & Drug Administration. Many antipsychotics are used as mood stabilizers, though first resort remains a mood stabilizer such as lithium carbonate. Many mood stabilizers, with the exception of lithium, are anticonvulsants. The mechanism of action of mood stabilizers is not well elucidated or understood.

Common mood stabilizers:

– Lithium Carbonate (Carbolith), regular mood stabilizer;
– Carbamazepine (Tegretol), anticonvulsant mood stabilizer;
– Valproic acid (Valproate), anticonvulsant mood stabilizer;
– Valproate semisodium (Depakote), anticonvulsant mood stabilizer;
– Lamotrigine (Lamictal), atypical anticonvulsant mood stabilizer;
– Gabapentin, atypical GABAergic anticonvulsant mood stabilizer;
– Pregabalin, atypical GABAergic anticonvulsant mood stabilizer;
– Oxcarbazepine, anticonvulsant mood stabilizer;
– Topiramate, atypical sulfamate - substituted saccharide anticonvulsant mood-stabilizer.

Anxiolytics and hypnotics

Barbiturates were first used as hypnotics and as anxiolytics, but as time went on, benzodiazepines (Lowell Randall and Leo Sternbach, 1957) were developed in the 1960s and 1970s. Eventually they led to billions of doses being consumed annually. Originally thought to be non-dependence forming in therapeutic doses, unlike barbiturates, as prescriptions were increased, problems with addiction and dependence came to light. Benzodiazepines have widely supplanted barbiturates for treatment of almost all conditions in developed countries due to a much greater therapeutic ratio and less proclivity for overdose and toxicity.

Common anxiolytics & hypnotics:

– Diazepam (Valium), benzodiazepine derivative;
– Nitrazepam (Mogadon), benzodiazepine derivative;
– Zolpidem (Ambien, Stilnox), an imidazopyridine;

– Chlordiazepoxide (Librium), benzodiazepine derivative;
– Alprazolam (Xanax), benzodiazepine derivative;
– Temazepam (Restoril), benzodiazepine derivative;
– Clonazepam (Klonopin), benzodiazepine derivative;
– Lorazepam (Ativan), benzodiazepine derivative.

Depressants are psychoactive drugs that temporarily reduce the function or activity of a specific part of the body or brain. Examples of these kinds of effects may include anxiolysis, sedation, and hypotension. Due to their effects typically having a "down" quality to them, depressants are also occasionally referred to as *"downers"*. *Stimulants* or *"uppers"*, which increase mental and/or physical function, are considered to be the functional opposites of depressants. Depressants are widely used throughout the world as prescription medicines and as illicit substances. When these are used, effects may include anxiolysis, analgesia, sedation, somnolence, cognitive/memory impairment, dissociation, muscle relaxation, lowered blood pressure/heart rate, respiratory depression, anesthesia, and anticonvulsant effects. Some are also capable of inducing feelings of euphoria. Depressants exert their effects through a number of different pharmacological mechanisms, the most prominent of which include facilitation of GABA and/or opioid activity, and inhibition of adrenergic, histamine and/or acetylcholine activity. Anaesthetics, sedatives, tranquillizers and alcohol are examples of depressants.

Depressants are used both individually and clinically for therapeutic purposes in the treatment of a number of indications, including the following:

– To reduce feelings of anxiety, panic, and stress;
– To induce sleepiness and relieve insomnia;
– To induce analgesia and relieve aches and pains;
– To reduce convulsions/seizures in the treatment of epilepsy;
– To cause muscle relaxation for those with muscle pain or spasms;
– To lower blood pressure and/or heart rate;
– To boost the mood and/or enhance sociability.

Antipsychotics are drugs used to treat various symptoms of psychosis, such as those caused by psychotic disorders or schizophrenia. Antipsychotics are also used as mood stabilizers in the treatment of bipolar disorder, even if no symptoms of psychosis are present. Antipsychotics are sometimes referred to as neuroleptic drugs and some antipsychotics are branded "major tranquilizers".

There are two categories of antipsychotics: *typical antipsychotics* and *atypical antipsychotics*. Most antipsychotics are available only by prescription.

Common antipsychotics:

- Chlorpromazine (Thorazine), typical antipsychotic;
- Haloperidol (Haldol), typical antipsychotic;
- Perphenazine (Trilafon), typical antipsychotic;
- Thioridazine (Mellaril), typical antipsychotic;
- Thiothixene (Navane), typical antipsychotic;
- Trifluoperazine (Stelazine), typical antipsychotic;
- Aripiprazole (Abilify), atypical antipsychotic;
- Olanzapine (Zyprexa), atypical antipsychotic;
- Quetiapine (Seroquel), atypical antipsychotic;
- Risperidone (Risperdal), atypical antipsychotic;
- Ziprasidone (Geodon), atypical antipsychotic.

2. Placebo. Definitions and effects

A placebo has been defined as "a substance or procedure that is objectively without specific activity for the condition being treated". Under this definition, a wide variety of things can be placebos and exhibit a placebo effect.

Pharmacological substances administered through any means can act as placebos, including pills, creams, inhalants, and injections. Medical devices such as ultrasound can act as placebos. Sham surgery, sham electrodes implanted in the brain, and sham acupuncture, either with sham needles or on fake acupuncture points, have all exhibited placebo effects. Bedding not treated to reduce allergies has been used as a placebo to control for treated bedding. The *physician* has even been called a *placebo.*

Special studies found that patient recovery can be increased by words that suggest the patient “would be better in a few days”, and if the patient is given treatment, that “the treatment would certainly make him better” rather than negative words such as “"I am not sure that the treatment I am going to give you will have an effect". The placebo effect may be a component of pharmacological therapies: pain killing and anxiety reducing drugs that are infused secretly without an individual’s knowledge are less effective than when a patient knows that he is receiving them.

Likewise, the effects of stimulation from implanted electrodes in the brains of those with advanced Parkinson's disease are greater when they are aware they are receiving this stimulation.

The word ***'placebo',*** Latin for "I will please", dates back to a Latin translation of the Bible by Jerome. It was first used in a medicinal context in the 18th century. In 1785 it was defined as a "commonplace method or medicine" and in 1811 it was defined as "any medicine adapted more to please than to benefit the patient", sometimes with a derogatory (critical) implication but not with the implication of no effect. Placebos were widespread in medicine until the 20th century, and they were sometimes endorsed as necessary deceptions. In 1903 Richard Cabot said that he was brought up to use placebos, but he ultimately concluded by saying that "I have not yet found any case in which a lie does not do more harm than good". In 1961 Henry K. Beecher found that surgeons he categorized as enthusiasts relieved their patients' chest pain and heart problems more than skeptic surgeons. In 1961 Walter Kennedy introduced the word ***nocebo.***

The placebo phenomenon is related to the perception and expectation which the patient has; if the substance is viewed as helpful, it can heal, but if it is viewed as harmful, it can cause negative effects, which is known as the nocebo effect.

Expectancy and conditioning. Placebos exert (apply) an "expectancy" effect whereby an inert substance which is believed to be a drug has effects similar to the actual drug. Placebos can act similarly through classical conditioning, where a placebo and an actual stimulus are used simultaneously until the placebo is associated with the effect from the actual stimulus. Both conditioning and expectations play a role in placebo effect, and make different kinds of contribution.

Conditioning has a longer lasting effect, and can affect earlier stages of information processing. The expectancy effect can be enhanced (improved) through factors such as the enthusiasm of the doctor, differences in size and color of placebo pills, or the use of other inventions such as injections. In one study, the response to a placebo increased from 44% to 62% when the doctor treated them with "warmth, attention, and confidence".

Expectancy effects have been found to occur with a range of substances. Those who think a treatment will work display a stronger placebo effect than those who do not, as evidenced by a study of acupuncture.

Because the placebo effect is based upon expectations and conditioning, the effect disappears if the patient is told that their expectations are unrealistic, or that the placebo intervention is ineffective. A conditioned pain reduction can be totally removed when its existence is explained. It has also been reported of subjects given placebos in a trial of anti-depressants, that "Once the trial was over and the patients who had been given placebos were told as much, they quickly deteriorated."

Because placebos are dependent upon perception and expectation, various factors which change the perception can increase the magnitude of the placebo response. For example, studies have found that the color and size of the placebo pill makes a difference, with "hot-colored" pills working better as stimulants while "cool" colored pills work better as depressants. Capsules rather than tablets seem to be more effective, and size can make a difference. One researcher has found that big pills increase the effect while another has argued that the effect is dependent upon cultural background. More pills, branding, past experience, and high price increase the effect of placebo pills. Injection and acupuncture have larger effect than pills. Proper adherence to placebos has been found to decrease mortality.

Motivation may contribute to the placebo effect. The active goals of an individual, changes their somatic experience by altering the detection and interpretation of expectation-congruent symptoms, and by changing the behavioral strategies a person pursues. Motivation may link to the meaning through which people experience illness and treatment. Such meaning is derived from the culture in which they live and which informs them about the nature of illness and how it responds to treatment. Social observation can induce a placebo effect such when a person sees another having reduced pain following what they believe is a pain reducing procedure.

The placebo effect can work selectively. If an analgesic placebo cream is applied on one hand, it will reduce pain only in that hand and not elsewhere on the body. If a person is given a placebo under one name, and they respond, they will respond in the same way on a later occasion to that placebo under that name but not if under another.

The placebo effect could only be documented in studies in which the outcomes (improvement or failure to improve) were reported by the subjects themselves. The authors concluded that the placebo effect does not have "powerful clinical effects," (objective effects) and that patient-

reported improvements (subjective effects) in pain were small and could not be clearly distinguished from reporting bias.

Placebos do not work as strongly in clinical trials because the subjects do not know whether they might be getting a real treatment or a sham one. Where studies are made of placebos in which people think they are receiving actual treatment (rather than merely its possibility) the placebo effect has been observed. Other writers have argued that the placebo effect can be reliably demonstrated under appropriate conditions.

Similar to the placebo effect, inert substances have the potential to cause negative effects via the ***nocebo effect*** (*Latin nocebo = "I will harm").* In this effect, giving an inert substance has negative consequences.

Another negative consequence is that placebos can cause side-effects associated with real treatment. One example of this is with those that have already taken an opiate, can then show respiratory depression when given it again in the form of a placebo.

3. The placebo phenomenon and the doctor-patient relationship

A study of Danish general practitioners found that 48% had prescribed a placebo at least 10 times in the past year. The most frequently prescribed placebos were *antibiotics for viral infections***,** and *vitamins for fatigue.* Specialists and hospital-based physicians reported much lower rates of placebo use. A 2004 study in the British Medical Journal of physicians in Israel found that 60% used placebos in their medical practice, most commonly to "fend off" requests for unjustified medications or to calm a patient. The accompanying editorial concluded, "We cannot afford to dispense with any treatment that works, even if we are not certain how it does." Other researches have argued that open provision of placebos for treating ADHD in children can be effective in maintaining ADHD children on lower stimulant doses in the short term.

Critics of the practice responded that it is unethical to prescribe treatments that don't work, and that telling a patient that a placebo is a real medication is deceptive and harms the doctor-patient relationship in the long run. Critics also argued that using placebos can delay the proper diagnosis and treatment of serious medical conditions.

Roughly only 30% of the population seems susceptible to placebo effects, and it is not possible to determine ahead of time whether a placebo will work or not.

All placebo effects eventually wear off, thus making the placebo effect impractical for long term or chronic medical matters.

Patients rightfully want immediate relief or improvement from their illness or symptoms. A non-placebo can often provide that, while a placebo might not. Legitimate doctors and pharmacists could open themselves up to charges of fraud since sugar pills would cost pennies or cents for a bottle, but the price for a "real" medication would have to be charged to avoid making the patient suspicious.

About 25% of physicians in both the Danish and Israeli studies used placebos as a diagnostic tool to determine if a patient's symptoms were real, or if the patient was malingering. Both the critics and defenders of the medical use of placebos agreed that this was unethical. The British Medical Journal editorial said, "That a patient gets pain relief from a placebo does not imply that the pain is not real or organic in origin the use of the placebo for 'diagnosis' of whether or not pain is real is misguided."

Beyond ethical issues and the integrity of the doctor-patient relationship, prescribing pure placebos is bad medicine. Their effect is unreliable and unpredictable and cannot form the sole basis of any treatment on the NHS.

The desire for relief from pain, "goal motivation", and how far pain is expected to be relieved, increases placebo analgesia. Another factor increasing the effectiveness of placebos is the degree to which a person attends to his symptoms, "somatic focus". Individual variation in response to analgesic placebos has been linked to regional neurochemical differences in the internal affective state of the individuals experiencing pain.

Children seem to have greater response than adults to placebos.

For many patients doctors have accustomed to keep obligatory ritual: to write out the prescription. Doctors know that frequently only one form of the prescription operates more strongly, than the registered medicine, he can help the patient to get rid of excruciating pain. Medicines are obligatory not in all cases, and the belief in convalescence is necessary always. Therefore the doctor can write out a placebo when support and encouragement will bring more advantage to the patient, than the most well-known and expensive pills.

The placebo is an imitation of the medicine, the harmless tablets of dairy Saccharum packaged and packed the same as the present medicine.

Researches have shown, that 90% of people addressing for the help to doctors, suffer from the melancholy. The doctor sees that his experience and support is more important than the registered medicines, and he tries to not put off natural process of convalescence.

If the patient knows, that he is given a placebo it does not render any physiological effect. It once again confirms: *the organism of the person is capable to transform hope for convalescence to palpable biochemical changes.*

The placebo proves that it is impossible to part mentality and physiology. Illness can strike mentality and affect a physical condition, or, on the contrary, deterioration of a physical condition will be reflected in mental equilibrium.

But a placebo doesn't always work effectively. It is considered, that the success of application of a placebo directly depends on mutual relations of the doctor and the patient.

When there is no good human mutual relation between the doctor and the patient to apply a placebo it is useless. In this sense the doctor is, perhaps, the most important figure and process under the name "*placebo"*.

Questions for self-evaluation:

1. Define the area of psychopharmacology.
2. Enumerate and explain the effect of the main groups of psychiatric medications.
3. Characterize antidepressants.
4. Describe the action of stimulants.
5. Describe the effect of mood stabilizers.
6. Characterize anxiolytics and hypnotics.
7. Explain the action of depressants.
8. Identify the action of antipsychotics.
9. Explain the placebo phenomenon.
10. Describe the nocebo effect.
11. Explain the connection between the placebo and the patient expectation.
12. Why children show greater compliance than adults to placebos?
13. Describe the placebo phenomenon and the doctor-patient relationship

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PSYCHOTHERAPY. TYPES OF PSYCHOTHERAPY. MEDICAL APPLICATIONS OF PSYCHOTHERAPY

Structure:

1. Psychoanalysis.
2. Behavioral techniques.
3. Cognitive-behavioral therapy.
4. Client-centered therapy.
5. Family and group therapy.
6. The pedagogical psychotherapy used by doctors.

Key terms: psychotherapy; psychoanalysis; behavioral techniques; cognitive-behavioral therapy; treatment techniques; client-centered therapy; family and group therapy, pedagogical psychotherapy; psychotherapeutic treatment.

1. Psychoanalysis

Psychotherapy implies the treatment of mental or emotional disorders and adjustment of problems through the use of psychological techniques rather than through physical or biological means.

Psychoanalysis, the first modern form of psychotherapy, was called the "talking cure," and the many varieties of therapy practiced today are still characterized by their common dependence on a verbal ex-change between the counselor or therapist and the person seeking help.

Twentieth-century views on personality have been heavily influenced by the psychodynamic approach of Sigmund Freud who proposed a three-part personality structure consisting of the *id* (concerned with the gratification of basic instincts), the *ego* (which mediates between the demands of the id and the constraints of society), and the *super-ego* (through which parental and social values are internalized). In contrast to type or trait theories of personality, the dynamic model proposed by Freud involved an ongoing element of conflict, and it was these conflicts that Freud saw as the primary determinant of personality. His psychoanalytic method was designed to help patients resolve their conflicts by

exploring *unconscious* thoughts, motivations, and conflicts through the use of *free association* and other techniques.

The therapeutic interaction is characterized by mutual trust, with the goal of helping individuals change destructive or unhealthy behaviors, thoughts, and emotions. It is common for experienced therapists to combine several different approaches or techniques. Freudian psychoanalysis places emphasis on uncovering unconscious motivations and breaking down defenses. Therapy sessions may be scheduled once or even twice a week for a year or more. *This type of therapy is appropriate when internal conflicts contribute significantly to a person's problems.*

2. Behavioral techniques

According to the theory behind this approach, once behavior is changed, feelings will change as well. Probably the best-known type of behavioral therapy is *behavior modification,* which focuses on eliminating undesirable habits by providing positive *reinforcement* for the more desirable behaviors. Another behavioral technique is systematic *desensitization,* in which people are deliberately and gradually exposed to a feared object or experience to help them overcome their fears. A person who is afraid of dogs may first be given a stuffed toy dog, then be exposed to a real dog seen at a distance, and eventually forced to interact with a dog at close range. Relaxation training is another popular form of behavior therapy. Through such techniques as deep breathing, visualization, and progressive muscle relaxation, clients learn to control fear and anxiety.

In contrast to the psychoanalytic method of Sigmund Freud (1856-1939), which focuses on *unconscious* mental processes and their roots in the past, behavior therapy focuses on observable behavior and its modification in the present. Behavior therapy was developed during the 1950s by researchers and therapists critical of the psychodynamic treatment methods that prevailed at the time. It drew on a variety of theoretical work, including the *classical conditioning* principles of the Russian physiologist Ivan Pavlov (1849-1936), who became famous for experiments in which dogs were trained to salivate at the sound of a bell, and the work of American B.F. Skinner (1904-1990), who pioneered the concept of *operant conditioning,* in which behavior is modified by changing the response it elicits. By the 1970s, behavior therapy enjoyed

widespread popularity as a treatment approach. Over the past two decades, the attention of behavior therapists has focused increasingly

Many therapists have begun to use ***cognitive behavior therapy*** to change clients' unhealthy behavior by replacing negative or self-defeating thought patterns with more positive ones. As an initial step in many types of behavioral therapy, the client monitors his or her own behavior carefully, often keeping a written record. The client and therapist establish a set of specific goals that will result in gradual behavior change. The therapist's role is often similar to that of a coach or teacher who gives the client "homework assignments" and provides advice and encouragement. Therapists continuously monitor and evaluate the course of the treatment itself, making any necessary adjustments to increase its effectiveness. A number of specific techniques are commonly used in behavioral therapy. Human behavior is routinely motivated and rewarded by positive reinforcement. A more specialized version of this phenomenon, called *systematic positive reinforcement*, is used by behavior-oriented therapists. Rules are established that specify particular behaviors that are to be reinforced, and a reward system is set up. With children, this sometimes takes the form of tokens that may be accumulated and later exchanged for certain privileges. Just as providing reinforcement strengthens behaviors, withholding it weakens them. Eradicating undesirable behavior by deliberately withholding reinforcement is another popular treatment method called *extinction.* For example, a child who habitually shouts to attract attention may be ignored unless he or she speaks in a conversational tone. *Aversive conditioning* employs the principles of classical conditioning to lessen the appeal of a behavior that is difficult to change because it is either very habitual or temporarily rewarding. The client is exposed to an unpleasant stimulus while engaged in or thinking about the behavior in question. Eventually the behavior itself becomes associated with unpleasant rather than pleasant feelings. One treatment method used with alcoholics is the administration of a nausea-inducing drug together with an alcoholic beverage to produce an aversion to the taste and smell of alcohol by having it become associated with nausea. In counter conditioning, a maladaptive response is weakened by the strengthening of a response that is incompatible with it. A well-known type of counter conditioning is systematic desensitization, which counteracts the anxiety connected with a particular behavior or situation by inducing a relaxed response to it instead. This method is

often used in the treatment of people who are afraid of flying. ***Modeling,*** another treatment method, is based on the human tendency to learn through observation and imitation. A desired behavior is performed by another person while the client watches. In some cases, the client practices the behavior together with a model, who is often the therapist.

3. Cognitive-behavioral therapy

Some behavior-oriented therapy methods are used to alter not only overt behavior, but also the thought patterns that drive it. This type of treatment is known as ***cognitive-behavioral therapy*** (or just cognitive therapy). Its *goal is to help people break out of distorted, harmful patterns of thinking and replace them with healthier ones.*

Cognitive therapy is an approach to psychotherapy that uses thought patterns to change moods and behaviors, a therapeutic method based on the principle that maladaptive moods and behavior can be changed by replacing altered or inappropriate ways of thinking with thought patterns that are more desirable and more realistic.

In cognitive-behavioral therapy, a therapist may talk to the client, pointing out illogical thought patterns, or use a variety of techniques, such as thought substitution, in which a frightening or otherwise negative thought is driven out by substituting a pleasant thought in its place.

Pioneers in the development of cognitive behavior therapy include Albert Ellis (1929), who developed rational-emotive therapy (RET) in the 1950s, and Aaron Beck (1921-), whose cognitive therapy has been widely used for depression and anxiety. Cognitive behavior therapy has become increasingly popular since the 1970s. Growing numbers of therapists have come to believe that their patients' cognitive processes play an important role in determining the effectiveness of treatment. Currently, almost 70% of the members of the Association for the Advancement of Behavior Therapy identify themselves as cognitive behaviorists. Like behavior therapy, cognitive behavior therapy tends to be short-term (often between 10 and 20 sessions), and it focuses on the client's present situation in contrast to the emphasis on past history that is a prominent feature of Freudian psychoanalysis and other psychodynamically oriented therapies. The therapeutic process begins with identification of distorted perceptions and thought patterns that are causing or contributing to the client's problems, often through detailed record keeping by the client.

Some *self-defeating ways of thinking* identified by Aaron Beck include:

– all-or-nothing thinking;
– magnifying or minimizing the importance of an event;
– overgeneralization (drawing extensive conclusions from a single event);
– personalization (taking things too personally);
– selective abstraction (giving disproportionate weight to negative events);
– arbitrary inference (drawing illogical conclusions from an event); and
– automatic thoughts (habitual negative, scolding thoughts such as "You can't do anything right").

Once negative ways of thinking have been identified, the therapist helps the client work on replacing them with more adaptive ones. This process involves a repertoire of techniques, including self-evaluation, positive self-talk, control of negative thoughts and feelings, and accurate assessment of both external situations and of the client's own emotional state. Clients practice these techniques alone, with the therapist, and also, wherever possible, in the actual settings in which stressful situations occur (*in vivo*), gradually building up confidence in their ability to cope with difficult situations successfully by breaking out of dysfunctional patterns of response.

Today cognitive behavior therapy is widely used with children and adolescents, especially for disorders involving anxiety, depression, or problems with social skills. *The therapist then works to change erroneous beliefs and perceptions by instruction, modeling, and giving the child a chance to rehearse new attitudes and responses and practice them in real-life situations.* Cognitive behavioral therapy has worked especially well, often in combination with medication, for children and adolescents suffering from depression. It can help free depressed children from the pervasive feelings of helplessness and hopelessness that are supported by selfdefeating beliefs. Children in treatment are assignned to monitor their thoughts, and the therapist points out ways that these thoughts (such as "nothing is any fun" or "I never do anything right") misrepresent or distort reality. Other therapeutic techniques may include the completion of graded task assignments, and the deliberate scheduling of pleasurable activities.

Cognitive behavioral therapy is also used for children with conduct disorder, which is characterized by aggressive, antisocial actions, including hurting animals and other children, setting fires, lying, and theft. Through a cognitive behavioral approach (which generally works better with adolescents than with younger children because of the levels of thinking and control involved), young people with this disorder are taught ways to handle anger and resolve conflicts peacefully. Through instruction, modeling, role playing, and other techniques, they learn to react to events in socially appropriate, nonviolent ways. Other childhood conditions for which cognitive behavior therapy has been effective include generalized anxiety disorder and attention deficit/hyperactivity disorder. It can help children with ADHD become more controlled and less impulsive; often, they are taught to memorize and internalize the following set of behavior guidelines: "*Stop—Listen— Look—Think—Act."*

The treatment is based on the principle that maladaptive behavior (ineffective, selfdefeating behavior) is triggered by inappropriate or irrational thinking patterns, called *automatic thoughts.* Instead of reacting to the reality of a situation, an individual automatically reacts to his or her own distorted viewpoint of the situation. *Cognitive therapy* focuses on changing these thought patterns (also known as cognitive distortions), by examining the rationality and validity of the assumptions behind them. This process is termed cognitive restructuring. Cognitive therapy is a treatment option for a number of mental disorders, including agoraphobia, Alzheimer's disease, anxiety or panic disorder, attention deficit-hyperactivity disorder (ADHD), eating disorders, mood disorders, obsessive-compulsive disorder (OCD), personality disorders, posttraumatic stress disorder (PTSD), psychotic disorders, schizophrenia, social phobia, and substance abuse disorders. It can be useful in helping individuals with anger management problems, and has been reported to be effective in treating insomnia. It is also frequently prescribed as an adjunct, or complementary, therapy for patients suffering from back pain, cancer, rheumatoid arthritis, and other chronic pain conditions.

Cognitive therapy is usually administered in an outpatient setting (clinic or doctor's office) by a therapist trained or certified in cognitive therapy techniques. Therapy may be in either individual or group sessions, and the course of treatment is short compared to traditional psychotherapy (often 12 sessions or less).

Therapists are psychologists (Ph.D. or M.A. degree), clinical social workers (M.S.W., D.S.W., or L.S.W. degree), counselors (M.A. or M.S. degree), or psychiatrists (M.D. trained in psychiatry). Therapists use several different techniques in the course of cognitive therapy to help patients examine thoughts and behaviors.

These include:

• *Validity testing.* The therapist asks the patient to defend his or her thoughts and beliefs. If the patient cannot produce objective evidence supporting his or her assumptions, the invalidity, or faulty nature, is exposed.

• *Cognitive rehearsal.* The patient is asked to imagine a difficult situation he or she has encountered in the past, and then works with the therapist to practice how to successfully cope with the problem. When the patient is confronted with a similar situation again, the rehearsed behavior will be drawn on to deal with it.

• *Guided discovery.* The therapist asks the patient a series of questions designed to guide the patient towards the discovery of his or her cognitive distortions.

• *Journaling.* Patients keep a detailed written diary of situations that arise in everyday life, the thoughts and emotions surrounding them, and the behaviors that accompany them. The therapist and patient then review the journal together to discover maladaptive thought patterns and how these thoughts impact behavior.

• *Homework.* In order to encourage self-discovery and reinforce insights made in therapy, the therapist may ask the patient to do homework assignments. These may include note-taking during the session, journaling (see above), review of an audiotape of the patient's session, or reading books or articles appropriate to the therapy. They may also be more behaviorally focused, applying a newly learned strategy or coping mechanism to a situation, and then recording the results for the next therapy session.

• *Modeling.* Role-playing exercises allow the therapist to act out appropriate reactions to different situations. The patient can then model this behavior. Cognitive-behavioral therapy (CBT) integrates features of behavioral modification into the traditional cognitive restructuring approach. In cognitive-behavioral therapy, the therapist works with the patient to identify the thoughts that are causing distress, and employs behavioral therapy techniques to alter the resulting behavior. Patients

may have certain fundamental core beliefs, known as schemas, which are flawed, and are having a negative impact on the patient's behavior and functioning. For example, a patient suffering from depression may develop a social phobia because he/she is convinced he/she is uninteresting and impossible to love. A cognitive - behavioral therapist would test this assumption by asking the patient to name family and friends that care for him/her and enjoy his/her company. By showing the patient that others value him/her, the therapist exposes the irrationality of the patient's assumption and also provides a new model of thought for the patient to change his/her previous behavior pattern (i.e., I am an interesting and likeable person, therefore I should not have any problem making new social acquaintances).

Additional behavioral techniques such as *conditioning* (the use of positive and/or negative reinforcements to encourage desired behavior) and systematic desensitization (gradual exposure to anxiety-producing situations in order to extinguish the fear response) may then be used to gradually reintroduce the patient to social situations.

Cognitive therapy may not be appropriate for all patients. Patients with significant cognitive impairments (e.g., patients with traumatic brain injury or organic brain disease) and individuals who are not willing to take an active role in the treatment process are not usually good candidates. Because cognitive therapy is a collaborative effort between therapist and patient, a comfortable working relationship is critical to successful treatment. Individuals interested in cognitive therapy should schedule a consultation session with their prospective therapist before starting treatment. The consultation session is similar to an interview session, and it allows both patient and therapist to get to know one another. During the consultation, the therapist gathers information to make an initial assessment of the patient and to recommend both direction and goals for treatment. The patient has the opportunity to learn about the therapist's professional credentials, his/her approach to treatment, and other relevant issues.

Because cognitive therapy is employed for such a broad spectrum of illnesses, and is often used in conjunction with medications and other treatment interventions, it is difficult to measure overall success rates for the therapy. Cognitive and cognitive behavior treatments have been among those therapies not likely to be evaluated, however, and efficacy is well-documented for some symptoms and problems. Some studies

have shown that cognitive therapy can reduce relapse rates in depression and in schizophrenia, particularly in those patients who respond only marginally to antidepressant medication. It has been suggested that this is because cognitive therapy focuses on changing the thoughts and associated behavior underlying these disorders rather than just relieving the distressing symptoms associated with them.

4. Client-centered therapy

Client-centered therapy is an approach to counseling and psychotherapy that places much of the responsibility for the treatment process on the patient, with the therapist taking a non-directive role. Developed in the 1930s by the American psychologist Carl Rogers, client-centered therapy, also known as non-directive or Rogerian therapy departed from the typically formal, detached role of the therapist common to psychoanalysis and other forms of treatment. Rogers believed that therapy should take place in the supportive environment created by a close personal relationship between client and therapist. Rogers's introduction of the term "client" rather than "patient" expresses his rejection of the traditionally authoritarian relationship between therapist and client and his view of them as equals. The client determines the general direction of therapy, while the therapist seeks to increase the client's insightful self understanding through informal clarifying questions. Rogers believed that the most important factor in successful therapy was not the therapist's skill or training, but rather his or her attitude. Three interrelated attitudes on the part of the therapist are central to the success of client-centered therapy: *congruence, unconditional positive regard,* and *empathy.*

Congruence refers to the therapist's openness and genuineness, the willingness to relate to clients without hiding behind a professional facade. Therapists who function in this way have all their feelings available to them in therapy sessions and may share significant ones with their clients. However, congruence does not mean that therapists disclose their own personal problems to clients in therapy sessions or shift the focus of therapy to themselves in any other way.

Unconditional positive regard means that the therapist accepts the client totally for who he or she is without evaluating or censoring, and without disapproving of particular feelings, actions, or characteristics. The therapist communicates this attitude to the client by a willingness to

listen without interrupting, judging, or giving advice. This creates a non-threatening context in which the client feels free to explore and share painful, hostile, defensive, or abnormal feelings without worrying about personal rejection by the therapist.

The third necessary component of a therapist's attitude is empathy. The therapist tries to appreciate the client's situation from the client's point of view, showing an emotional understanding of and sensitivity to the client's feelings throughout the therapy session. In other systems of therapy, empathy with the client would be considered a preliminary step enabling the therapeutic work to proceed, but in client-centered therapy, it actually constitutes a major portion of the therapeutic work itself. A primary way of conveying this empathy is by active listening that shows careful and perceptive attention to what the client is saying.

In addition to standard techniques, such as eye contact, that are common to any good listener, client centered therapists employ a special method called reflection, which consists of paraphrasing and/or summarizing what a client has just said. This technique shows that the therapist is listening carefully and accurately and gives clients an added opportunity to examine their own thoughts and feelings as they hear them repeated by another person. Generally, clients respond by elaborating further on the thoughts they have just expressed.

Two primary goals of client-centered therapy are: *increased self-esteem* and *greater openness to experience. S*ome of the related changes that it seeks to foster in clients include increased correspondence between the client's idealized and actual selves; better self-understanding; decreases in defensiveness, guilt, and insecurity; more positive and comfortable relationships with others; and an increased capacity to experience and express feelings at the moment they occur.

Beginning in the 1960s, client-centered therapy became allied with the human potential movement. Rogers adopted terms such as "person-centered approach" and "way of being" and began to focus on personal growth and self-actualization. He also pioneered the use of encounter groups, adapting the sensitivity training (T-group) methods developed by Kurt Lewin (1890-1947) and other researchers at the National Training Laboratories in 1950s. While client-centered therapy is considered one of the major therapeutic approaches, along with psychoanalytic and cognitive-behavioral therapy, Rogers's influence is felt in schools of therapy other than his own, and the concepts and methods he developed

are drawn on in an eclectic fashion by many different types of counselors and therapists.

5. Family and group therapy

Family therapy has proven effective in treating a number of emotional and adjustment problems. While the client's immediate complaint is the initial focus of attention, the ultimate goal of family therapy is to improve the interaction between all family members and enhance communication and coping skills on a longterm basis (although therapy itself need not cover an extended time period). ***Group therapy***, which is often combined with individual therapy, offers the support and companionship of other people experiencing the same problems and issues. Therapy is finished when the treatment goals have been met or if the client and/or therapist conclude that it isn't working. It can be effective to phase out treatment by gradually reducing the frequency of therapy sessions. Even after regular therapy has ended, the client may return for periodic follow-up and reassessment sessions.

6. The pedagogical psychotherapy used by doctors

The goal of therapy, from the perspective of doctor's influence on patient's self-consciousness, is the improvement of patient's ability for self-management and mental self-regulation in order to actively counteract the illness.

Doctor should be by all means a psychologist because this will allow him to understand better the character and patient's individual reactions. Doctor should also be a teacher who possess didactic skills because some aspects of the psychohygiene demand this quality.

Pedagogical psychotherapy (individual or collective) can be successfully applied in any medical establishment, and it will help solve the following problems:

– Decrease of patients' level of ignorance.

– Decrease of the intensity of alarm feelings (like anger, guilt, shame, depression).

– Substantiation and suggestion of an optimistic medical prospect.

– Social involvement of the ill person.

During the sessions of pedagogical psychotherapy, mutual encouragement or so-called "psychotherapeutic mirror", experiences sharing and empathy are stimulated.

In order to be successful in the field of medical pedagogics, psychohygiene, psychoprophylaxis and psychotherapy it is necessary to develop some *professionally important qualities*:

– To be generous, indulgent and remain calm when there is a need to repeat something several times (education implies a lot of repetition).

– To take the position of an assistant, to avoid instructive tone, to remember and carry out a rule: "Help, do not humiliate".

– To be always punctual and strong-willed. The will is shaped through overcoming of difficulties and consequently it is necessary to learn from difficulties and obstacles, not to avoid them, but to meet and overcome.

– To be kind, to be able to forgive patients' tactlessness.

– To improve oneself: the knowledge, the personal qualities, indefatigably to search for new, more effective strategies for work.

– To share the experience with colleagues. To be able to listen, to develop in oneself not only the art of speech, but also the "art of silence".

A basis for good resistibility to illness, according to N.I. Rejnvalda's (1978), are the properties of the organism, the nervous system. The active vital position and, accordingly, intensive counteraction of illness, as a rule, are based on the account of interests of a society.

Patients, for whom appreciable social interests are characteristic, actively cooperate with the doctor during treatment. The major precondition for successful treatment is the development of conscious motivation for active overcoming of illness.

When talking about the relation "patient-illness" it is necessary to take into account the influence of psychogenic factors, the emotional condition of the patient, the disscusions between patients, the possible complications, the character of treatment, the forecast, etc. The estimation of illness is influenced by contact with seriously ill patients, by the information gathered from the conversations with acquaintances and family, or with the personnel. Quite often patients interpret tendentiously "cases from practice" - from educational films and magazines like "Health". Negative influences come from hospital conditions, isolation from habitual social medium and ceasing of work activities.

Carrying out correction of the patient's "concept" of illness, the doctor discusses with him the results of his inspections, convinces him, that the underlying causes of illness aren't the organic changes, helps the

patient to catch the connection between emotional factors and symptomatology. During this period the doctor gives the patient the corresponding information and acts as an expert.

Mutual relations with the patient go deep; the doctor becomes the assistant of the patient during his hard work in his private world.

At the final stage, the doctor strengthens the activity again and even direct it towards testing and fastening of the new ways of experience and behaviour by the patient.

For effective realization of any suggestions, the following are necessary:

– Deep contact with the patient.

– Clinical analysis, acquaintance with patient's social – psychological portrait.

– Separate psychotherapeutic methods and receptions during the reorganization of the system of attitudes of the person.

– Change of the attitude not only for the disputed experiences, but also for concrete, current, everyday situations.

– Coordination of personal and public interests, normalization of interpersonal attitudes, interactions with family, people, and society.

Main principles of simple psychotherapeutic treatment imply:

– To not overpersuade the patient that "he cannot have those attributes (symptoms) of which he complains", and on the contrary, to explain clearly the mechanism of occurrence of these attributes.

– When explaining, to use easy, clear examples from daily life.

– To guide the patient towards the right decision in a disputed situation so that he would think that he reached it without help, while he was all the time imperceptibly supervised.

– To carry out influence on the people from the patient's entourage in order to install confidence, that he does not have serious disease, but only some minor problems.

– If necessary, to involve other persons, for example wife, children, relatives, employees etc., when making a decision.

– If necessary, to refer to a psychiatrist.

– To not admit iatrogenic.

The most serious problem presently is the influence of stress on health. We are oppressed with an abundance of ideas, disagreements, opinions, which we fail to understand. We suffer from the excess of information which simply we are not capable to acquire. In result - chaos

and confusion, a set of strong sensations and a disadvantage for the present feelings. Our nervous system is not an empty phrase, is not an invention. From this point of view, it is doubtful, that a placebo (or any other medicine) renders effect if not the person's of passionate aspiration to live. It adjusts the patient's perception of treatment and gives internal ability to the organism to struggle (resist) against illness.

The placebo transforms the will to live into a physical reality and guiding force.

Mental health professionals exist to improve the mental health of individuals, couples, and families. Because mental health covers a wide range of elements, the scope of practice greatly varies between professionals. Some professionals may enhance relationships while others treat specific mental disorders and illness. Often, as with the case of psychiatrists and psychologists, the scope of practice may overlap.

Most qualified mental health professionals will refer a patient or client to another professional if the specific type of treatment needed is outside of their scope of practice. Additionally, many mental health professionals may sometimes work together using a variety of treatment options such as concurrent psychiatric medication and psychotherapy.

Additionally, specific mental health professionals may be utilized based upon their cultural and religious background or experience.

Questions for self-evaluation:

1. Explain the working technique of psychotherapy.
2. Identify the main theories of psychoanalysis.
3. Explain the strategy of cognitive therapy as a treatment option for mental disorders.
4. Describe the client-centered therapy.
5. Identify the main principles of cognitive-behavioral therapy.
6. Explain the role of three interrelated attitudes in client-centered therapy: congruence, unconditional positive regard, and empathy.
7. Identify the two primary goals of client-centered therapy.
8. Explain the strategy of family and group therapy.
9. Explain the main theories of pedagogical psychotherapy.
10. What imply the main principles of psychotherapeutic treatment?

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THE PSYCHOHYGIENE AND PSYCHOPROPHYLAXIS

Structure:
1. The health culture.
2. Main concepts of psychohygiene.
3. Main concepts of psychoprophylaxis.

Key terms: the health culture; burnout syndrome; psycho-hygiene; psychic health protection; megalopolis syndrome; mental disorder prevention.

1. The health culture

The theme of the cultural behaviour and the good manners of the individual is an old and eternal one. In the course of time approval has been granted to different cultural rules, norms and requirements for behaviour, activity and lifestyle. From among these regulated rules there are some mandatory, eternal and undeviating, subject just of life and health of the human beings, united in the concept health culture.

The health culture is defined as a combination of knowledge, adjustments, relationships, persuasions and behaviours in regard to restoration, protection, becoming a stronger individual and social health. The health culture has not just medical, but also social, psychological, pedagogic, juridical, legal, economical etc. elements. The well being both of the single person and of the entire society depends on the way they are constructed and combined.

As every other culture, the culture of health shows the existence of knowledge and behaviour for health protection and is shown in the observance of rules of hygienic and labour norms, rest, feeding, sleeping, engaging in sports, entertainment etc., formed as an individual position and an internal conviction of the individual. In the same time it is a normative system presenting mandatory requirements to all

members of the society and it could be expressed as a morality, ethics or a popular opinion and behaviour. Existence of the high culture of health and education turns the individual into more useful for the society and for itself, helps it to develop itself and to become perfect in harmony with the environment and with the requirements of its own nature.

The physical development includes the processes of growth, development and maturing and is determined by the condition of the structure, morphologic and functional characterizations of the organism, which are in the basis of the development of the age of the individual. There are two groups used as indicators to measure and evaluate it:

1) *anthropometric* - on their part are divided into somatoscopic, somatic and physiometric and

2) *biological age* indicators including: dental and bone age indicators and virility indicators.

The physical growth is determined by the influence of internal factors inheritable, innate, hormonal, metabolic, and by extraneous factors of feeding, engaging in sports, etc.

An important regulator and stimulator of the physical development is the *systematic motive activity and engaging in sports of the growing up.* The motive activity is a physiological need of the organism as well as the air, nutrition and water. The positive effects for the organism in result of the systematic motive activity and engaging in sports are outlined in three directions: *generally developing effects, recovering strengthening and educational*. For example, the energetic motive action leads to considerable changes of the support-motive system the bone growth rate and the constructing of bone microstructure, there are higher height indicators, bodily mass, mass of the skeleton muscularity etc. Concerning the heart system the positive effects consists of improvement of the heart blood irrigation at the expense of the capillary network, increased heart mass, the percussive capacity, the values of the pulse frequency and of the maximum arterial blood pressure are lowered which leads to more effective and frugal heart activity.

The above mentioned norms for twenty-four-hour motive activity ensure to the growing up organism above all strong and harmonious body development, emotional equability, high efficiency and good health. If the implementation of the norms is under 50 % then the condition of motive deficit occurs. When the latter becomes chronic and

is accumulated in the organism, a hypodynamya condition occurs, considered a pre-morbid one and a significant risk factor for many diseases. It consists in low steadiness and resistance of the organism, getting fat, degraded functional possibilities of the organs and of the systems of the organism, low resistance, adaptive and protective abilities, anxiety and depression, decreased activity, general condition and mood of the individual, etc.

The etiology of ***psycho-hygiene*** come from (psyche greek - soul, spirit, consciousness; higienos greek - healing, sanative) - healing soul; ***psycho-prophylaxis*** (psyche greek - soul, spirit, consciousness; prophylaktikos greek - protecting) protecting soul.

The correct development of the psyche and psychic health of young boys and girls is influenced by two types of factors: *inborn* (genetic) and *social* (from the family or out-of-family environment). In the terms of psycho-hygiene of great importance are the social factors because if we know them we could avoid them, and their unwholesome influence averted. The family environment factors, that most frequently influence in disadvantageous way on the developing of unstable psychic, are:

a) disagreement between parents that makes young boy or girl unreliable, depreciates the authority of the parents, very often deprives them of parental love and confidence;

b) parental attitude to the child of emotional indifference and coldness or of excessive love and care. Out-of-family disadvantageous influences are connected with regards to the bad social and psychic climate in school and the bad example of the street, in places of public resort.

When conditions and preconditions for unreal, defective and incorrect reflection of the environment are set up it is possible a prolonged conflict with the environment which leads to harming of the psychic health. In this regard the psycho hygiene and psycho-prophylaxis develop actions ensuring adequate adapting and satisfying of biological, psychic and social needs. The psychic health constructs itself on these needs. Depending on to what extents are satisfied these needs, is formed up the psychic equilibrium or non-equilibrium of the individual, which traces the trends for further psycho-hygiene and psycho-prophylactic activity.

How vital it is to cherish your mental health?

Do you know that your mental health which seems alright and stable now can get totally messy tomorrow? Yes, it's true, because the line between sanity and craziness is indeed very thin. Any more or less shaky stress or depression can push you towards a mental disorder.

Did you know that there are so many mental disorders attempting to chase you down and start possessing your mind that cherishing your psychological health and doing anything you can to prevent those shaky moments is vital? Did you know that some mental disorders are caused by continuous stress and depression? When was the last time you were depressed? Your answers to these questions are the best evidence of the fact that cherishing your mental condition really is important, they are your motivation to save yourself from such mental disorders and highly unpleasant conditions as personality, emotional, eating disorders, panic attacks, addictions, psychosis, bipolar disorders, phobias etc.

Did you know that every third person needs serious assistance of a professional who specializes in psychological disorders? Quite scary statistics, don't you think? Mental problems usually have certain signs which when noticed hint at the fact that if you don't deal with them ASAP, they may settle down in your head forever, and you wouldn't want that, would you?

As a rule the symptoms of mental disorders imply the fact that a person's behaviour becomes very different from what he/she has been before. Often signs of mental problems affect a person's ability to think and speak sensibly; even movements of a mentally disordered person are chaotic and prove that this person has serious difficulties going about his/her daily routines.

Now you know that the soon you detect problems within your mental health and the sooner you start dealing with them medically, the higher your chances to be healed are.

2. Main concepts of psychohygiene

Psychohygiene is the science of the protection and the acquisition of the mental health. The psychohygiene is an important protection factor, against the emergence of *burnout syndromes.*

The term was used already in the year 1900 by the german psychiatrist Robert Summer (1864 - 1937), which justified 1896 the psychiatric hospital pouring.

C. W. Beers postulated the *major tasks of the psychohygiene* as:

- Providing for the preservation of the mental health, preventing of spirit and nervous diseases and defect conditions.
- Perfection of the treatment and care that psychologically patients.
- Clearing-up over the meaning of the psychological anomalies for the problems of the education, the economic life, that criminality and at all the human behaviors.

These tasks are to be fulfilled by promotion of the social welfare service and cooperating with public and private social institutions.

Tasks according to *World Federation of Mental Health*: "Mental health means a condition, which favors the optimal physical, intellectual and emotional development of the individual, as far as this development with other individuals gets along. A healthy society is that, which secures such a development of its members and around its own upward development, under tolerance opposite at the same time is differently anxious to societies."

K. Mierke sees *three levels of the psychohygiene:*

1. The preventive psychohygiene has the healthy attitude of the individual and the society as a goal.

2. The restitutive psychohygiene is to be introduced in anxious life crises or conflict situations promptly as regenerative and corrective measures.

3. The curative psychohygiene takes care of restrictions already existing, in order to heal these with clinical or psychotherapeutical procedures.

There are some factors which influence the personality mental state:

- Emotions. There are things and events in this life and those are events that make us feel the peculiar way. We always have responses for each thing and event that matters. We have those responses and those are emotions we have about them. It is common for people to have emotions; it is the reaction of our psychic.

There is nothing wrong in emotions and there is nothing wrong in expressing those. But, there are people that hide their emotions. They hide aggression they have and they hide other negative emotions and with this behavior they cause a great damage to their psychics, you know. There should be the way out for emotions because emotions are like storm. Imagine, what will happen with your flat in case you lock a storm there. And the same happens to your psychic when you lock your

emotions inside of you. No one says that you have to shout and yell at people, but you need to find the let-out for your emotions because otherwise they will tear you apart one day. Emotions need the way out and so express those.

- Hard feelings. There are people in this life and they are people of our lives. They are our friends and they are our relatives or they are just people we know and people we work together with, or they are people we are in love with. They are of different characters and different nature and sometimes we care about them and sometimes we don't. As a the rule, we never have hard feelings about those people we don't care about but we always have something like hard feelings when it is about those people we love. We take as the offences those things they say or do and we keep that offence and emotions of it deep inside of us. We put the poison into our hearts and that stuff poisons us and our mental health. There is no way for people to act like that. All those hard feelings need the way out or otherwise they will greatly damage you and your psycho. On case there is an offence of you, then you have to talk about it to that person you have hard feelings for. You have to clear thing out and reduce the inner pressure.

- Inner factors. The second and the most dangerous group of factors are about those that come from the inside. The outside factors may be defeated and may be ignored by people and it is possible to run away from those and give a rest for your psychic. Though, there is no way for people to run away from those factors in case they are deep inside of people. Those are hard feelings people have and those are unsolved problems of people. And those are also unsaid words people keep in their minds and so on and so forth. Our brain is constantly operating and it never stops and so we have all those thoughts of us and in most cases people are thinking about all those problems they have because they know that those problems have to be solved. And it is the inner factor of the stress people undergo; it is the inner factor of the negative stress people undergo. And there is no way to reduce that stress by loneliness or running away. Inner factors are more dangerous and so people have to deal with those and they need help of doctors in order to deal with those.

- Attack from the outside. In case dealing with those are factors that influence our mental health we should say that those may be divided into two main groups. And those groups are about external and internal

factors that damage out psychic and so our mental health. Here it is all about the external factors, about factors that come from the outside. They are people around us and it is our work we have and those duties we have according to the job we must do. And those are cars on the streets that are recognized by people as a prospective danger and it is a noise all over in the streets that also irritates people. The outside factors mean everything we have around us and that everything is all those things we would like to throw out of this life but we can't. And so, we grow mad and irritated about each of those factors and it is another stress for our psychic. There is no way for people to get rid of those actors but they can run away from those at least for a while. Each person need a silent rest from time to time, it is the necessary procedure under conditions of nowadays.

- Bad news. People need to know about all those events in the world and they like watching TV and reading newspapers because there they can find the whole information they need. Though, today that news are mostly of negative kind and so every single day people take a huge mass of negative information. That information influences people and provokes certain emotions of them. In case those are bad news and bad information them it is common that provoked emotions are also of negative kind. People may forget about news and live further but they have already got the doze of negative stress that damaged their psychic. TV is another factor that influences out mental health and that actually damages and weakens our mental health. And that is why there is no way for people to neglect it and they have to ask for psycho council's help in order to deal with that whole negative stress and in order to improve their mental health till that health is not influencing their physical condition. Bad news means negative information and negative information means stress, constant stress.

- Megalopolis syndrome. Have you ever pay your attention to those people on the streets? Have you ever pay your attention to you when you are at the street? If you did, then you must have noticed that they are (and you are also) people with dull faces. There are no positive emotions on faces of those people and they are stern and cold and angry and aggressive. It is like they see no one and nothing around them. And they are people with an ability to ignore everything around them in case it has nothing to do with them. They are nervous and aggressive and in case you collide with one that one and you will grow angry at once. It is

the megalopolis syndrome of people. They are mad and aggressive because their mental health and their psycho are health damaged. It is the megalopolis syndrome and it is typical for every second liver of the city. It is a result of damaged psycho and constant and permanent stress people undergo. They need something to reduce that pressure and so they need some relaxing activities and they also need loneliness from time to time.

Mental health is a big deal, though sometimes people underestimate it. They don't know that mental health is greatly connected with physical one and the first one influences the second one. And there are factors that condition out mental health, out psycho state. The more of stress there is for our psycho – the greater damage is. And they are nervous and difficult situations that are the reasons for that stress. People that live in the city are people deprived of calm and peace. There are always folks around them and there is that whole fuss of the city and there is no peace and rest, you know. So, the psycho of city people is always under the pressure and it is not that easy for our mental immunity to resist that stress. So, the longer and greater that stress it the harder it is for our mental immunity to resist it and when the immunity is totally exhausted the mental problems start. People grow nervous and they grow angry and aggressive. Even the tiniest problem may make people run mad and that aggression is usually expressed vividly. People need more of mental rest and peace.

3. Main concepts of psychoprophylaxis. Psychotherapy directed toward the prevention of emotional disorders and the maintenance of mental health [psycho + prophylaxis].

To prevent means: action so as to avoid, forestall, or circumvent a happening, conclusion, or phenomenon.

Prevention in medicine is seen as action taken to decrease the chance of getting a disease. For example, cancer prevention includes avoiding risk factors (such as smoking, obesity, lack of exercise, and radiation exposure) and increasing protective factors (such as getting regular physical activity, staying at a healthy weight, and having a healthy diet). Prevention also means taking advance measures against the occurrence of something possible or probable; prefer.

For instance, disease/disorder prevention /control: increasing human or animal resistance against disease (e.g., immunization), control

of transmission agents, prevention and control of environmental hazards, or for prevention and control of social factors leading to disease; includes preventive measures in individual cases; postcoordinate with specific disease.

Mental disorder prevention imply the decreasing the risk of mental disorders, including the prevention and control of social factors leading to mental disease.

1. Discuss the concept "socially important illnesses".
2. Which of the school diseases are closely connected and conditioned by the harmful factors of school society, and are called "specific professional diseases"?
3. What is the reason about stress in pupils' age and what are the ways and means to its overcoming and compensating?

In principle the *psycho-hygiene* and *psycho-prophylaxis* are directed to psychic health protection by the means of:

1) setting up of the optimum for the nerve system and brain functioning and complete development of the psychic qualities and characteristics of the individual;
2) settling (of) many-sided, humane and interindividual relationships;
3) building up skills to manage stress and resolve conflicts;
4) eliminating of the conditions that form tiredness and overfatigue;
5) raising of the resistance of the psyche against harmful environment factors;
6) promotion of the role of the sport and physical culture for psyche and psychic health consolidation;
7) ensuring sufficient restorative and regular sleep for the organism;
8) harmonizing between labor and rest, and sleep and free time spent according to the hygiene, in order to achieve a steady protection against psychic loads and failures;
9) setting up the conditions for labour that satisfies and ensures positive emotions.

Among the leading reasons for the school diseases are: chronic mind tire and overwork, irregular nutrition, bad hygiene conditions and discomfort, systematic lack of rest, abuse with alcohol, smoking, drugs, stress factors, etc. Stress in school age is in most cases connected to:

long-lasting psycho-emotional traumatic situations, created by teachers, school authorities, chronic informational and regime entrusts and overloads, constant anxiety, fear of examination, of failure, lack of time,

etc. The wide-spread psychology of unhealthy behaviour, altogether with the unrealistic optimism, underrating of health threats, coming from the risk factors, the skepticism and the mistrust to health initiatives, primitive ideas for the illness, low health culture, etc. contributes to extend of diseases and risks for the student's health.

The prophylactics of school illnesses needs extending of the personal responsibility of the students for their own health and for the health of the others; development of some private skills for dealing with the stress; reducing the harmful habits and situations, supporting the unhealthy way of life - reducing of the abuse with alcohol, drugs, smoking, popularization of sports, regular nutrition, organized rest, etc.

The change in the way of life of the young people by providing of duly information for their health and the threatening risk factors, as well as the creation of conditions for formation of skills, values, relations, inviting to healthy choices in complicated life situations and to health-approbating models of behaviour, contributes to protecting from illnesses and risks and lead them to a healthy lifestyle.

Questions for self-evaluation:

1. Explain the topic of mental health culture.
2. Define mental health.
3. What factors can contribute to mental health?
4. What factors can disturb the personality mental state?
5. Name major tasks of the psychohygiene, postulated by C. W. Beers.
6. Name common goals of psychohygiene and psychoprophylaxis.
7. Define the etiology of the term psychoprophylaxis
8. What measures imply the mental disorder prevention?
9. What measures imply the prophylactics of school illnesses?

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Appendix

International Statistical Classification of Diseases and Related Health Problems - 10th Revision		
Chapter	**Blocks**	**Title**
I	A00-B99	Certain infectious and parasitic diseases
II	C00-D48	Neoplasms
III	D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
IV	E00-E90	Endocrine, nutritional and metabolic diseases
V	F00-F99	**Mental and behavioral disorders**
VI	G00-G99	Diseases of the nervous system
VII	H00-H59	Diseases of the eye and adnexa
VIII	H60-H95	Diseases of the ear and mastoid process
IX	I00-I99	Diseases of the circulatory system
X	J00-J99	Diseases of the respiratory system
XI	K00-K93	Diseases of the digestive system
XII	L00-L99	Diseases of the skin and subcutaneous tissue
XIII	M00-M99	Diseases of the musculoskeletal system and connective tissue
XIV	N00-N99	Diseases of the genitourinary system
XV	O00-O99	Pregnancy, childbirth and the puerperium
XVI	P00-P96	Certain conditions originating in the perinatal period
XVII	Q00-Q99	Congenital malformations, deformations and chromosomal abnormalities
XVIII	R00-R99	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified
XIX	S00-T98	Injury, poisoning and certain other consequences of external causes
XX	V01-Y98	External causes of morbidity and mortality
XXI	Z00-Z99	Factors influencing health status and contact with health services
XXII	U00-U99	Codes for special purposes

Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)

1. Classification of mental disorders usually first diagnosed in infancy, childhood, or adolescence

- Mental retardation
- Learning disorders
- Motor skill disorder
- Communication disorders
- Pervasive developmental disorders
- Attention-deficit and disruptive behavior disorders
- Feeding and eating disorders of infancy or early childhood
- Tic disorders
- Elimination disorders
- Other disorders of infancy, childhood, or adolescence

2. Delirium, dementia, and amnestic and other cognitive disorders

- Delirium
- Dementia
- Amnestic disorders
- Other cognitive disorders

3. Mental disorders due to a general medical condition not elsewhere classified substance-related disorders

- Alcohol-related disorders
- Amphetamine use disorders
- Amphetamine-induced disorders
- Caffeine-related disorders
- Cannabis-related disorders
- Cocaine-related disorders
- Hallucinogen-related disorders
- Inhalant-related disorders
- Nicotine-related disorders
- Opioid-related disorders

4. Phencyclidine-related disorders

- Sedative-, hypnotic-, or anxiolytic-related disorders
- Polysubstance-related disorder
- Other, or unknown substance-related disorder

5. Schizophrenia and other psychotic disorders

- Mood disorders
- Depressive disorders
- Bipolar disorders

6. Anxiety disorders

- Somatoform disorders
- Factitious disorders
- Dissociative disorders

7. Sexual and gender identity disorders

- Sexual dysfunctions
- Paraphilias
- Gender identity disorders

8. Eating disorders

9. Sleep disorders

- Primary sleep disorders
- Sleep disorders related to another mental disorder

10. Impulse-control disorders not else where classified

11. Adjustment disorders

12. Personality disorders

13. Other conditions

MULTIAXIAL CLASSIFICATION SYSTEM

- Axis I – Clinical disorders; other conditions that may be a focus of clinical attention
- Axis II – Personality disorders; mental retardation
- Axis III – General medical conditions
- Axis IV – Psychosocial and environmental problems
- Axis V – Global assessment of functioning.

Possible helpful strategies in dealing with difficult patients:

1. Try to be firm and direct but appear concerned and compassionate rather than judgemental or disgusted. Ask about washing, laundry, toileting. Be prepared for patients to deny problems.
2. Examine your own reactions: Ask yourself "What is it about this particular person that makes me react negatively to them?"
3. Consider your communication skills.
4. Consider, "Am I a heartsink doctor?"
5. Keep a reflective diary.
6. Review the patient's notes.
7. Consider a change of focus - think about the person behind the illness; consider what life is like in their shoes.
8. Share the problem within the practice or with a colleague from outside the practice. Peer group discussions of difficult cases may be helpful. What are others' perceptions and insights?
9. Consider a meeting to establish ground rules for your continuing doctor-patient relationship. Make this non-confrontational, if possible. Benchmark - some patients have no idea what the average consultation or referral rate is. Agree how and when you will meet.
10. Be explicit about what you (personally, the practice, the NHS in general) can provide as well as your limitations.
11. Try to be in control of the relationship. If you feel that you are being manipulated, decide whether this a battle worth fighting and whether or not to disclose to the patient that you recognise their behaviour (they may not).
12. Make sure that all those in contact with the patient (e.g. reception staff, nurses, out-of-hours workers) behave consistently and are aware of your management plan.
13. Do not take responsibility for areas over which you have no power. Behavioural change must come from the patients themselves.
14. Where the doctor-patient relationship fails despite remedial actions, the best course of action is to pass the patient to an alternative doctor within the practice or beyond.
15. Remember your successes.

Some techniques for calming patients down

Before you can resolve an issue for a frustrated patient, you must first engage them in a way that will calm them down enough to make a rational discussion possible. Each situation is unique and should be handled as such, but there are recognized techniques that are generally effective in calming patients.

Let the patient vent. In most cases, patients who are difficult just want to let off some steam. They want to get their dissatisfaction or a perceived slight off their chest and they want someone to listen and acknowledge them. For this reason, your first strategy for dealing with an angry or difficult patient should be to let them vent. Moving too quickly into problem-solving and failing to give the patient a chance to express his or her feelings is likely to backfire. Some patients will blow off steam in fifteen seconds and others will take five minutes. Give them the time they need to work through their frustration.

Step back and say to yourself, "OK, this is where I let them get it all out." While the patient is venting their frustration or telling their story, you can begin to develop a rapport by using phrases like, "That sounds frustrating," "I see," "Go on," or "And then what happened?" When the patient is finished be sure to ask, "Is there anything else I should know about this?" This way you are certain to get all of the details about the cause of their anger or frustration.

Apologize and agree. After the patient has vented completely, it's time to apologize for their inconvenience and explain why the problem occurred. If you do this before they vent they will not listen to you because they haven't felt heard, and your explanations will only make them angrier. Don't blame anyone, simply apologize. Use statements like, "I understand how upset this situation has made you," or "I'm sorry this happened, but I'm glad you're bringing it to our attention."

It's difficult to continue to argue or be upset with someone who is agreeing with you. But be careful not to "admit fault" or agree in a way that might put your hospital, clinic, or one of your healthcare providers at risk for a malpractice claim. For example, you would not want to say, "You are absolutely right, we should have gotten you scheduled for that x-ray much sooner than we did." But you can agree that the issue is frustrating for the patient and empathize with their situation. "I'm sorry you've had this scheduling problem. Let's work to get you on the schedule now."

Doctor Phil's Personality Test

Instruction: Respond to these 10 questions, by choosing one of the answers proposed below:

1. When do you feel you're best?

a) in the mornings
b) during the afternoon and early evening
c) late at night

2. You usually walk...

a) fairly fast, with long steps
b) fairly fast, with little steps
c) less fast head up, looking the world in the face
d) less fast, head down
e) very slowly

3. When talking to people you

a) stand with your arms folded
b) have your hands clasped
c) have one or both your hands on your hips
d) touch or push the person to whom you are talking
e) play with your ear, touch your chin, or smooth your hair

4. When relaxing, you sit with..

a) your knees bent with your legs neatly side by side
b) your legs crossed
c) your legs stretched out or straight
d) one leg curled under you

5. When something really amuses you, you react with...

a) big appreciated laugh
b) a laugh, but not a loud one
c) a quiet chuckle
d) a sheepish smile

6. When you go to a party or social gathering you...

a) make a loud entrance so everyone notices you
b) make a quiet entrance, looking around for someone you know
c) make the quietest entrance, trying to stay unnoticed!

7. You're working very hard, concentrating hard, and you're interrupted.....

a) welcome the break
b) feel extremely irritated
c) vary between these two extremes

8. Which of the following colors do you like most?

a) red or orange
b) black
c) yellow or light blue
d) green
e) dark blue or purple
f) white
g) brown or gray

9. When you are in bed at night, in those last few moments before going to sleep you are..

a) stretched out on your back
b) stretched out face down on your stomach
c) on your side, slightly curled
d) with your head on one arm
e) with your head under the covers

10. You often dream that you are...

a) falling
b) fighting or struggling
c) searching for something or somebody
d) flying or floating
e) you usually have dreamless sleep
f) your dreams are always pleasant

POINTS:

1. (a) 2 (b) 4 (c) 6
2. (a) 6 (b) 4 (c) 7 (d) 2 (e) 1
3. (a) 4 (b) 2 (c) 5 (d) 7 (e) 6
4. (a) 4 (b) 6 (c) 2 (d) 1
5. (a) 6 (b) 4 (c) 3 (d) 5 (e) 2
6. (a) 6 (b) 4 (c) 2
7. (a) 6 (b) 2 (c) 4
8. (a) 6 (b) 7 (c) 5 (d) 4 (e) 3 (f) 2 (g) 1
9. (a) 7 (b) 6 (c) 4 (d) 2 (e) 1
10. (a) 4 (b) 2 (c) 3 (d) 5 (e) 6 (f) 1

Now add up the total number of points.

OVER 60 POINTS: Others see you as someone they should "handle with care." You're seen as vain, self-centered, and who is extremely dominant. Others may admire you, wishing they could be more like you, but don't always trust you, hesitating to become too deeply involved with you.

51 TO 60 POINTS: Others see you as an exciting, highly volatile, rather impulsive personality; a natural leader, who's quick to make decisions, though not always the right ones. They see you as bold and adventuresome, someone who will try anything once; someone who takes chances and enjoys an adventure. They enjoy being in your company because of the excitement you radiate.

41 TO 50 POINTS: Others see you as fresh, lively, charming, amusing, practical, and always interesting; someone who's constantly in the center of attention, but sufficiently well-balanced not to let it go to their head. They also see you as kind, considerate, and understanding; someone who'll always cheer them up and help them out.

31 TO 40 POINTS: Others see you as sensible, cautious, careful and practical. They see you as clever, gifted, or talented, but modest. Not a person who makes friends too quickly or easily, but someone who's extremely loyal to friends you do make and who expect the same loyalty in return. Those who really get to know you realize it takes a lot to shake your trust in your friends, but equally that it takes you a long time to get over if that trust is ever broken.

21 TO 30 POINTS: Your friends see you as painstaking and fussy. They see you as very cautious, extremely careful, a slow and steady plodder. It would really surprise them if you ever did something impulsively or on the spur of the moment, expecting you to examine everything carefully from every angle and then, usually decide against it. They think this reaction is caused partly by your careful nature.

UNDER 21 POINTS: People think you are shy, nervous, and indecisive, someone who needs looking after, who always wants someone else to make the decisions and who doesn't want to get involved with anyone or anything! They see you as a worrier who always sees problems that don't exist. Some people think you're boring. Only those who know you well know that you aren't.

Hippocratic Oath – Modern Version

I swear to fulfill, to the best of my ability and judgment, this covenant:

I will respect the hard – won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.

I will apply, for the benefit of the sick, all measures [that] are required, avoiding those twin traps of over treatment and therapeutic nihilism.

I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon`s knife or the chemist's drug.

I will not be ashamed to say "I know not," nor will I fail to call in my colleagues when the skills of another are needed for a patient`s recovery.

I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and of my own frailty. Above all, I must not play at God.

I will remember that do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person`s family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.

I will prevent disease whenever I can, for prevention is preferable to cure.

I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sounds of mind and body as well as the infirm.

If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.

Written in 1964 by Louis Lasagna, Academic Dean of the School of Medicine at Tufts University, and used in many medical schools today.